Princes Park Health Centre:
The Destruction of Community Based GP Services

Keep Our NHS Public Merseyside
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PRINCES PARK HEALTH CENTRE: 
THE DESTRUCTION OF 
COMMUNITY BASED GP SERVICES

“Dr Cyril Taylor who started up that surgery back then had a dream, and a plan to bring the best health care to the patients and that’s what those doctors have done for decades. To see that decimated by a private company is totally unacceptable, so I am going to stay and I am going to fight this and hope that we can get our surgery back to where it was”

Princes Park Health Centre patient

Contributors

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February 2015
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Finally a special thank you to all the patients of Princes Park Health Centre who completed the surveys, provided accounts of their experiences, attended meetings and will continue the fight for health care.
FOREWORD

We all know the NHS is being privatised, but the injustice experienced by the people of Liverpool 8 revealed in this report still took our breath away. The Health & Social Care Act 2012 included the abolition of Primary Care Trusts (PCTs). As part of the ensuing reorganisation, contracts for the salaried GP surgeries that had been held by the PCT were put out to tender.

As soon as Princes Park Health Centre was handed to a private company - SSP Health Ltd (on April Fools Day 2013), patients, staff and campaigners started screaming about it, but no-one in power was listening.

One of the SSP directors had already written to the Telegraph backing Lansley’s monster Health and Social Care Bill: the other runs over twenty companies including property and private medical care. Healthcare services at Princes Park Health Centre started to deteriorate from day one and it is clear that the priority for those running the practice has shifted from patients to profit.

The authorities responsible for providing primary care services did nothing, so Keep Our NHS Public Merseyside took the trouble to organise a meeting in Arabic, English and Somali, giving voice to the community whose views had been ignored at every step. Their words, and findings from the survey they completed are reported here.

Princes Park is not the only Health Centre enduring a similar disintegration, and we all need to raise awareness and create a swell of public opinion to ensure that those responsible for running health services listen and acknowledge that privatisation is not working and our NHS is not for sale.

Members of Keep Our NHS Public Merseyside

February 2015
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EXECUTIVE SUMMARY

This report reveals a practice in chaos, unable to fulfil its responsibilities for patient care. Patients living in the Princes Park area of Liverpool are being let down by a system that does not care.

Although on a smaller scale and of a different nature, the similarities between what is happening at Prince Park Health Centre (PPHC) and what occurred in Mid Staffordshire NHS Foundation Trust are unnerving.

In the executive summary of the Francis report into the findings from the inquiry into Mid Staffordshire NHS Foundation Trust, there is a section on ‘Lessons learned and related key recommendations’. In this, Francis identified negative aspects of the culture that were in part responsible for the failure of authorities to listen and respond to what was happening. These were:

- A lack of openness to criticism;
- A lack of consideration for patients;
- Defensiveness;
- Looking inwards not outwards;
- Secrecy;
- Misplaced assumptions about the judgements and actions of others;
- An acceptance of poor standards;
- A failure to put the patient first in everything that is done.

Despite cries of never again, the NHS has not learned, because, each and every one of these can be found in the PPHC story.

BACKGROUND

Renowned for its innovative approach to patient care in the 70s and 80s, PPHC was regarded as a beacon in the world of primary care. It provided high quality holistic care through services that met the health needs of the local community. Despite the challenging environment; with a relatively mobile population and a high proportion of immigrants speaking many different languages, PPHC supported a cadre of dedicated, committed staff; and it was a place where people enjoyed working. This was at a time when practices in deprived areas elsewhere were struggling to recruit staff and provide an adequate service.

The deterioration at PPHC from a flagship model of community-based primary care to being ranked in the bottom 300 out of nearly 8,000 GP practices in the country² appears to have started with the introduction of salaried GPs. This was linked to increasing bureaucracy and a reduction in practice freedoms to innovate. Enthusiastic staff who wanted to make a difference used to be attracted to PPHC, but instead they started to move on. A prime example of what happens when health care becomes subject to market forces.

The quality of services deteriorated dramatically when PPHC was taken over in April 2013 by SSP Health Ltd, a private health care provider based in Wigan. In 2011, services at PPHC along with twelve other practices in Liverpool were put out to tender and eventually ended up as part of the larger contract managed by SSP Health. This resulted in GPs being employed by a company, which owns over 40 surgeries throughout the North West. Since the beginning of the NHS in 1948, GPs have been independent contractors, owning their practices. Thus instead of the practice being the equivalent of the small corner shop, it has become more like a branch of a huge supermarket chain.

² www.liverpoolecho.co.uk/news/health/see-how-good-your-gp-7398685 and https://gp-patient.co.uk/

Keep Our NHS Public (KONP) Merseyside raised the alarm when the contract for GP services at PPHC went out to tender but as this report will show, important questions about that process remain unanswered. Following the takeover of the practice by SSP, KONP has on several occasions met with senior staff from Liverpool CCG and NHS England Merseyside, the two agencies responsible for primary care, in an attempt to get them to address the problems emerging at PPHC, but with little success. In April 2014, with the situation continuing to deteriorate, KONP organised a survey and a public meeting in the Kuumba Imani Centre. The meeting brought together members of the local Arabic, English and Somali speaking communities in order to understand the effect of these changes on patient care; find out more about what was happening; give a voice to those not being heard and explore options to improve the situation. Accounts of patients’ experiences given at the meeting, in depth interviews with patients and a patient access survey provided a wealth of data about what patients were actually experiencing when trying to access and use services provided at PPHC.

Patients expressed a high level of dissatisfaction. One of the most commonly articulated issues was that patients found it increasingly difficult to get an appointment and as a result they suffered a serious delay in receiving care; or were driven to use A&E or walk-in centres inappropriately.

Numerous minor clinical errors were reported and the over reliance on locums has caused a serious lack of continuity of care. By January 2015 there were no full time and only three part time permanent GPs at PPHC. A tight appointment schedule, means that patients with complex chronic conditions spend too much of their allotted time relaying their story, leaving insufficient time for an adequate consultation. Locums coming to PPHC do not know the patients well and tend to be from outside the area. They have little knowledge or understanding of the community, the needs of the different groups or the structure of the various support services. There are insufficient practice nurses with one of the consequences being that clinics such as the well woman clinic, which was pioneered at Princess Park, being permanently discontinued.
Similarly a reduction in the number of experienced administrative staff means that the day-to-day functions necessary for the smooth running of the Centre are often not completed. The original ethos of PPHC where everyone worked together to meet the needs of the community has been lost. Rather it has become a place where relative strangers come to work for a company whose primary responsibility is to maximise profits for the shareholders and where the needs of patients are secondary.

Results from the national Ipsos Mori survey of GPs (published in July 2014 and covering the time since SSP took over responsibility for primary care services) corroborate the findings from the local community survey and issues expressed so clearly at the community meeting. The national survey shows that PPHC was below CCG (regional) average in every aspect of care.3

When KONP tried to raise awareness of issues with staff from NHS England (Merseyside Local Area Team) and Liverpool CCG, they encountered very little concern or interest. Despite the wealth of evidence to the contrary, an opinion was expressed that PPHC was no worse than other practices. A CQC inspection of PPHC took place in January and PPHC failed in three key areas. An improvement programme was implemented and on re-inspection in June 2014, PPHC was certified as meeting national standards.4 KONP has concerns about the depth and manner of the inspection undertaken by CQC.

Patients were advised to express their concerns through their local patient participation group. However, since SSP took over responsibility for PPHC there has only been a single meeting called (Jan 2014) and even this was held during the day at an inconvenient time for most people. The opportunity to have a meaningful discussion through this channel is non-existent.

3 https://gp-patient.co.uk/practices/N82076?term=Princes+Park+++Ssp+Health+Limited+%28L8+0SY%29
This report, in addition to presenting background to the demise of PPHC and an overview of the current situation includes recommendations about what needs to be done to ensure patients at PPHC receive the service to which they are entitled.

RECOMMENDATIONS

These recommendations mirror some of those from the Francis report into the Mid Staffordshire crisis. They require SSP company directors and every person serving patients at PPHC to be held to account, so that we end up with a safer, committed, compassionate and caring service at PPHC.

1. In practice, this means that Merseyside area team of NHS England and the local CCG should take responsibility for the services they commission and develop a common set of core values. They must create a system which recognises and applies the values of transparency, honesty and candour. They should measure the commitment to these values (i.e. cultural health) in all parts of the commissioning system.

2. The patients at PPHC must be the first priority. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.

3. There must be zero tolerance of any aspect of the service provided at PPHC that does not comply with fundamental standards. The Directors of SSP and those who are responsible for providing such care must be held to account. Standards need to be formulated not only to conform to regulations or the letter of the law as written in the GP contract, but must rather promote the spirit of good quality care. This will increase the likelihood of the service being delivered safely and effectively.

4. It is important that Merseyside area team of NHSE as the commissioner, and the CCG listen to the narrative contained in this report and take
appropriate action, since it gives a voice to those who are not empowered to complain and be heard.

5. Commissioners must be prepared to take action to put patients first and intervene where substandard or unsafe services are being provided. They must take control and provide alternate services or take other measures necessary to protect patients from the risk of harm. They must order a provider such as SSP to stop provision of a GP service that is not up to standard.

6. Serious non-compliance with quality standards for care or non-compliance leading to actual or potential harm to patients, should render the Directors of SSP liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.
BACKGROUND AND HISTORY OF PRINCES PARK HEALTH CENTRE

During the 1980’s the innovative approach taken at Princes Park Health Centre (PPHC) prefigured many of the practices that are common today.

PPHC was established by councillor and GP Cyril Taylor in 1977 and from its inception the centre pioneered new approaches to medicine derived from a holistic view of patient health, with an emphasis on preventing illness rather than simply reacting and curing when it struck. The approach took patients’ lives and associations into account in order to give their health care a social context. At PPHC, patients established a relationship with their GP; practice nurses ran clinics supporting people with long term conditions and an experienced administrative team ensured smooth running of the practice with records kept up to date and prescriptions filled etc. The Centre was seen by patients and staff as an essential part of the community.

For example, PPHC was one of the first practices in the country to have social workers, a physiotherapist and district nurses. The GPs understood the need for these services as they often saw patients in their own homes. PPHC was also the first outside of London to have its own ‘Well Woman Clinic’. The area of Liverpool at the time was very poor with many people living isolated lives. Many patients were survivors of mental, physical or sexual abuse and Drs Katy Gardner and Sheila Abdulla participated in local campaigns for women’s rights and took a keen interest in the mental health of their patients as well as their physical wellbeing. This was an unusual approach in a decade that tended to treat mental illness as something shameful.

The end of the 80s and the dawning of the 90s brought a change in the demographics of PPHC, with many of the original black British residents having moved away. A host of overseas conflicts brought a new wave of refugees from areas such as Kosovo, and the Somali and Yemeni communities expanded. Indeed the majority of refugees living in the city were registered to PPHC at one time.
This was also the decade in which problems began. The relatively low income that GPs received as a part of a partnership in a deprived area deterred many from working at PPHC. The doctors who had previously been self-employed became salaried and employees of the NHS; which allowed PPHC to attract fresh faces. However, this caused its own problems as bureaucracy and the need to hit various targets stifled the organic creativity that had previously blossomed at PPHC. Under the previous system the waiting room had been host to poetry readings and art exhibitions, but these bursts of colour were replaced by mandated questioning of patients and the enforcement of what at times felt like somewhat arbitrary targets.

Many of the refugees and asylum seekers had difficulties communicating in English and PPHC introduced a system of extra length appointment for people with English as a second language, which served to direct resources to the most vulnerable people and communities.

A process of tendering for GP services was introduced during the latter years of the Labour government and expanded in recent years by the Tories. The ten salaried GP practices in Liverpool including PPHC were put out to tender. The first attempt failed and the process had to be repeated, resulting in considerable uncertainty and many staff leaving.

**Figure 1: Diverse views of Toxteth**
BACKGROUND TO THE CURRENT SITUATION

Although Tony Blair's new Labour government introduced the widespread provision of NHS clinical services by the private sector, the Cameron coalition government expanded and accelerated the process.

Two months after the coalition came to power, the GP magazine ‘Pulse’ reported that over 200 surgeries were already being run by private companies.5

The NHS support federation obtained data from PCTs on the spread of APMS (Alternative Provider Medical Services) contracts, which surged following the Labour Government's nationwide rollout of Darzi centres and APMS practices. It found that 227 GP surgeries and health centres in England were run by 23 commercial companies, with nine firms, including Chilvers McCrea, Care UK and Assura Medical (taken over by Virgin), holding ten or more contracts. Other companies that were making big inroads into the primary care market included Intrahealth, The Practice PLC and Malling Health.

As Glasgow GP Margaret McCartney earlier recounted in the Financial Times (‘Like a beast put into our cage’, 1st Sept 2007), the story starts in Creswell, in north-east Derbyshire. In 2005, the practice went out to tender, a government initiative designed to increase competition among potential healthcare providers. UnitedHealth Europe (part of the UnitedHealth Group, a multi-billion dollar US corporation) was appointed as preferred bidder and then won the tender. Local resident Pam Smith challenged this decision and later applied to the Appeal Court, arguing that the community had not been adequately consulted in the tender process. The Department of Health claimed there was no need to consult the community. The appeal was upheld in August 2006, and in February 2007, the new tender was won by another

5 www.pulsetoday.co.uk/private-companies-now-running-more-than-200-gp-surgeries/11036525.article#.U-3h81RdUuk
private healthcare company, Chilvers McCrea. The GP previously employed at
the Cresswell surgery, Dr Elizabeth Barrett, wrote a detailed account of the
tendering process and her own bid to run the surgery as a community service.
She commented:

“UnitedHealth Europe has, as its president, Simon Stevens, who
was advisor on health policy to Downing Street for seven years
until he left to take over his senior role in UHE. Not only did he
have in-depth advance knowledge of the thrust of the new White
Paper, he must have played a part in designing the legislation.
The question needs to be asked as to whether the playing field
can ever be level under these circumstances. It doesn’t matter
how excellent an NHS practice is, it has not had the opportunity
to walk the corridors of power in this way.”

Simon Stevens is now Chief Executive of NHS England, the organisation created
under the 2012 Health and Social Care Act to commission GP services.

In the midst of the Derbyshire battle, Sefton PCT announced plans to privatise
a surgery in Maghull. In September 2006 over 150 furious local residents,
including many pensioners, packed a meeting called by Keep Our NHS Public. In 2007, as protests escalated in Sefton Council and the local media, Sefton PCT
reversed its plans.

Care UK and The Practice went on to acquire three sites in Liverpool. They are
among the group of 24 Sefton and Liverpool surgeries now managed by SSP.

The 350 page Health and Social Care Act 2012 contains detailed legislation
allowing the large scale privatisation of all aspects of the NHS in England and
that is what is now happening. Very large contracts for the long term provision
of a wide range of health services are being awarded to private sector

7 www.labournet.net/ukunion/0609/maghull1.html
8 www.labournet.net/ukunion/0704/maghull1.html)
companies (70% of contracts in the last 12 months have been given to private bidders), which means that taxpayers' money is being diverted into private shareholder profits rather than being reinvested in NHS health services.

There are widespread published accounts of inadequate private primary and secondary care services around the country - for example, the deaths which occurred as a result of acknowledged clinical management failures of the Harmoni GP out of hours service in Hackney and the Carillion-owned Surgicentre in Stevenage. Massive amounts of money have also been wasted on establishing complicated new legal and managerial structures for making privatisation and competition happen. In England, the term NHS no longer describes a national service but is increasingly a logo used for a contracting operation open to Europe-wide competition and - if the Government fulfils its intention of including healthcare within the forthcoming EU-US trade partnership - open to the full US private sector.

What health services require is of course collaboration, not competition. In summary, the impact on the English NHS of the Health and Social Care Act 2012 has been to remove:

- the Secretary of State’s duty to provide a National Health Service
- the requirement for a health service in every part of England (a universal service)
- the requirement for a full range of care in every part of England (a comprehensive service)
- the requirement for all healthcare to be free at the time of use

And thanks to enforced competition and to commercial confidentiality, we have also lost the possibility of seamless collaboration between the various health services we use (an integrated service).

The NHS is still going through a period of upheaval and many are wondering what can be done to prevent the backdoor privatisation that so often results in services being stripped away. Many PPHC patients and staff believe that the centre needs to return to its roots and the values it stood for originally.
Continuity of care is efficient and urgently needed so that staff can build up relationships with patients and better understand their needs. Staff, especially those in the front line, need to be nurtured, supported and valued for the great job that they do.
HOW SSP WON THE TENDER FOR GP SERVICES

The public was not consulted when in the summer of 2011 Liverpool Primary Care Trust (PCT) decided to put the management of PPHC and twelve other Liverpool surgeries out to tender, nor when in January 2012 the tender was aborted and the specifications changed, nor during the transition period after November 2012 when the contract was eventually awarded to SSP Health, a private company owned by two Wigan GPs.

PPHC was one of 10 PCMS practices whose staff, including GPs were directly employed by Liverpool Community Health, an NHS Trust formed following the PCT split into commissioning and provider arms. SSP was awarded a contract for the management of these PCMS practices along with two others already run privately by ‘The Practice’ and one by ‘Care UK’, and a further 10 surgeries in Sefton.

Keep Our NHS Public (KONP) campaigner Mr Sam Semoff, a patient at PPHC stated in December 2012 “There will certainly be changes to the service, but the public were never consulted. The PCT broke its own procedure.”

In Sept 2011, Mr Semoff asked Liverpool PCT for minutes of all meetings which discussed tendering for PCTMS practices (as they were originally called), and was told on 13 Sept 2011 that disclosing this information would prejudice commercial interests. The PCT also said it would not be in the public interest to disclose which healthcare providers had indicated interest.

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9 The former Liverpool PCMS practices were: Everton Road Health Centre, Fiveways Family Health Centre, Garston Family Health Centre, Kensington Park Practice, Marybone Health Centre, Netherley Health Centre, Park View Medical Centre, Princes Park Health Centre, Stanley Road Medical Centre and West Speke Health Centre. Breeze Hill and Robson Street surgeries were formerly managed by ‘The Practice’, while ‘Care UK’ managed Mersey View. SSP now also hold the contract for Orrell Park Medical Centre. The Office of Fair Trading “invitation to comment” in this link refers to 22 surgeries, (including the 10 Sefton practices): http://webarchive.nationalarchives.gov.uk/20130701191414/http://www.oft.gov.uk/OFTwork/mergers/Mergers_Cases/2012/SSPHealth

10 Liverpool PCT RFI/FOIA/7892
Mr Semoff asked “Which body originally proposed inviting tenders?” and was told “The North West Strategic Health Authority suggested that it was good practice to market test the services provided.” A year later, the PCT revealed that in November 2011 after the Department of Health (DH) had announced the abolition of the PCTs but long before the Health and Social Care Bill passed through Parliament, Deputy Chief Executive David Flory had written to all PCTs, stating “PCTs should divest themselves of any remaining PCTMS contracts by summer 2012”. Liverpool PCT took that as a direct instruction.

The PCT also told Mr Semoff in 2011 that there would be no consultation with the public as “as there is no material change specified in the tender for the services currently provided.”

In January 2012 the tender was aborted and the specifications changed so that work previously carried out by practice nurses would be done by GPs. This material change to the service required public consultation and also affected the financial basis of the tender. The decision to abort the process provoked protests from GPs as reported by GP Online in January 2012.11

A spokeswoman for Liverpool PCT and NHS Sefton said the decision had been taken because the specification for contractors failed to ‘adequately define the minimum standards of patient care’ required. Details have never been made public.

After the specifications were changed, Liverpool Community Health withdrew from bidding and a staff member told the Liverpool Daily Post (28 June 2012) that removing practice nurses “means the quality of care to patients would diminish” and the moves were simply “unsafe”.12


12 Liverpool Daily Post on 28 June 2012. A similar article appeared in the Liverpool Echo that day www.liverpoolecho.co.uk/news/liverpool-news/private-companies-set-tender-contract-3343341
SSP Health was founded in 2007 by Dr Shikha Pitalia and her husband Dr Sanjay Pitalia, who own all the shares in the Company.13 Shikha Pitalia, with a 51% stake in SSP, is an award-winning GP who signed a letter to the Telegraph on 10 May 2011 welcoming Andrew Lansley’s Health Bill, claiming it would bring “Enormous benefits to the most elderly, infirm and vulnerable”.14 Sanjay Pitalia, with 49%, is a director of 28 active companies, including those involved in property development and private medicine. Pall Mall Medical is one; its Manchester arm was founded in 2009 and a Liverpool branch opened in 2013. The CEO of SSP Health and Pall Mall Medical is Stephanie Byrom, formerly Primary Care Solutions Manager at Atos Origin (now known as Atos).15

Another company owned entirely by Shikha and Sanjay Pitalia was United League Commissioning LLP, which tried but failed to become the Clinical Commissioning Group (CCG) for St Helens and then for Wigan. The ULC company accounts list 25 directors, of whom 23 resigned on 1 May 2011, leaving only Shikha and Sanjay Pitalia. The company is now dissolved.16

In June 2011, the Advertising Standards Authority (ASA) heard a complaint. The SSP Health website claimed they operated Greenland Ave surgery in Bolton, whose GP said they did not. SSP Health explained that SSP Health was not a company name but rather an “identity name” used to refer collectively to the practices they were involved with. But according to Companies House, Company No: 06359596 SSP Health Limited is in the business of “The provision

13 The website www.duedil.com compiles information from Companies House, and shows that SSP Health Ltd is Company No. 06359596, with two shareholders, the husband and wife team of Wigan GPs Shikha Pitalia (51%) and Sanjay Pitalia (49%). Sanjay Pitalia is director of 33 companies, of which 28 are trading and includes Pall Mall Medical a private medical provider and several property companies.
15 http://uk.linkedin.com/pub/stephanie-byrom/20/154/845
16 www.duedil.com information on United Commissioning League LLP (Company Registration OC335981)
of general practitioners of medical services”. The ASA ruled against SSP
Health.\(^\text{17}\)

SSP Health was involved in one of the strategic pilot projects which
foreshadowed the Health and Social Care Act 2012. Their information pack
mentions awards for practice based commissioning and involvement with FESC
and ‘world class commissioning’.\(^\text{18}\) FESC was the framework for procuring
external support for commissioners, introduced by the Department of Health
(DH) in February 2007 towards the end of the Blair government.\(^\text{19}\)

In October 2007 under Prime Minister Gordon Brown, the Director General of
Commissioning at DH Mark Britnell sent a letter from DH to the Chief
Executives of all Strategic Health Authorities and Primary Care Trusts.\(^\text{20}\) He
announced the 14 FESC supplier companies. These are appointed to advise
SHAs and PCTs on the healthcare they should purchase. The companies were
some of the biggest players in the world of consultancy, insurance, and private
health, including Aetna Health Services, Axa PPP Healthcare, BUPA, Humana,
KPMG, McKinsey, UnitedHealth Europe, and Tribal Consulting.

Mr Britnell also announced seven possible pilot schemes, including Ashton,
Leigh and Wigan PCT. By 2008 ALWPCT was talking with UnitedHealth, BUPA,
Humana, McKinsey and Tribal. They gave Tribal Consulting a £4.8m three
year contract, to cover organisational development, practice based commissioning,
health information, shaping supply, demand and utilisation management, and

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\(^{17}\) Advertising Standards Authority Complaint Ref: 151501 www.asa.org.uk/Rulings/Adjudications/2011/6/SSP-
Health/TF_ADJ_50897.aspx#.U67S0VRdUuk

\(^{18}\) www.ssphealth.com/jobs/SSP%20Health%20Information%20Pack.pdf — NB the information pack is now
somewhat out of date as it incorrectly lists Dr Bal Duper as Medical Director.

\(^{19}\) http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstati-
istics/Publications/PublicationsPolicyAndGuidance/DH_065818

information management. The project used a risk stratification tool pioneered by Johns Hopkins University.\textsuperscript{21}

By 2011, most of Tribal’s health consultancy work was swallowed by Capita whose aim was to provide support services to GP commissioning consortia. In January 2012, Capita published its own glossy brochure on risk stratification, including a quote from Dr. Balwinder Duper, Clinical Lead of the Atherleigh consortium.\textsuperscript{22} Dr Duper stated:

“Capita is giving clinicians focus to work to structures that are rigorous, open to scrutiny, and allows for benchmarks against others. It has brought discipline to commissioning. They’ve transferred commissioning knowledge to me; now I’ll be able to pass it on.”

Dr Duper was previously SSP Health Medical Director, and is still identified as such in the SSP information pack, although in fact SSP no longer has a Medical Director (see next section). Dr Duper is a full time GP in Manchester and the Primary Care Quality Lead for South Sefton CCG.\textsuperscript{23}

For his part, Mark Britnell became Global Head of Health at KPMG and a member of the kitchen cabinet advising Cameron on the 2012 Health Bill. In October 2010 Mr Britnell told a NY conference “GPs will have to aggregate purchasing power and there will be a big opportunity for those companies that can facilitate this process ... In future, the NHS will be a state insurance provider, not a state deliverer ... The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years.”\textsuperscript{24}

\begin{itemize}
  \item \textsuperscript{21} \url{www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/1020/1020w229.htm}
  \item \textsuperscript{22} \url{www.capitaconsulting.co.uk/Downloads%20Capita%20Consulting/Risk%20stratification%20and%20predictive%20modelling%20service.pdf}
  \item \textsuperscript{23} \url{www.southseftonccg.nhs.uk/library/SSCG%20May%202014%20Part%201A.pdf}
  \item \textsuperscript{24} \url{http://www.spinwatch.org/index.php/issues/more/item/5343-%E2%80%9Cthe-nhs-will-be-shown-no-mercy-says-cameron-health-adviser}}
On 1 April 2013, as the Health and Social Care Act came into force, SSP took over responsibility for PPHC and 12 other Liverpool surgeries. They had been managing 10 Sefton surgeries since 31 January. A petition in Arabic, English and Somali, signed by hundreds of Toxteth residents, called for the authorities to consult the public over the decision to award the contract to SSP:

Restore our Health Centre, cancel SSP, consult the public.

“We, Liverpool 8 residents, call on all NHS commissioning bodies to reverse the decision to hand the management of Princes Park Health Centre to the private company SSP Health; restore the role of practice nurses; consult the public before any changes to our service.”

As part of the Act, responsibility for commissioning GP services had transferred to a new body, NHS England. When Keep Our NHS Public (KONP) members presented the petition to NHS England in April 2013, the group expressed concerns over how the contract had been awarded; the risks that continuity of care would be eroded by the use of locums; how the extra time required for vulnerable patients with multiple health issues and the use of interpretation services with non-English speaking patients would be affected. The group also highlighted the potential conflicts inherent in private management of a public service.

MEDICAL DIRECTOR OR COMPANY DIRECTOR?

Company Directors prioritise the financial functioning of their company and its returns to shareholders. A Medical Director is responsible for clinical governance – ensuring the care and safety of patients. The two roles are distinct, and disagreement is possible.

Previously, the Medical Director of SSP was Dr Bal Duper a Manchester based GP. However, following the announcement that the contract had been awarded to SSP, a KONP member Sam Semoff, who is also a patient at PPHC,
phoned SSP asking to speak to the Medical Director, only to be told that there wasn't one, and the Pitalias themselves were acting in that role.

Through a freedom of information (FOI) request in March 2013, KONP asked NHS England “Does the absence of a medical director pose risks either in the long term or the short term to patients?” and if so “what are those risks and if no medical director is in place by 1st April 2013, how will they be managed?”.

At their first meeting in April 2013, the local area team of NHS England Merseyside told KONP they would clarify this issue with SSP. In June 2013 NHS England Merseyside said that based on advice from their own Medical Director John Hussey, a Medical Director (for SSP) is not necessarily required if adequate and clear clinical governance pathways are present. NHS England Merseyside confirmed that the Pitalias would act as Medical Directors but that a GP, Dr Shamim Rose, had been appointed as GP lead for quality in SSP’s Liverpool surgeries. KONP asked what clinical governance pathways were in place and how their functioning was assured. NHS England Merseyside agreed to clarify this.

KONP asked the Liverpool Clinical Commissioning Group, if CCG member Dr Rose was employed by SSP as their quality lead. In March 2014, the CCG stated “To our knowledge, SSP does not employ anyone in the role of lead GP for quality in SSP’s Liverpool surgeries.” KONP now asked NHS England:

1) Are the “adequate and clear clinical governance pathways” previously referred to by Dr Hussey in place?

2) What are the pathways referred to in the above question?

3) What processes are in place to ensure that these pathways are implemented, given that the Medical Director has a primary responsibility for patient safety that is distinct from the commercial interests of company directors?
On 28 March 2014, almost a year after NHS England was told that SSP Company Directors were acting as Medical Director, the Commissioning organisation gave a remarkable answer:

“NHS England does not hold this information.

“However, I can advise that two of the SSP directors are medically qualified. In the absence of a medical director these partners are responsible for clinical governance and quality within the organisation, including implementation of any processes and policies.

“NHS England does not hold information regarding the pathways referred to in your request. You may wish to approach SSP Health directly to obtain this information.”

It appears that NHS England does not know whether adequate and clear clinical governance pathways, in the words of their own Medical Director on Merseyside, are in place or functioning at PPHC. Without that information, how can they decide if SSP is fulfilling or breaching its contract? Responsibility for the commissioning of primary care services sits with NHS England rather than the Clinical Commissioning Group to avoid any risk of conflict of interest, since CCGs are composed of GPs. Yet NHS England fails to acknowledge the conflict of interest inherent in Company Directors acting in the Medical Director role.

At a meeting with KONP members on 21st July 2014, the Medical Director of NHS England (John Hussey) refused to be drawn on the potential conflict of interest in the Company Directors assuming the role of Medical Director as well. Hussey said that each practice was required to have its own clinical governance framework and that although he had seen the standard clinical governance framework for SSP, he had not seen one specifically for PPHC. Hussey also said that if KONP wanted a copy, it should be requested through the patient participation group.
ISSUES THAT HAVE ARISEN AT PPHC UNDER THE MANAGEMENT OF SSP

APPOINTMENTS

In June 2013, KONP advised NHS England about the morning queues of patients seeking appointments at PPHC. As well as being frustrating for patients, the lack of appointment could affect demand for other NHS services such as A&E.

The chaos came to a head at another local SSP surgery when one day no GPs were available. As reported in the Liverpool Echo on 28 August 2013, Bootle MP Joe Benton said: "I have been contacted by a number of constituents who are patients at the SSP Health Litherland Town Hall Medical Centre and I shared their concern at the apparent lack of GP cover last week and potentially for this coming week. In the best interests of my constituents I have formally raised the matter with NHS England, the Clinical Commissioning Group and South Sefton Care Quality Commission."

CARE QUALITY COMMISSION (CQC) VISIT

The CQC is the regulator responsible for ensuring “...GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care”.

The CQC carried out two inspection visits to Litherland, and one to PPHC. The first Litherland report said action was required on the care and welfare of people who use services, staffing, assessing and monitoring the quality of service provision, complaints and records. Litherland patients told the CQC

25 www.thefreelibrary.com/PROBE+INTO+MISSING+GPs%3b+Patients+left+waiting+for+appointments.-a0341061353

26 www.cqc.org.uk/sites/default/files/old_reports/1-713509460_Litherland_Practice_INS1-939554235_Responsive_-Concerning_Info_01-11-2013.pdf
there was no regular GP at the practice and there were many occasions when the practice did not have locum GP cover. This had a serious impact on patients requiring timely repeat prescriptions. Patients were concerned about the continuity of care because they saw a variety of different doctors. A follow-up report found improvements, but that action was still required on the management of medicines as the CQC “were not assured that prescribed medicines always reflected patients' current clinical needs”.

The PPHC inspection took place on 7 January 2014. The CQC said action was needed on respecting and involving people who use services, safeguarding service users from abuse, and assessing and monitoring the quality of service provision, but concluded that the surgery met the standards for care and welfare of people who use services, cooperating with other providers, and staffing.

The CQC recognised a major problem in the appointments system and quoted patients who described long delays and lack of information, but the regulator did not investigate or comment on the root causes. These could include rising demand, insufficient clinical staff, problems with over reliance on locums, failure to predict the real length of appointments for patients with multiple conditions and/or working through interpreters and/or time required for locums to read notes, an inadequate system for booking appointments, insufficient admin staff, turnover of admin staff, lack of training and IT problems.

The CQC regarded the appointments crisis as an issue of “Respecting and involving people who use services”, and concluded that this “Has a minor impact on people who use the service” and, oddly, that “People experienced care, treatment and support that met their needs and supported their rights.”


The CQC did mention that although there was no record of this incident, a patient reported that they were left with a bleeding wound for over thirty minutes in the waiting room with other patients, before being advised to attend the 'walk in centre' for treatment. Substantial evidence from former staff and current patients shows that care was and is widely affected by problems including the lack of appointments.

During the CQC inspection, a practice nurse mentioned how an asthmatic patient was unable to get an appointment, then had an asthma attack and was rushed into the Royal, ending up very ill on the respiratory unit. On 16th April 2014 a patient told the public meeting “I am diabetic. I am still waiting for Princes Park to contact me. I ended up taking drugs without diagnosis or prescription. I’ve moved my family to another GP for their protection.” Another diabetic patient told the meeting “I had to wait until 5:00pm for an injection which meant I had to borrow an injection from my daughter and come back to the surgery at 6:00pm. You phone but can’t get through for appointments.” Another resident said “My mum was wrongly diagnosed twice. The GP is not there to answer this, as it’s a locum.”

When locums fail to turn up for clinics, or when locums arrive but clinics have not been booked, patients are not seen. The dependence on locums is inefficient because a locum unfamiliar with individual patients needs to divert a considerable proportion of the 10 minute consultation time to reading the notes. Failure to inform themselves of the relevant background for each patient will increase the risk of the GP missing something and essentially not providing an adequate service.

In the wake of the CQC inspection, SSP introduced a new appointments system. According to the former receptionist, appointments are now available but typically a week in advance. Patients remain frustrated as they often come to PPHC needing an appointment that day. Meanwhile, SSP advertise their own private services suggesting that they help patients to avoid NHS queues.

According to the receptionist, staff at PPHC have noticed an increase in the number of errors detected by the pharmacy, such as medication prescribed for the wrong patient. “The person will go in, have a consultation, and medication
is prescribed to that person when it should have been for the person before, which is major really.” It is unclear if such errors are systematically recorded or audited.

There are also delays in obtaining prescriptions. Sam Semoff states “I was on a combination drug, which became unavailable because of the manufacturer. So the pharmacy needed two separate prescriptions, but it took nearly a week to get the two prescriptions from the GP”.

Unlike their report on Litherland, the CQC inspectors did not examine the actual staff numbers on duty over a period. Instead, at Princes Park “We asked staff from the practice whether there was sufficient staffing for workload; we were told there was.” This is disputed by the former receptionist – who was diverted to a back room during the inspection – and the former practice nurse who did speak to the CQC inspectors.

When SSP took over, staff were transferred under TUPE regulations, which should preserve their terms and conditions, but this protection didn’t last long. A press release issued by Unison on 1 Aug 2013 said that “Eight practice managers in Sefton and four nurse practitioners in Liverpool are at risk of redundancy and some will be offered new jobs on worse terms and conditions.” Paul Summers, UNISON Regional Organiser said, “Another week goes by and we see another private health care company proposing redundancies for local workers. These 12 staff have a combined 150 years’ experience in the NHS and yet in just over four months of working for SSP Health, they are being thrown on the scrap heap. Patient services will be affected by these cuts and SSP have already increased the charges to patients. We have taken legal advice and lodged claims to the employment tribunal service for what we believe is a breach of TUPE regulations.”

In the end, SSP withdrew the immediate threat to the senior nurses. However, nurse numbers at PPHC have continued to decrease and now there are just two practice nurses. Eventually this forced the end of the ‘Well-Woman Clinic’, a very popular weekly drop-in service pioneered by PPHC in the 1980s. There have also been days when there are no practice nurses available due to sickness or annual leave.
When SSP took over responsibility for PPHC there was good continuity of service for patients provided by one full-time and five part-time permanent GPs as well as five nurses who provided 127.5 hours of service each week. As of September 2014 PPHC was staffed irregularly by three part-time permanent GPs and a variety of locums, some of whom were termed ‘permanent locums’ or recently rebranded as ‘GPs on zero-hours contracts’ and the nursing provision was reduced to 60 hours per week.

The CQC report also contradicts its own conclusions on care. “We also noted negative feedback about the practice on the NHS Choices website. The main theme emerging from all information sources concerned the appointments system, lack of constancy relating to medical staff, and the negative impact this was having on patient treatment and care. We saw no records which confirmed that the issues of concern raised by people who used the service had been fully documented, investigated and actioned.” Given the negative impact on treatment and care, how did the CQC conclude that care met the required standard? Did they dismiss the comments from all information sources? Likewise, if people were complaining about the lack of constancy of medical staff, how could the CQC judge that staffing met the required standard? Is this a problem with the CQC, or with the standards?

As the CQC, NHS England and Liverpool CCG know, high turnover of staff, demoralisation, reduction in nursing staff and over-reliance on locums all affect quality of care. Allowing the situation to continue for over a year means that despite the personal integrity of individuals, the regulator and commissioners, all have failed to put the needs of PPHC patients at the centre of their work.
Although this report focuses on what is happening at PPHC, and is based on solid evidence, very similar problems have been reported at other SSP practices. Sefton MP Bill Esterson told the local newspaper that patients from practices run by SSP were going to him to complain about surgeries being shut when they should be open, the reliance on locums and difficulties getting an appointment. (See article in Appendix 6 – Criticism of SSP health Ltd from Sefton MP Bill Esterson). Patients complained about the practices ‘falling apart’. Mr Esterson also claimed that government had ‘washed its hands’ of the problem.

It cannot be coincidence that KONP found exactly the same issues at PPHC, which suggests that SSP is engaged in a strategy of putting profit before patients.
The following section describes the main issues revealed at the Kuumba Imani Centre meeting in April 2014 and from the in-depth individual patient interviews that followed.

During the meeting patients were encouraged to tell their stories and express their views about PPHC. Notes were taken of the discussions and these have been reviewed and analysed to discover the most important or serious issues.

The findings synthesise the main themes emerging directly from the numerous discussions and comments held on the day, together with the findings from a patient survey and patient interviews. Case studies are presented to highlight some of the important issues raised. The testimony of these patients clearly indicates a system under severe stress that is failing to provide an adequate service. Patients feel very upset that the previously good service has deteriorated in quality. They feel frustrated, abandoned and helpless, not knowing what they can do.

LACK OF APPOINTMENTS

One of the issues mentioned numerous times relates to the problems faced by patients in actually getting to see a doctor or a nurse at all. People talked about queues forming outside in the early morning with fighting to get in and practice staff restricting the numbers allowed; with those failing to get in being advised to go home as there were no appointments.

As one Arabic woman said:

“Queue at 7:30 had thirty-nine people. They let in ten”
LACK OF CONTINUITY AND INADEQUATE CARE

The fact that the practice now seems to be run by locum doctors was another cause for great concern. Many of the patients in the local community have one of more long term conditions and need continuity of care. Patients complained about the inefficiencies in having to explain their complex situation to a different doctor every time. There were also numerous reports of locums being rude to patients. There was a feeling that in general locums had neither the time nor the patience to deal with them appropriately.

Patients talked about their loss of faith in the ever changing roller coaster of locums, and about the locum’s inability to engage meaningfully with members of the local community. There were several stories about patients who eventually managed to get the care they needed by going to a walk-in centre or to accident and emergency (A&E) at the hospital. These patients felt empowered to do this either because they could not get an appointment or felt they were receiving inadequate treatment from a locum. The concern is for those who for one reason or another felt unable to seek out the care they need.

Figure 2: Meeting at Kuumba Imani Centre in April 2014
There were stories about people having to take quite dangerous or drastic action when they could not get in to see a doctor or nurse at PPHC.

An Arabic woman said:

“I’m diabetic. I had to wait until 5:00pm for an injection, which meant I had to borrow an injection from my daughter and come back to the surgery at 6:00pm.”

PPHC serves a mixed community with a large number of people coming from a Somali or Arabic background. Many of the older members of this community do not speak English well, so interpreter services are important for them. There were reports of interpreter services not being booked or not working properly.

There was some discussion about whether the changes at PPHC were due to a general ‘belt tightening’ in the NHS or were more specific to PPHC. Several people attending the meeting reported that they had actually left PPHC and registered with other practices where they received better treatment and care. One woman said she was:

“Really shocked to get good treatment there, just like we used to have here”

Clearly indicating that services provide by PPHC are not the norm in the NHS and are worse than those provided elsewhere.

Several patients lamented the deterioration in services and about the need to save services

“The health centre has to be saved from private enterprise and from any organisation that puts profit before patients. The health centre needs permanent doctors not locums. Continuity is vital for patients with enduring health conditions. The practice needs to become more patient friendly and less bureaucratic. There needs to be a return to services such as the Well Woman clinic. I have remained loyal to Princes Park Health Centre whilst members of my family and friends have moved to other practices. However, my recent health scare and
the time delay in me receiving treatment has forced me to re-evaluate my situation. It is with a heavy heart that I am now seeking to register with another practice.”

In order to capture patients views, patients were asked to complete a survey about the care they were currently receiving at PPHC. In total 274 completed surveys were returned and the results analysed.

Patients were asked to rate the quality of the service they received in a range of factors. The factors chosen were identified as areas of concern from previous discussions with smaller groups of patients.

Patients were asked to rate the quality of the service they received at PPHC on a Likert scale ‘Poor’, ‘Fair’, ‘Good’, ‘Very good’, ‘Excellent’ or ‘Does not apply’.
Figure 3 indicates the level of satisfaction with the opening hours and the availability of appointments. Patients were asked about how easy or difficult it was to get an appointment and how long they had to wait. On average, no areas were rated as good or better and in every category eight out of ten (80 percent) of patients rated the service as only poor or fair.

**Figure 3: Patients opinion about clinical staff availability at the practice**
Figure 4 indicates the level of satisfaction with the quality of the services provided at PPHC. Patients were asked about things such as the range of services available and whether they felt they had time to express their concerns during an appointment. The area generating the highest level of dissatisfaction in the survey was about continuity of care, where nearly nine out of ten (88 percent) of the 251 patients who responded felt that the service was poor (76 percent) or only fair (an additional 12 percent). This corroborates the discussions at the meeting where the use of locums and resulting lack of continuity was highlighted as a major issue for patients.

**Figure 4: Patient opinion about services**
Figure 5 indicates satisfaction with reception staff and how they invite patients with long term conditions to come in for regular checks. Although these results indicate greater satisfaction than for clinical services, they are not good and of the 259 patients who responded, about half (50 percent) felt that the way they were treated by reception staff was poor and an additional one in five (20 percent) felt that it was only fair. Eighty five percent of the 234 respondents said that the opportunity to make compliments or complaints was only poor (62 percent) or fair (23 percent), representing the area with the highest level of dissatisfaction in this group of questions.

**Figure 5: Patient opinion about the staff and in general**
As part of the survey, patients were invited to make any additional comments, including offering suggestions for services that were not provided, but they felt were needed.

The most common suggestion was about the need for blood tests, and others suggested an x-ray facility would be beneficial.

Several patients felt that extended opening hours would be helpful for people who work. One patient commented that there was no drinking water available. Given that the population in the area is multicultural, several patients said that it would be very helpful if someone on the reception could speak Arabic, Somali or Urdu or at least there should be an interpreter available.

However, the vast majority of the other comments reiterated what was said during the meeting, especially about the difficulties getting an appointment. Several patients commented on how the service had deteriorated over the last few years, making it ‘absolutely disgraceful’.
The interviews with individual patients reinforce the findings from the meeting and the surveys.

One interviewee reported that the appointment system was always poor, but that it had worsened since SSP took over responsibility. The interviewee mentioned that the important thing was that previously patients were able to see the same doctor, so there was greater continuity of care:

“I have to say the appointments’ system was always bad, even before the SSP. I always had problems making appointments. The good thing was there were regular doctors who were based in the HC that you knew; you could see the next time you went in. And they knew my history and they knew me a bit, so it was, yes, a better continuity of care ... It just seemed to be the same doctors there all the time.”

The interviewee described the current difficulties in getting an appointment:

“To have to come to a health centre three times to secure an appointment is not acceptable, and I am not sick like some people are who are lining outside at 7:30 every morning. These people are very ill, some of these people are quite disabled! It’s like we’ve gone backwards and we’re working and existing below minimum standards, instead of best practice.”

The interviewee described the action taken when appointments were unavailable:

“Sometimes I had to go to the walk-in centre. They are very good but they haven’t got the same power as a GP and there are certain things they can’t do and they don’t know me.”

In relation to how things had changed and worsened in recent times, one interviewee reported how previously PPHC would accommodate any
patient who came in with an urgent need, but that this was no longer the case. The patient said:

“I would end up at the surgery in panic. And they would always accommodate me, they would allow me to sit in a quiet room while they would slot me in to see the next doctor. Without that I think things would have escalated and it would have made my problems worse.”

This same patient went on to say:

“Dr. Cyril Taylor who started up that surgery back then had a dream and a plan to bring the best health care to the patients and that’s what those doctors have done for decades. To see that decimated by a private company is totally unacceptable, so I am going to stay and I am going to fight this and hope that we can get our surgery back to where it was.”

Another patient said:

“I joined the practice because it was such a good practice, with such a good reputation ... The doctors were fantastic, you could see any of them and they were all brilliant. So you never had to worry about seeing the same doctor, because they were all equally good.

“Over the years there were occasions when it was difficult to get an appointment and other times when it’s been really easy. But it’s never ever been the way it is now. Never! It was just a leading practice, everybody loved going there. The doctors were great, the nurses were good, the admin staff were good, so it was fine ...

“All the really good doctors have all left ... and it’s virtually impossible to get an appointment. I went on my computer, because I am trying to book online now, So I went online Monday at 1 o’clock. I wanted an appointment for this week, it wasn’t anything serious, so I wasn’t in a hurry, and I looked online, and at first it looked that there was loads of appointments ... so I thought this is great, things have
improved. Then I realized, the dates were next week. So think about this: one o’clock on a Monday, there was ONE appointment left for the whole week, which was Thursday 2.20pm, which was the one that I booked. So there were no appointments at all! This was on Monday, so if you were ill, there was nothing for you this week ... and this is a locum by the way, this isn’t one of the regular doctors.”

This patient went on to explain the action required if you need to be seen:

“Now, if I have something that I really need seeing to, I go to the walk-in centre.

“So if this couple [referring to SSP owners] are trying to save money, they are actually making a rod for their own back, because if you go to the walk-in, I know that the doctors’ practice gets quite a big bill. So if they are trying to save money, they’re going the wrong way about it. Because I would now go to the walk-in anytime, if I need something urgently.”

In relation to the problems linked to seeing locums all the time and the importance of continuity of care, one interviewee said:

“And often I am having to explain everything from the beginning again, even though they’ve got notes, they don’t seem to have read them or the notes maybe aren’t very good and they ask me things which are very basic, like ‘Oh, so what medication are you taking?’ And, you know, it should be just there for them to see ... Something that worried me was that one doctor prescribed to me a medication which I had fears about taking it and I didn’t take it. And when I read more about it myself, some of the very common, apparently very common side effects are things that, I think, the doctor should have talked to me about.” And I also felt that this medication is something that he should have looked at my history before prescribing it to me.”
Another interviewee said:

“I’ve had a few different locums not really being that interested. They just kind of tap away, they don’t even look at me or talk to me. I think the fact that I can’t see the same doctor, I think that’s a really big problem ... We have to explain almost our whole history of the problem every time ... or maybe they are not writing good notes about for the next doctor. So I think the continuity of care, the lack of it, is a really big problem there. “

Another patient mentioned how previously there was great continuity of care, but that now PPHC was staffed with locums:

“Over a 35 year period all I’ve seen was three doctors. They knew me very well, they could deal with me very efficiently. I don’t think a locum can do that.”

The vulnerability experienced by patients is expressed very clearly by the following extract from an interview with a PPHC patient:

“This one locum I saw, who was a really really bad appointment ... It was the first time I’d seen this doctor, who was a locum ... and again, he didn’t know ... he obviously hadn’t read any of my notes ... or he sort of skim read them and hadn’t really understood some of it. He thought I was having some treatment at the hospital which I had been, but it had stopped ... and I was feeling very low because I wasn’t well ... and I asked him if there is any other kind of support I could get apart from just being given more painkillers. I’ve been in constant pain for about six months with an injury. And he spoke to me very rudely, he just put it back on to me and said ‘Like what?’ ... And I just felt because I was, I think you know, when we are ill we feel vulnerable, don’t we, so when we go to a doctor, we are not in any good state to sort of fight for what we think is, what we know. They’ve got this position of authority as well and sometimes when you feel ill and a bit, it’s difficult to sort of stand up to. Even when you know that they’ve been wrong. So I started crying because I just
felt so awful and he just said to me ‘Hmm this is interesting, I’ve noticed this link before between people with your condition and emotions’, and he kind of was looking at me like a sort of clinical case, not treating me like a human being basically - and then he said to me that he also thought that I should lose weight. It was a really cold day and I had on loads and loads of clothes, so he couldn’t even see my body shape or he hadn’t weighed me. And I just thought that was really just completely inconsiderate and just wrong really.”

In relation to the possible action that could be taken one interviewee explained that although patients could leave the practice and register elsewhere, it was important to hold the company running PPHC to account:

“I’m considering leaving because it is such a bad service, but I think the campaign should focus on trying to take it up with the CCG that they are not providing an adequate service ... You know they shouldn’t be allowed to run the health centre any more. But I don’t know, because they are a private company, I don’t know what power the CCG has, but then they should still be having to abide by certain ethics as doctors.

“Another sort of consequence of not being able to get the help I need from them is that I am now paying for some private treatment and I am on minimum wage and I am just worried about, you know, money sort of issues now as well as my health ... I am sure that there must be other things, other kinds of help on the NHS that I can get at the moment, but I am not being offered anything.”

One patient explained how difficult it was to make a complaint when you are not feeling well:

“I thought about it and also about specifically complaining about the locum who was rude but I just feel I don’t know if I got the energy at the moment. I feel like I need to put my energy into trying to get well and also I’m trying to keep my job, you know, and I just don’t know if
I want to put some of my energy into going down that route. I think it would be a good idea if more of us start to complain in a more formal way, but, I don’t know. I think I’d be more willing, at the moment, to complain as a part of a group, because I think we have more power. I feel like just my voice on its own, it’s just not gonna be enough.

And I also think about other people who are more vulnerable and who haven’t got the language skills and haven’t got a voice. I just feel there must be a lot of people who are having a really bad time there.”

Another patient felt that there hadn’t been any sufficient consultation about the transfer of ownership of PPHC to SSP and that there should have been a lot more public discussion about what the changes might mean for patients.

“I think all this commissioning that’s gone on, with all practices, that’s a wider issue. I think that’s a thing that the government just pushed through without any consultation. They say they did a consultation but they didn’t because I was a community worker at the time and I was the only one who heard about it, with the other community workers. So we went round a few GP practices to talk to patient groups and nobody knew anything about it, and this was supposed to be a consultation with the public, it didn’t happen, it didn’t happen, because nobody knew. In fact, most people today don’t know that their practices are owned by a business. If you ask any member of public, they don’t know.”

Several patients felt that the only solution was to ask SSP to leave or ensure that the responsible authorities took action to have them removed. They recommended:

“NHS England to ask SSP to leave and sever the contract.”
Another patients said:

“It’s completely ruined the practice. It seems to be all about profit, about making money, saving money, and where is all the money going and why, why have the doctors left... why?”

Another recommended:

“First of all, they’ve got to sit down, with doctors, with patients, with nurses, with staff, with admin staff and listen to what’s going on. And then they have to stop thinking about profit and making money, they’ve got to provide a proper service that attracts good doctors who will stay and ensure continuity of care.”

Figure 6 is a case study based around an interpreter’s experience of recent care provided to four patients at PPHC. The case study provides examples of the discourteous, disrespectful manner in which these vulnerable patients were treated by locums at PPHC.

They serve to provide an understanding of why the patients at PPHC are so reluctant to be served almost permanently by locum doctors.
### Patients with different cultural needs: The interpreter’s experience

**Patient 1:** Mrs M had suffered long term medical problems and needed to be seen at least once a fortnight by her GP. Because of the sensitivity of her illness, she always requested a female doctor but she rarely saw the same doctor twice. On FOUR occasions, I walked into the room with her as her interpreter, to find ourselves faced with a MALE doctor. On one occasion, a young, white male doctor starting 'firing' questions at Mrs M. Rather than provide simple 'Yes or No' answer, she begins to explain how she was feeling. The doctor interrupted her and told me to tell her to answer the question. He instructs her to: "sit on the bed, raise your right leg, raise your left leg. Where's the pain? That's fine, you can get off now." Her movements are so slow, she needed assistance to get on and off the bed, help to lie down and help to understand the questions. I don't know how she would have coped had she been alone. I was flabbergasted with his rude, offhanded manner and needless to say, both Mrs M and myself left the room in a state of shock.

**Patient 2:** Mrs Y is an elderly lady who suffers from a variety of illnesses and has recently had knee replacement surgery. Her visits to the GP are probably more for reassurance than anything else. On one occasion, she explained all her concerns to me and I tried to summarise the problems and present them to the GP in a manner he could understand. He was a middle-aged Irish man, who was chewing gum. Since I have worked as an interpreter in this field for over 35 years, I am familiar with medical terminology. The doctor asked me if I was a doctor. I said ‘No’. He then asked me if I worked in the medical profession and again I replied ‘No’. Mrs. Y then asked me to ask him to check her blood pressure. I asked him to reassure her with regards to her blood pressure. He checked it and said nothing. I asked him 'Is her blood pressure OK?' to which he replied: ‘180 over 90’ and left it at that. We left the room more depressed than when we entered.
Patient 3: Mrs S is a woman who also suffers from a multitude of illnesses and has been going to and from the doctor for the last 10 years. Her illnesses include COPD, chronic back pain, sciatica, arthritis, intra-uterine problems, severe anaemia and severe depression. The DWP had asked her to find a job. She contacted the surgery in order to get a 'sick note' that would indicate that she was not well enough to work. On this occasion, she saw a doctor who said to her: 'I can't give a three month note! You want me to lose my job?'

Mrs S explained that up until now, she had been getting a three month sick note. He said to her: 'Come back and see whoever it was who gave you three months, because I can't do it. You look fine to me.' On her way out of the room, she mentioned to the doctor: 'I asked to see a lady doctor; I don't know why they sent me to you.' To which he replied 'I don't want to see you again either, arrange at reception to see someone else'

Patient 4: Mr M is a man in his 60s who has enjoyed relatively good health and rarely goes to the GP. However recently he had developed severe abdominal pain and had been rushed into hospital. On discharge, he was advised to see his GP who could order further investigations. He expected investigations to see the cause of his crippling abdominal pain. He walked into the doctor's room (after requesting a male doctor) to see a female doctor. She asked to examine his abdomen. He raised his shirt. She exclaimed, 'For God's sake, I can't examine you like that. Get it off.' He felt extremely embarrassed to undress in front of me, and I drew the curtain around him to preserve some of his dignity.

As the doctor examined him, she asked a series of questions. One such question was 'Are you passing wind?' He replied 'No.' She then scoffed: 'You're lying to me, it's impossible not to pass wind.' She then wrote him a prescription and sent him away. No investigations were requested.
On the NHS Choices website, there are comments from patients and results from the annual survey of patients at GP practices throughout the country. Recent results for PPHC are shocking.29

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice. The survey published in July 2014 found that on average PPHC was below average in all areas. When the weighted CCG (regional) results were explored, PPHC was below average except in relation to receiving out-of-hours care quickly. However, this question was only answered by eighteen patients and of these twelve felt it was about right whilst six said it took too long to receive out-of-hours care.

This national survey corroborates the issues discussed at the meeting and reported in the local community survey reported here.

The national survey found that PPHC was below CCG average in relation to:

- Contacting the GP surgery and making an appointment
- Being treated well and with dignity by the GP
- Being treated well and with dignity by the nurses
- The level of privacy and helpfulness at reception
- Waiting times
- Overall experience

The NHS Choices website also allows patients to enter a review and rate their GP’s services. PPHC only received a very low 1.5 stars out of a possible five. Nobody can read the recent comments supplied by patients without feeling

29 https://gp-patient.co.uk/practices/N82076?term=Princes+Park+++Ssp+Health+Limited+%28L8+0SY%29
great sadness about the lack of care and atrocious services provided for this community.

SUMMARY OF FINDINGS

In summary several themes emerged from the survey, interviews, discussions and comments, which overall indicate a health centre under severe stress that is failing to provide an adequate service. The main concerns identified were:

1) Appointments - People talked about queues forming outside in the early morning with patients fighting to get in, and practice staff restricting the numbers allowed; those failing to get in being advised to go home as there were no appointments. This is having a huge impact on quality of care and there is some evidence to suggest that this is leading to increased and inappropriate use of more expensive alternatives such as hospital A&E departments, and walk-in centres. Since the CQC inspection, there have been some minor improvements to the appointments system, but the overall problem remains.

2) Locums - Patients talked about their loss of faith in the ever changing roster of locums, and about the locum’s inability to engage meaningfully with members of the local community. These findings provide clear evidence that there is an over-reliance on locums at PPHC and this is leading to patients not being given enough time to communicate effectively with the GP. Locums are spending too much time reading past medical histories. In a community where long term conditions are prevalent, this represents a highly inefficient use of resources. As with all NHS services, funds for GP services are limited and it is incumbent on managers to use funds efficiently and effectively.

3) Translation - PPHC serves a mixed community with a large number of people coming from a Somali or Arabic background. Many of the older members of the community do not speak English well, so interpreter services are important for them. There were reports of interpreter services not being booked or not working properly.
REPORT OF MEETING WITH NHS ENGLAND

Members of Keep Our NHS Public met with representatives of NHS England Merseyside on 21 July 2014, following their invitations to discuss issues relating to PPHC. Present from NHS England were Dr. John Hussey, Medical Director, Mr Anthony Leo, Director of Commissioning and Mr Tom Knight, Head of Primary Care.

Mr Leo began by saying they were working with SSP on a range of issues to improve services, that there have been improvements in services and in particular with the appointments system, and that Healthwatch confirmed this. Mr Leo then referred to independent reports but he did not indicate the source of the reports.

Dr Hussey said he had not seen any evidence that the level of complaints about SSP surgeries including PPHC, was greater than for any other surgery. He maintained that the best way to improve services was not through pushing contractual issues but through the patient participation group. When reminded that there had been only one meeting of the patient participation group in 16 months and that had been in January 2014, he suggested that SSP don't see it as a priority, as so much is happening.

Since May KONP has been asking to see a day to day record showing the availability of GPs at PPHC including a designation of whether they are employed by the practice (part time or full time), ‘temporary locums’, ‘permanent locums’, or ‘GPs on zero hour contracts’. Contrary to KONP findings, Leo insisted there were eight doctors at Princes Park and that five had been TUPEd over from Liverpool Community Health. Dr Hussey said NHS England was not in a position to ask for rosters, nor did he see the point of it. During the discussion KONP highlighted the pressures on doctors and problems with continuity of care with locums spending half of the allotted consultation time looking at the computer because they had no idea of the patient’s background.
Although it is an aspiration, Dr Hussey felt that continuity of care isn't a contractual requirement and could not be enforced. He acknowledged that staffing a surgery primarily with locums was not ideal but that often it could not be helped. Returning to the question of the rosters he said NHS England would only ask for them if there was evidence that continuity of care was being affected. He gave his assurance that if concerns were raised formally such as patients making a complaint about the lack of continuity of care he would investigate but to date he had not seen any written complaints. He suggested that if a patient wanted to see the rosters, the preferred method would be to make a request through the patient participation group.

Ever since SSP took over Princes Park, KONP has highlighted the fact there is no independent medical director with responsibility for ensuring that quality of care is prioritised over profit. Previously KONP was told by Dr Hussey that a medical director was not necessary and that NHS England did not have any evidence that the required clinical governance pathways to ensure quality of care were not in place. Although the role of medical director is assumed by Drs Sanjay and Shikha Pitalia, the owners of SSP, KONP have questioned how they can make clinical decisions independent of the need to maximize company profits.

Dr Hussey refused to be drawn on a possible conflict of interest, reiterating that there is no requirement for a medical director but that every practice must have its own clinical governance framework and that most are encouraged to have a lead GP to oversee this. He said SSP has a lead GP in each practice to do this and that although he has seen not seen the clinical governance framework for PPHC, he was sure they had one. He said he had seen the standard SSP clinical governance framework, which was as good as for other practices. He said that NHS England did not have a copy but that if KONP wanted a copy it could be requested through the patient participation group.
GOVERNANCE AND DUE DILIGENCE

Due diligence is the process that takes place between a company being awarded a contract and the actual start date. It is designed to ensure that the company is capable of meeting the specifications of the contract. KONP has been attempting to find out if due diligence took place in relation to the SSP contract, and if so where was the report. Mr Leo insisted it had taken place and that as the Department of Health had said, a record must be with NHS England and they would look for it. Both he and Dr Hussey queried as to why KONP wanted to see the report. Mr Leo lamented the fact that it would be a lot of work to track this down, which would divert them from their job of improving care for patients. But if that's what KONP wanted them to do, they would, but it would interfere with their work for patients. Dr Hussey said problems at PPHC were evident before SSP took over, with high turnover of staff.

During a meeting in 2013, Mr Knight referred to an audit of services at PPHC. Since May 2014, KONP has been asking to see a copy of the action plan for delivery of services that resulted from the audit. Mr Knight said that a report on the action plan had been prepared and submitted to SSP and that they were awaiting SSP’s response. Mr Leo said the process would be completed in coming weeks, hopefully by August 2014, after which it would go to the CCG.

Dr Hussey queried why KONP would want to see the action plan and was unable to say whether the action plan or the report would be in the public domain, but said that they would need to take advice on this.

NAMED GP

Recently government announced that patients over 75 years of age would have a named GP. Patients at PPHC were sent a letter stating that Drs Sanjay and Shikha Pitalia would be their named GPs. Dr Hussey said it only meant they had overall responsibility for care but not delivery of care. He thought it was a ridiculous concept, but not because of the Pitalias and he refused to be drawn on how this could work if a surgery is staffed primarily by locums.
CONCLUSIONS AND RECOMMENDATIONS

The demise of PPHC from a flagship model of community-based primary care to being ranked in the bottom 300 out of nearly 8,000 GP practices in the country is a prime example of what happens when health care becomes subject to market forces.

The initial reasons for putting PPHC and twelve other surgeries in Liverpool out tender remain unclear as do the reasons for cancelling the first procurement process and rewriting the specifications.

Services provided since April 2013 when SSP took over responsibility have deteriorated significantly and at the community meeting and through the in-depth interviews undertaken, it is clear that some potentially serious incidents have occurred. Patients report problems with getting prescriptions, results of blood tests go astray and feedback from hospital consultations is not added to their notes.

Patients at PPHC struggle to get an appointment and as a result they either suffer for a protracted period of time before getting any treatment or go to A&E or the local walk-in centre, even though they know that these services should be provided by the GP. This clearly represents inefficient practice and is bound to increase costs to the NHS in the long run.

Perhaps the most disappointing aspect of the new SSP management is the staff turnover with the loss of many committed GPs and practice nurses. The increasing dependence on locums is causing significant problems in relation to continuity of care, which is essentially impossible and therefore absent. Several members of staff reported that they found conditions intolerable since SSP took over. The emphasis now is on saving money rather than patient care.

It is interesting to note that an advertisement for Pall Mall Medical – offering express appointment with a private GP appeared on websites linked to the NHS and PPHC. Pall Mall Medical is owned by the Pitalias who are also the Directors of SSP Health. There is a conflict of interest when those
commissioned to provide GP services for the NHS are offering private GP services for profit. A logical conclusion is that the services at PPHC are being pared back, to drive patients towards private practice.

**Figure 7: Advertisement for Pall Mall Medical**

![Advertisement for Pall Mall Medical](image_url)
Numerous attempts to get Liverpool CCG, who have responsibility for quality of care, and NHS England who hold the contract to address some of these issues have been unsuccessful. It would appear part of the problem lies in the way the tender specifications were framed, enabling SSP to appear to be providing adequate care, regardless of the quality of service. The agencies that oversee the provision of primary care, including the CQC, appear to be powerless in ensuring that patients get the services they need and to which they are entitled.

Sadly it remains to be seen what kind of tragedy will ensue before the situation improves.

These recommendations mirror some of those from the Francis report into the Mid Staffordshire crisis. They require SSP company directors and every person serving patients at PPHC to be held to account and contribute to a safer, committed, compassionate and caring service.

1. In practice, this means that Merseyside area team of NHS England and the local CCG should take responsibility for the services they commission and develop a common set of core values. They must create a system which recognises and applies the values of transparency, honesty and candour. They should measure the commitment to these values (i.e. cultural health) in all parts of the commissioning system.

2. The patients at PPHC must be the first priority. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.

3. There must be zero tolerance of any aspect of the service provided at PPHC that does not comply with fundamental standards. The Directors of SSP and those who are responsible for providing such care must be held to account. Standards need to be formulated not only to conform to regulations or the letter of the law as written in the GP contract, but
must rather promote the spirit of good quality care. This will increase the likelihood of the service being delivered safely and effectively.

4. It is important that Merseyside area team of NHSE as the commissioner and the CCG listen to the narrative contained in this report and take appropriate action, since it gives a voice to those who are not empowered to complain and be heard.

5. Commissioners must be prepared to take action to put patients first and intervene where substandard or unsafe services are being provided. They must take control and provide alternate services or take other measures necessary to protect patients from the risk of harm. They must order a provider such as SSP to stop provision of a GP service that is not up to standard.

6. Serious non-compliance with quality standards for care or non-compliance leading to actual or potential harm to patients, should render the Directors of SSP liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.
APPENDICES

APPENDIX 1 - LEAFLET PUBLICISING MEETING
Princes Park Health Centre  
Patient Survey  

Every since a private company called SSP Health took over Princes Park Health Centre patients have complained about various problems such as being unable to get appointments. Our campaign would like to know the extent of these problems and what people think of the services they are getting. This information will help get those agencies responsible for the running the NHS to ensure patients receive the services they need.

Please complete the following survey by ticking the appropriate boxes. Remember “poor” (for example) can mean the service is not available or the quality is “poor”. Place the completed survey in the accompanying Freepost envelope and put it in the post box (no stamp needed) by 15th May 2014.

<table>
<thead>
<tr>
<th><strong>About the Practice</strong></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Does Not Apply</th>
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<tbody>
<tr>
<td>1. The opening hours for the Practice are</td>
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<td>2. The ease of contacting the Practice by telephone is</td>
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<td>3. The chances of seeing a Doctor/Nurse on the day I contact the Practice is</td>
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<td>4. The chances of seeing a Doctor/Nurse within 48 hours is</td>
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<td>5. The chances of seeing a Doctor/Nurse of my choice is</td>
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<td>6. The opportunity to speak to a Doctor/ Nurse on the phone is</td>
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<td>7. The time spent waiting to see the Doctor/Nurse is</td>
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<td>8. The availability of appointments for advance booking is</td>
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<td>9. The continuity of care (being able to see the same Doctor) is</td>
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<td>10. The information provided by the Practice about its services (e.g. repeat prescriptions, test results) is</td>
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<td>11. The Practice waiting room (e.g. furniture, literature available, position of the TV screen) is</td>
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<tr>
<th><strong>About the Doctor/Nurse</strong></th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Does Not Apply</th>
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<tr>
<td>12. The Doctor’s/Nurse’s explanation to me is</td>
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<td>13. The amount of time I have to see the Doctor/Nurse usually is</td>
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<td>14. The amount of time I have to see the Doctor/Nurse if I need an interpreter or have a complex problem is</td>
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</table>
15. The opportunity the Doctor/Nurse gave me to express my concerns or fears is

16. The way the Reception Staff treat me is

17. The time spent waiting to see the Receptionist is

18. The respect shown for my privacy is

19. The opportunity for making compliments or complaints to this Practice about its service and quality of care is

20. The information provided by the Practice about how to prevent illness and stay healthy (e.g. alcohol use, health risks of smoking, diet habits, etc.) is

21. The system to call me in for regular checks about ongoing health problems (i.e. diabetes, COPD, etc) is

22. How many times has your appointment been cancelled within the last 12 months?

23. Are there any services that are not provided that you think are needed?
   (List in box below)

24. Any other comments you wish to make about the practice?
   (List in box below)

This survey is being carried out by Keep Our NHS Public Merseyside; c/o News for Nowhere, 96 Bold Street, Liverpool L1 4HY (Postal Address Only); keepournhspublicmerseyside@yahoo.com
APPENDIX 2.2 - PATIENT ACCESS SURVEY - SOMALI

## Xaruunta Caafimada ee Prince Health Centre

**Afti Laga Qaaday Dadka Xanuuns Anaya**

Ilaa iyo intii ay ganen shirkadda SSF masuuliyaddii caafimaad ee Princess Health Park Centre dadka buuxay ka caabaneeye waxyaalad ay ka mid tahay siddii ay diiwhaatin ku badan sida. Kambanigayaga waxu jeec yihiin uu ugu hesho dhiba inta ay waa dadka u malahayeen inaan tahay adeegay ay helaan. Maakhirin kaas oo ah waxay ku haysanaahay haddii aad ka qaaday masuuliyada NHST in ay maamulkaan in ay siyaan daka bakaanka u baahan yihiin.

Fadlan waxa xiriir buuxa afdiintay waxaan u ogaahay in halka ay tahay lidata in ay micaa haddii uu adeeg gurani karo adeeg liista ama adeeg aan u helin. Fadlan sano celiya in ta kalaa hayaasaa bishan May 15 ka badan u baahnin in tilmaalbaa ahaan u dhajisaa.

### Waxayaa la Caruunta Caafimaadka ee Dhakhterkaaga

1. Saacaada furninka dhakhtarku waa
2. Sida u fuduc ee balanta loogu heli karo talofoonka waa
3. Fursada aad arkooyso Dhakhterka ama neersaata maalinta aad la xidhiidho dhakhtarkaaga waa
4. Fursada aad arkooyso dhakhtarkaaga ama neersa 48 saacadood gudahaad u waa
5. Fursada aand ku arkooyso dhakhterkayaga ama neersa aad doontay waa
6. Fursada aand kula hadalayo telefoonka dhaktarka ama neerstya waa
7. Wahmatiiga aand sugayo in aan arko dhakhterka ama neerstya waa
8. Heelgarka aand helo balanta in aan wakhati hore samaysto waa
9. In aan karo in aan arko dhakhterkii markii hore waa
10. Warka uu isyo sida jawaabtii aan ka sugaya iyo dawooyinka iyo kadadaraay markii waa
11. Xuruuna caafimaadda sida loo quruxyo waa

### Ku Saabsan Dakhtaarinta Ama Neersata

12. Faahfahinta dhakhterka iyo neerst u siiyaan waa
13. Wahmatiiga aand arko dhakhterka iyo neerstaa had iyo geer waa
14. Wahmatiiga aand arko dhakhterka iyo neerstaa hadi aad u beeboon hay turjiimaan ama hawal faahfaah u baahan
15. Wahmatiiga uu dhakhterka ama neerstu isii in aan ugu sharaxo baqadinta ama welwalka aan qabo waa
About the staff Ku Saab san Shargalaa

16. Sida aya ila dhaqmaan shagagalaha fashiyi meesha ofliska waa □ □ □ □ □ □ □
17. Waktiga aan sugayo in aan arko shagagalaha fashiyi xafiiska waa □ □ □ □ □ □ □
18. Israamka ku saabsan in lay silyo muul astuuran waa □ □ □ □ □ □ □

Gud Ahaan

19. Fursadaha aan kaga qaban lahaa ama u habalyana lahaa waxa wanaagsan ee lay qabtay waa □ □ □ □ □ □ □
20. Wararka uu dhakhtar ku bixiro sida aan isaga difaadu lahaa xanuunada iyo sida aan u ahaan lahaa qof caafimaadka qaba waa □ □ □ □ □ □ □
21. Sida laygo yeedi lahaa in aan marba is eegu sida caafimaadka yahay □ □ □ □ □ □ □

Abadan Kow 2 3 4 5 Iyo
Inkabadan □ □ □ □ □ □ □

22. Ismisu jeer ayaan badanteedha laga kantsal gareeyey □ □ □ □ □ □ □

23. Ma jiraan waxayelo aad u bahentalay oo aanada iminka laaguqaban ood doonayso in lagu qabio
   Ku qor sanduuga hoose

24. Waxa kale ood doonayso in aad ka hadasho oo ku saabsan dhakhtaraga.
   Ku qor sanduuga hoose

This survey is being carried out by Keep Our NHS Public Merseyside; c/o News for Nowhere,
98 Bold Street, Liverpool L1 4HY (Postal Address Only); keepournshpublicmerseyside@yahoo.com
**APPENDIX 2.3 - PATIENT ACCESS SURVEY - ARABIC**

**مركز برينست بارك الصحي**

**أstellات المرضى**

منذ أخذة شركه خاصه تدعو أس أم بير مسئولية أدارة مركز برينست بارك الصحي، الأمراض يشكون من مشاكل عدد مثل صعوبه الحصول على مواعيد أجهزة ومعرفة مدى هذه المشاكل وكيف يترك الناس عن الخدمات التي يحصلون عليها. هذه المعلومات مساعد لجعل هذه الكتابات المنسية عن أدارة وزارة الصحة أن تظهر حصول المرضى على الخدمات التي يحتاجون إليها.

فظلال أكمل الإستبيان أدناه بواسطة التاشير على المربع المناسب (ضعيف) على سبيل المثال) يمكن أن تعني أن الخدمات غير متوفره أو أن جودة الخدمات (ضعيف). وضع الإستبيان في الظرف المصحع المرفق في البريد (لا يحتاج إلى طابع). قبل 14/05/15م.

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<th>مرض الجدير</th>
<th>أوقات الدوام في المركز هي:</th>
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<td>سهولة التواصل من خلال الملف هي:</td>
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<td>الفرضه لرؤية الطبيب / المرضه في اليوم الذي أصل فيه بالمركز هي:</td>
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<td>الفرضه لرؤية الطبيب / المرضه في خلال 48 ساعه هي:</td>
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<td>الفرضه لرؤية الطبيب / المرضه لثب أختياري هي:</td>
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<td>الفرضه لتحدث إلى الطبيب / المرضه عبر الهاتف هي:</td>
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14- نسبة الوقت التي أمكنت من رؤية الطبيب/الممرض إذا أحتجت لمعد أو عندي مشاكل متعلقة هي:

15- التوقعات التي أعلنت أي من قبل الطبيب/الممرض لظهور أهداف أخرى أو عودتي هي:

حول الموظفين:

16- الطريقة التي يعمل بها موظفون الاستقبال معي هي:

17- هل تشير الوقت لأنظار رؤية الاستقبال هي:

18- أظهر الأحترام لخصوصتي هي:

علم:

19- أمكنية أجراء مواصلته أو شكوني الى هذا المركز حول خدمات ودودة الخدمات هي:

20- تطوير المعلومات من قبل المركز حول خدمات حول كيف يمكنحنب الوضوح والخضوع على الصحة (مثل استخدام الكحول والاضرار الصحية للإكثير، عادة السماء بالإخ)

21- نظام الإتصال بـ هذا المركز حول الصحة المحلي (مثل:

السكري، مرض الأنسداد الزواني، الخ) هي:

22- كم من المرات تم فيها أنباء موعدك؟

23- هل هناك خدمات ليست متوفرة، انت تعتقد أنها طورية؟

(قائمة في أسفل المربع)

This survey is being carried out by Keep Our NHS Public Merseyside; c/o News for Nowhere, 96 Bold Street, Liverpool L1 4HY (Postal Address Only); keepournhspublicmerseyside@yahoo.com
Julie Jones worked as a receptionist at Princes Park Health Centre for 28 years until resigning in June 2014.

I had a month off sick, due to stress. I'm normally quite a calm person, I can cope with things, I lead a very active life, and I'm only part-time as well, and yet it's really ground me down. All day long I'd do nothing but apologise, covering things and trying to placate people, really feeling very hopeless, I mean what can we do? I, as a receptionist, was supposed to do admin, but because there was no staff, everyone was leaving and no-one was getting employed, I'd never get off the front desk for five hours, and sometimes I'd just go running out of there, I don't know how I got home.

I'm healthy and I want to stay healthy, I just don't think I could have seen it through there. I've got two and a half years to go before I get the pension so it is quite crucial that I do find another job. I just had to give up really. I decided because of my colleagues I must go in, and I worked a month's notice. And that was it.

What do you see as the current problems in the surgery?

Not enough GPs, whether they're locum or full-time GPs, available on a weekly basis anyway. Just not enough slots to offer people, not enough staff to deal with the sheer demand. There used to be five Practice Nurses, now there are two, one of them is part time.

How many GPs have been available on a day to day basis?

Sometimes two or three at the most, sometimes none.

When you say three GPs, you're talking about two available for appointments and one on-call?.

One on-call

The only GPs they have are the part-timers?

I don't think anybody's there full days of the week.
So what happens when somebody comes in and wants to get an appointment, but there aren't enough GPs?

Well we have to ask them is it something they feel is an emergency, are they really anxious that they're seen on the day, if that's the case, then we would naturally say an on-call doctor will call you back and speak to you. If someone doesn't have anyone to translate or can't speak English then we would put them on an Emergency slot, but if people can't speak English and they've brought someone in, we'd ask them to come back at a certain time.

If it's an emergency and not appropriate for a GP surgery then they need to go to A&E, but when SSP came, they stopped us sending anyone to Walk-in Centres. People will say “never mind I won't wait, I'll just go to the Walk-in Centre”, but the receptionist is to discourage them from doing so by offering an on-call GP on the day to contact them by telephone and deal with the problem in a number of ways:

1) ask the patient to come in to surgery for an emergency appointment
2) leave a prescription at the surgery for collection later, or even arrange for the pharmacy to deliver if appropriate
3) sometimes the surgery will leave a sick note.
4) For children under three months, an adult will always be asked to come in with the child to see the on-call GP

So if a person comes in and they're in need of care, and it's not severe enough to send them to A&E, then they would see the on-call doctor?

Well not necessarily, a doctor would call them up to speak to them. It's only if someone isn't speaking English and we don't think they could take the call, then we give them an emergency slot. Sometimes a family member rings up who speaks English, but can't be available with the patient to come in.

If a relative is translating, doesn't that raise issues of confidentiality?

It's always with the permission of the patient, to be honest that is how it's had to be.
It used to be before the 80s when the translation service was established, people would bring in relatives. The situation came to a head, I'm not sure if it was at Princes Park, when a woman came in with a male adult relative to translate, and it turned out he was abusing her, and that prompted getting the translation service set up and from then on there was a real move to avoid people bringing in relatives to translate.

I can't see that that's been happening though, for a long time, because we'll say “we'll get translation” and they'll say “no, no, I'll come in with my wife”. We can't say “no you can't do that”.

*The problems with people getting appointments, some of this was going on before SSP took over?*

Yes, I would say that it's always been a practice with a difference. I have been sent to other practices when they're stressed and there's not many staff there. I'm not very computer literate, and I've gone on to another system and just managed it fine, their idea of a busy day is absolutely a walk in the park compared to Princes Park, that was the difference.

*But it deteriorated when SSP took over?*

Yes, although it has settled down in the last couple of months, previous to that there was just locums, all booked, not turning up, saying they'd been sent somewhere else. That was unbearable, because people were coming in to surgery and we were that busy dealing with things, sitting down and there was no doctor there. They weren't even turning up, it was a ridiculous dialogue with them on the phone trying to get them over, or it was getting the bookings wrong, it was just chaotic. That was a terrible period of time, because on the front desk, all we're suffering all day is anger from everybody, we're just absorbing all the faults of the place.

*With the new appointments system when people come in, they may be able to get an appointment, but there's a backlog*

It's always a week in advance now, because, for a month all the appointments are on screen with just a couple to book on the day, so if people come in, if
there's three doctors in there may be about ten appointments available, which is not really adequate for the amount of calls we get and people coming through the door. Some people come in at 7:30am to wait to see doctors, and we're turning people away. So then it impacts on the on-call list, sometimes you've got 30 odd calls to make in the morning, and bringing some people in. And later on in the evening when you do a late shift, there's many things there that are turned on to the next day because the on-call doctors can't cope.

I think really that the surgery works better where there is more on the day.

**So has the change in the appointment system actually made it worse?**

Yes, definitely. It has created a lot more chaos. I've never been one for being able to book a long time in advance, because it does have a big DNA (did not attend) rate at the practice, people forget or they get better, you do have a lot of DNAs on the day as well which doesn't help.

*DNAs have always been a particular problem in a deprived area because people are under so much other stress that sometimes they just can't get to their appointments.*

Well there are all sorts of reasons for that practice and I felt it was always recognised years ago, the doctors understood it, they gave the staff a bit more money to keep them there, to deal with extra stress and the bigger problems that that practice entailed, and I appreciated that. But the Pitalias said “no, no”. We said this practice does have something different and he said it's just the same as anywhere else. It's not.

**Are there enough admin staff?**

No, there's pressure coming down all the time. When we're on the front desk, we don't really have time to do anything but speak to people, sort out problems, book them in, you're given mail to do, there's very little you can do when the pressure comes for dealing with prescriptions, chemists and everything, so loads more work filters down. Like they say there's 200 letters to do. Well any admin jobs that filter down to do on the front desk, which is just ridiculous, well then we have to say no we can't do it.
Things got delayed, things like recalls. Hardly any admin staff are in admin rooms which are half empty, so they're weighted down, stuff's getting shoved round all over the place.

*We heard that 800 letters went out the other day.*

And probably most of them shouldn't have gone out because they're that delayed, people have been in anyway and dealt with, so then there's duplications, then we're dealing with calls from people saying “I've just been in, do I need this doing?” and then you're spending ages sorting it out.

*Does the admin work include dealing with what happened in a consultation, or is that all down to the GP to deal with immediately?*

Well not immediately, they get letters, hospital things will come through, the doctor will see it and then hopefully act on what's there, but many things haven't been acted on, because they're getting picked up where medication isn't changed, or something's missed from a hospital discharge.

*So it could mean that when somebody's records are needed the records are not actually up to date?*

I think so, because mail is going to locum doctors, we're getting bundles of mail every day from hospitals.

*These would be letters from consultants advising what's the latest on a particular patient, and that's got to be entered onto the patient's records so that when the patient comes into to see the GP, the GP is up to date. I know in my own personal situation that hasn't happened on a couple of occasions.*

It is crucial isn't it. Some locums are missing things and we're finding it down the line, so when a doctor is seeing all the letters, things that have to be acted on should be acted on there and then or passed to someone to do, so they're passed to the admin people who haven't got time to do them, and then they get left for scanning

*If that letter isn't scanned in then the GP isn't up to date on what's happening.*
Well they do get scanned in, but there can be a delay. So there are some things which should go in sooner, but we know that a lot of the locum doctors don't act on a lot of stuff, or they leave things, don't follow stuff through, so they're sitting in the scanning pile when they should have gone to someone else to deal with quite soon.

*What other problems do you see?*

There's a lot more errors getting missed, which I'm very concerned about, on the medication side. I mean there's always human errors, but a lot more, serious things, like the person will go in, have a consultation, and medication is prescribed to that person when it should have been the person before, which is major really. And it is usually the “non-locums” as well, I don't know what else we call them.

*So these are errors by the GPs?*

Yes. I became really concerned, the pharmacies where the prescription's being taken to be dispensed, we're in contact with them all the time about things that they're not too sure that the doctor's done. The pharmacist rang up and said “I've got a prescription in and I'm sure it's for another person, for various reasons.” I took the details and looked on screen and saw it had been attributed to another person. They'd been seen consecutively and the doctor just hadn't moved down.

*Is there a system for recording all the prescription errors?*

Probably not. I put in a ‘significant event’ form last week, but I'm thinking that will just be left.

*Who do those go to?*

The manager. I'm not confident that will be dealt with.

*Would there be a record of the fact that the pharmacy had complained?*

No, there's no record kept of that, we're dealing with a lot of things on a daily basis.
To my mind, that would be an issue that somebody somewhere, either in the CQC or in NHS England, ought to be concerned about, are there more errors being picked up by pharmacies than there used to be? They ought to be very interested in that.

We're not auditing that, but I think it's something that should be, because whoever is doing prescriptions on the day, they're totally bogged down.

I was on a particular prescription which was a combination drug, and it became unavailable because of the manufacturer, so the only way that the pharmacy could do that was by two separate prescriptions, but they couldn't do that without the prescription coming from the GP, and it took nearly a week to get the two prescriptions from the GP so that the pharmacy could replace the drug.

There were some problems before SSP took over, in what way do you think the change when they took over the management, is actually responsible for this situation?

It wasn't right away, just when members of staff left as they would do normally, it hasn't been dealt with the way it would be normally. Every time a person has gone a new person hasn't been employed, certainly from our side of it that's what's happened, and the nurses have just disappeared.

It just feels soulless really. I felt the practice was almost like a community centre at times. I cared about the patients too and I've enjoyed the relationship I've had with them over the years, and watched them and their children grow up. But it just feels like we're in a lovely big building which is absolutely empty, nothing going on. We had a pokey little building before, everything happened there. There's just no communication at all. That's our old practice leaflet, it's no use looking back in the past but it gives you an idea of the concept.

Sam: I used to do some of these for Katy, the Prinny Park Post.

That was the practice leaflet. To be fair, that concept continued through for many years.

When do you think it started to go?
Probably when the bulk of those doctors that wanted to work in that place for what it had done and its reputation, when they went that's generally when it started changing really.

*When would that be?*

About five years ago I should think. Which was probably going to happen because of the changes in healthcare and the NHS, all of the pilots, and sort of taking away all of the things that were in surgeries, taking them away to the big satellite places and big centres, everything was going. Even the sign outside says we've got chiropody and blood clinics, there's nothing like that going on. It did previously, but since we went into the new building, nothing's come back to it.

*To be fair, isn't some of that done by LCH on the community side?*

Yes. At one of our meetings last year I explained about how this place used to be, we've got this lovely big building when are we going to start using it? And Neaka said “oh yes, we're going to soon, yes it's great”. And I explained how it was more of a community spirited thing, and she said “Oh yeah that's a good thing, that's what we'll be doing”. So, she was just playing along. So I've never been to her about anything since really.

*You remember Sheila and Katy working so hard to get the women's clinic established, and of course now that's been terminated, that must really be quite a blow to you.*

I was just amazed that there's no drop-in, it's ridiculous.

*How was that communicated to you?*

Well “we better take that clinic off next week because for the time being there isn't one because there's not enough nurses”.

*You've chosen to get out because it was an intolerable situation for you, but if you had the power to do something about this, what would you do?*

Employ permanent doctors, employ more nurses, and let us get on with our jobs really.
Do you think that SSP is capable of doing that?

No. They're not going to do, I know they're not. They've made it quite clear, haven't they? They don't know what the service is that's needed in this place, they don't have any understanding. Any given number of practices, you can't dilute them all into the common denominator, because it isn't a factory, it's people.

They're just hiring more and more locums, I suppose in a way it's better there are regular locums, but there are different names on a different basis. We come into work at eight o'clock, there'll be a name on the screen because they've booked them, we don't know if it's male or female, that is a huge problem, because of people's cultural needs. Many people will say “is this a woman or a man” I'll say “I'm sorry I have no idea”. So I suppose having the regular non-locums is a bit better.

It's just having no faith in the place, people are just leaving. The same people are coming through the door, and like the Christmas card list I showed to everybody last year, at Christmas time, there was about 36 people. This year there was about 15. It was absolutely incredible, in one fell swoop. Where's all the staff gone?

They just need to employ people who can cope. Even without SSP moving in there, there's a lot of demands put on staff there, and it's a challenge, and they need to employ people that can do that - doctors as well. There are plenty of doctors that can't cope with the challenge, haven't they, gone under. They're just not recognising that it's a different place. But he made it quite clear the first day that he was going to treat us, we're all the same, every practice was the same.

When the CQC came in to do their inspection, did they talk to you?

I've mentioned to you before about never coming away from reception for an hour to do the work that I'm supposed to do. Well amazingly enough I was put on a desk in the back to do admin, that was the first time in 12 months.

Did that mean they didn't speak to you?
No they didn't speak to me. Very odd. I was just in such a relief to get away. They just put another girl on the front. She wasn't very happy, because they were speaking to her there while all the madness was going on, it's always just chaotic.

So the CQC never tried to speak to you?

No

One of the things in their report, is that staff told them there were adequate numbers of staff. What would you have said if the CQC had spoken to you?

I would probably have said exactly what I'm saying to you, because I've said that all along, before I even gave my notice in, I've got nothing to hide, and I'd only tell the truth, and I'd say that we desperately need staff.
APPENDIX 4 - INTERVIEW WITH RETIRED PRACTICE NURSE

Jane Ford worked as a practice nurse in Princes Park Health Centre for nine years, resigning in May 2014.

I've been nursing since January 1984, I've got an unblemished career, I'm very very rarely off sick, never late, I'm very proud of my profession, and I've very recently resigned from nursing five, six weeks ago.

Why did you go into nursing?

When I was a child, I didn't even think I had a choice, that's what I wanted to do and that's what I ended up doing. I did a pre-nursing course in Mabel Fletcher College, and then I did my training in Broadgreen and worked there for a couple of years, I worked in Alder Hey, on the district as a community nurse for about 14 years, and then I've worked as a practice nurse throughout the city. I did all different centres when nurses were off sick, or on holiday, filling in for the nurses, bank work, so I've worked in many many surgeries across Liverpool over the years. Eventually I settled in Princes Park, and stayed there for nine years because as soon as I got there, that was where I was happiest, and that's the longest that I have ever been anywhere.

It was such a lovely atmosphere, quite calm, friendly, open minded, they would listen to you if you had any new ideas about trialling any sort of clinics or changing the hours to accommodate the clients. We could do a Saturday, for Somalian women to come in and talk about women's health because they were very busy through the week, cooking and looking after their families. Every idea that you came up with, if you put it before the GPs in our weekly meetings they were like “that's fine, yeah go for it, try that, see how you go”. So you were given a lot of freedom to practice, and that suited me.

We worked together as a team, the waiting room would be jam packed some mornings and then we'd just all say to each other “change of plan, I'll do nurse telephone triage, you be my on-call doctor, and the others will just bang away
in the background and we'll do what we can do today” so we don't have to send anybody away.

*Was this a commitment to meet the needs of different communities of vulnerable groups?*

It was completely a commitment, because you knew your patients that way, so if somebody came in and there was no appointments left, but you knew it was Mr X and he had mental health problems or he was vulnerable, you just couldn't let him go home, so you could either see him yourself, or speak to someone and say “He's just come in, there's no appointment but we really need to see him”. In some ways, the rules weren't the same every day because we could adapt to what we could see. We had enough doctors and enough nurses to deliver the care in a professional manner, in a safe manner, but we could adapt to the changes.

We had four practice nurses, and sometimes more. About five years ago, we'd have extra nurses brought in for training purposes, mentorship, they'd work with us, train with us, we would look after them, identify any particular problems they were having, and give them time and space, so they could watch what we did. I'm not saying it was perfect, but they would work alongside us for a couple of months and then they would be up and running, get their confidence and then go back to where they came from, or go somewhere else.

*Why did you leave?*

Over the last couple of years I became increasingly unsettled. There was the tender bid, changes, uncertainty. It just lost its ‘mojo’ for me, I didn't feel part of it anymore. A lot of the GPs that had worked there for years, they left and that changed the whole face of the thing. We were getting locum doctors in. Even moving into the new building, we didn't have the same sort of little community kitchen atmosphere, and so, I felt like starting to get disengaged from it because I wasn't getting any information from anybody. They weren't telling us what the process was, and we just knew that these changes that were coming weren't going to be for the best.
That was before SSP took over?

That started with the takeover process. And then when it was halted, we weren't really given too much information about why, it was all quiet for months and then we were out for tender again, the bidding was on and it just wasn't a very nice time, full of uncertainty with the disillusionment inside of Princes Park as well. We had fabulous GPs thinking “I can't really hang around”, and sometimes people were going to make life decisions. I think it swayed them to do what they were going to do, because they thought they were heading for some kind of disaster with takeover, and that created a big change in the ethos of Princes Park.

Katy, Martin and Mike all left?

Yeah, they all made big decisions faced with the uncertainty and they thought “Oh, I'm going to go now”. Lis stayed a bit longer, Mike went pretty soon on, Martin went, and Mike went, George went, and then Krish went, Dr Krish, he's fantastic, he kept us going when all the regulars, all the doctors that we'd worked really closely with, when they were all leaving, a lot of it fell onto him then and he worked so hard to keep the atmosphere going, and then we got Swami who came in as well. He tried very hard to keep it, they formed a little team, they did their best. Craig Mason came in, he was a fabulous GP, then as soon as he got wind of all this he was off as well.

We got new doctors in and we didn't know them. And some doctors coming in, the way we used to work wasn't their style. It was quite unique to Princes Park and not everybody wants to do it that way, and that's fine, that's their choice, some people like to have it more regimented by the day and stick to the rules.

How did things change when SSP took over?

Staffing levels dropped significantly, we were short on GPs. We became short on nurses. From the word go there was upset and complications and disruption. SSP came in heavy handed and decided that their nursing model wasn't going to be our nursing model. At the first meeting upstairs at Princes Park, they had told us that there would be no changes. Pretty soon they decided that they didn't want or need Band 7 nurses. There were four or five
Band 7 nurses, and they told them they couldn't really see a place for them at Band 7, and they would need to look at their contract, working hours, and where they would fit into the SSP model. So that's when the real unrest started.

As a Band 6, I was watching this and thinking it will be us next, definitely. Because we could see no reason on this earth why you would start getting rid of your Band 7 nurses. They're nurse prescribers so they write prescriptions, they do a complete consultation and the patient is discharged there and then, very similar to what a doctor does. We were short on doctors and then they're thinking of getting rid of the Band 7 nurses which, to me, was a bit of a no-brainer, they were helping us out of sticky situations. So we were all quite shocked.

The unions got involved, solicitors got involved, and the argument was upheld, the Band 7s are back in post now but first of all they had meetings with SSP which weren't particularly pleasant.

Mr. Pitalia was at the meeting in Everton Road. He didn't want any argument. He didn't want any meetings to be held outside of his meetings. Nobody is to be talking about SSP outside of these meetings. He didn't want us talking to each other, he didn't want us to have an opinion, really. Bully boy tactics in a way. We were arguing back to him saying “That's a bit Victorian isn't it? Obviously we've got opinions and we've got to say what we think. Obviously we're a bit uncomfortable with this situation, we don't know who you are, we don't know where you've come from, we don't know what the future holds for us”.

He wasn't really liking any of that, and banged on the table with his fist and just said, along the lines of, you're just going to have to put up with it really. You've been out to tender, nobody else wanted you. I've got you, or I've ended up with you, and I suggest we just move on and move forward. So that was that. And his wife became uncomfortable at his aggression, she was sitting next to him and wanted to control him and rein him in, because she could see that that wasn't going to go down well with us, and she sort of like pulled his jacket, and he just sat down, again.
We said “We can't be spoken to like that. That's not what we're about. If we've got anything to say we'll say it, we're not scared of him or anybody else on your Board. This needs highlighting, we need to speak to somebody.” But then, who was sitting next to him, in cahoots with him, is his Board, the whole lot of them, so we were saying there is nowhere to go, there is nobody really to talk to because obviously they all agree with him. If that was me and somebody had done that in a meeting, I would have stood up for that person and said “Hold on a minute, you know, you can't speak to people like that”. There was none of that, they all just sat silent on the top table and didn't speak up or say anything.

Were any GPs there or was this just practice nurses?

Just practice nurses. This was the second meeting, called really quickly because he was insinuating that there was cross words and unrest between his SSP nurses, and the nurses that he'd just taken over. And he wanted to stamp out any whispering, any ill feeling, any rumours. We just got an email to say it's imperative to go, so we all went thinking it was about development and new information for us, but it was a telling-off really.

They weren't supportive, they didn't come and sit and say “This is how it is”, “This is why we're doing it”. It was full on and aggressive, and the Band 7s just then became disillusioned with their post, didn't really function well at work, and so Clare went off sick for a while, and then we lost Clare as our nurse manager. I think the other Band 7 was off sick for a while too, so from there on in, the morale changed. Obviously the staffing level changed, we became absolutely run off our feet; it became a little bit unsafe. We were worried about the amount of people that we were seeing and that we were trying to deliver the healthcare the same way, but there was only two of us at the beginning of the week, and we were used to being at least three or four. So we had to just keep making changes all the time.

What was his attitude to the ethos of Princes Park, did he say anything?

No, no, he wouldn't have been capable of getting the ethos, you couldn't have had a conversation with him. We didn't meet him on a one-to-one. We didn't
have time to discuss anything with him, and I think it would have gone right over his head. He wouldn't have been interested, so no.

Did anybody say to him that Princes Park is a special situation with special needs population?

We'd raised concerns about Princes Park and the ethos there and how we worked, and how adaptable we are to change, and how we can't work with hardly any staff. We can't do what we've always done. We can't provide the care, and that Princes Park, because of its weighting, the amount of patients that we can categorise as at-risk, mental health patients, chronic diseases, a lot of patients with quite needy circumstances so that we did need a good teamwork in there to provide adequate healthcare for them. Female genital, FGM; all kinds that you can come across on the open door. There was a ‘Well Woman’ clinic on a Tuesday afternoon. That was just a drop-in, and that was for any woman with any issues, to just come and see a nurse.

They said we've brought in this nurse, Hazel somebody, who's going to come in and do the consultations her way in Princes Park. She said she was coming to do ten minute consultations with our clients, and she'd sort out the backlog of chronic disease, diabetics, COPD, all those things. I said “You won't be able to do our patients in ten minutes, that's disrespectful, it will take longer. They're not just coming in with COPD, they're not just coming in with asthma, it will take longer than ten minutes.” She said I've worked in practices right around the UK, I've done city centre in Birmingham, Cardiff, whatever, and I've been to Princes Park and you're no different than anyone else and I will do your patients in ten minute slots. I said “Well I'll have to give you the heads up on some of them before they come in then, if you've only got ten minutes for them, and explain their background” and she said I don't need anything, I'm just going to do what I do. A chronic disease assessment means that you've got to assess the whole patient, head to toe, assess the medication, 'How is it? How are you getting on with them? Do you need any changes,' and then monitor them and bring them back. I said “If you can do that in ten minutes I need to learn from you, you are fantastic and so can I sit in on your
consultations with you, because I'm just going to learn so much from you and you're going to change the whole face of delivery of care, brilliant.”

Did she let you in?

No, she didn't invite me in. But I went and found out after she'd done her clinic. One day she asked us to book a full clinic for her, so we did, and I was doing a drop-in ‘Well Woman’ on a Tuesday afternoon. Just packed out the door with women. She forgot she was supposed to be coming to Princes Park, so she was in Manchester or another SSP clinic. We rang her and she said tell Jane to start my clinic, and I said “I'm not starting your clinic, because I'm doing my own clinic”. She turned up in Princes Park and patients who'd come for spirometry, blowing into the machine, a lot of them had left because they'd been waiting for over an hour so they'd walked out. She caused a major kerfuffle. She upset the girls in reception, and I just said to her “when my clinic's finished you need to wait and I need to speak to you, and see how you think you can just come in here and do ten minute consultations, or not turn up or forget about us or whatever, so we need to have words.” So we did, and she was dismissive, arrogant. She was dangerous - probably is the word I'd apply to her, couldn't be spoken to, didn't want to listen. I don't know what was going on in her head, don't know her agenda, and she's gone.

She left SSP overnight, very quickly. We were told “Take her email address off your emails, and for no reason whatsoever contact her. If there's any questions about it speak to whoever in SSP”. It might have been Julie Cheetham.

Did they start using locums straight away?

I think we got locums in pretty quickly, yeah. They didn't turn up, they had full clinics booked so there was patients sitting outside for ages, there was admin errors and I don't know whether it was our admin or their admin. The doctors weren't turning up, or doctors would turn up and there were no patients in for them. The locums mostly came from Manchester so they didn't know Liverpool. They didn't know how to refer on because they didn't know the area. I got asked a few times “Where shall I refer them to?” Say it was an eye complaint, they didn't know about St Paul's, there was a drop-in there, had a
little A&E attached to it. We were constantly saying to them, this was in our working day, we're trying to run our clinics, “Are you ok with the whole clinic, do you know where everything is, do you know where to refer” and we just used to message them “If there’s anything you need to know, just message us and we'll come along and see you, and see if we can help you out”, all for the patient's benefit. Because we weren't confident that that was the best system ever.

There was no continuity of care, because patients were coming in and saying they've got to repeat themselves over and over again, they've got to explain the whole situation and time would be running out, because it's a ten minute consultation. The locum wouldn't have time to look into the whole history of the patient and then deliver his consultation in the given time, because of the time restrictions. The notes should all be there on the computer for the doctors to read, flick back and have a quick read of, but you know that there's more to it than that, there's a lot of background to a lot of illnesses. Familiarity can be a good thing and a bad thing, we know that as well, but that's what continuity of care is.

The consequence is they won't get the complete consultation. They won't get their health needs met and then there's a risk to the patient that whatever's happened has happened and they're maybe not on appropriate meds. They haven't been sent for the appropriate referral, so it's a huge risk.

Patients would make an appointment with us to come and see us, because we'd put them over to another doctor who wasn't a locum, or asking us could we help them out with their care or give them advice and support. They wanted to see somebody who they knew had been in Princes Park for years, so we were getting overloaded with inappropriate things really, but understandable. We were already down to two nurses. Patients wanted to ask us “What's going on here?” and tell us what was going on. SSP would be looking at that and saying “What were you doing that day, did you just chat to everybody?”

Certain patients know how to get appointments, and that was leaving a huge risk to patients with acute illnesses who needed to get in, like asthmatics and
babies with bronchiolitis and rashes and things. That was the big worry, were we seeing these patients or were they getting turned away? We don't know until maybe there was a disaster or something.

Were there any days on which there were no GPs?

I think we would have had a GP most days. I would probably say one GP plus the on-call.

Was there ever a day with no practice nurses?

I'm not sure how often that would happen but I know that has happened. It would be when Clare had left, when one would be on annual leave and another was off on sick, and I was at that time just doing Monday / Tuesday. So if someone was off that week, there would be Wednesday, Thursday, Friday not covered by nurses.

So there began to be a crisis over appointments.

In all fairness, there's always been a problem in Princes Park with appointments, that's a complete given. It's not easy to get an appointment because of the demand. How that changed was, there was less GPs, there was less nurses, so the appointment system obviously was overloaded, the demand stays the same but we just couldn't deliver the health care.

Did it get worse when SSP came in?

It got worse because we'd lost GPs, because there was all these locums and there was all these mixups with appointments. I'd say every other day there was a clinic on that was filled but the doctor didn't turn up, or the doctor turned up but there was no clinic on, there was always a disaster. I think they were saying that they'd put more locum doctors in for the appointment system but it didn't always materialise that way.

With SSP, what was the procedure if you thought something was wrong?

We would discuss it among ourselves, maybe the nursing team brought it to Clare, and then Clare would send off an email to managers saying a risk has been identified. She'd email Neaka, the practice manager, and then expect her
to deal with it or escalate it, whatever she wanted to do. She's not very effective, and she's employed by SSP. So she was trying to keep things sweet maybe for her job. I don't know her agenda. And I don't know if she came in and actually managed us. I never had any emails off her, from when she took over maybe three emails about things that were going on in Princes Park. [The former Practice Manager] Karen Hewitt would email you two or three times a day about what's happening.

_How would SSP respond when they got a concern raised with them?_

I can't remember us ever getting anything back from them. Or it would be ‘Oh we're looking at next week and we've got more GPs coming in next week’. That's the big point about SSP is they're not very accessible, they don't show themselves, you don't know who they are. They're not around. They're just not approachable.

_After Clare left, and something went wrong, what was the procedure then?_

It was the same. We'd say this is a bit risky and send out an email identifying risk, to Neaka. Maybe you wouldn't get a response.

_We know that they have a whistleblowing policy. Who was the person you were supposed to blow the whistle to?_

(very long pause). Don't know.

_You're a staff member and you don't know who to blow the whistle to._

mmnnnh

_They have a whistleblowing policy, they handed it out to the staff, and it doesn't tell you the name of the person you're supposed to blow the whistle to and that's why you didn't know_

Yeah, no we never, it's true. We've talked about that.

_You were in post when the CQC visited. Did they speak to you?_

yeah
Did you say that there were any issues of patient care arising from this situation?

We discussed access, appointment system, people at risk, the asthmatic patient who didn't get an appointment who ended up having an asthma attack and getting rushed into the Royal and she ended up on the respiratory unit and was very very ill, and that bothered me, and we used that as an example.

What was your impression of the SSP report?

From the CQC? It didn't correlate.

What do you think should happen now?

I think that the contract should be taken off them, and I think they should be held to question about where they got the contract from, what was their plan, what were they thinking, what did they intend to do, what was their big picture really of taking over these ten surgeries in Liverpool? What was their motive?
APPENDIX 5.1 – EXTRACT FROM WITNESS STATEMENT BY MS CLARE CORLESS (FORMER PRACTICE NURSE AT PPHC) TO INDUSTRIAL TRIBUNAL RE SSP

Staff levels at Princes Park began to deteriorate and the situation gradually worsened. There was a severe shortage of doctors which resulted in a lack of medical cover and support. The SSP began to use locum doctors more and more but they would often fail to turn up, or weren’t booked correctly in the first place. Even when we did have some cover from locums, it made working at Princes Park much harder than it previously had been because the locums were totally unfamiliar with the way the practice worked. This had a serious knock on effect to my role. Locums would order lab results, but then wouldn’t be there to collect them so somebody else had to mop up the work. Prior to the transfer, lab results would be collected electronically from the labs and were assessed by the clinician who had seen the patient and ordered the investigation. Now however the SSP said the nurses were to oversee the results. This meant going through each patient’s notes and investigating why the bloods had been ordered. Sometimes the locum doctors did not complete notes and this left the nurses wondering what the bloods had been ordered for. This is a clinical risk and again meant that nurses were overloaded.

Due to the lack of doctors, my colleagues and I were unable to approach the remaining doctors with queries as they simply didn’t have enough time to look at these. To say there was a severe lack of medical support is an understatement. Levels of administrative staff also reduced at the same time creating huge problems. There wasn’t enough cover for the reception desk as the SSP moved some of the reception staff to the admin team. The remaining staff were completely overloaded. Other staff would be moved to other practices if people were off sick leaving Princes Park even more understaffed. There was no strategy in place for any problems. Everything was in disarray. Everyone was at capacity and stress levels were high. Patients weren’t attended to so they were simply left waiting in the reception area. I often assisted where I could to help ease the situation, even though this wasn’t part
of my duties and responsibilities as a clinician and with the lack of GP cover, I was extremely busy myself. Two full time GPs had left prior to the transfer who were not replaced. Also one GP was on maternity cover and nothing was put in place to cover this leave.

I noticed, almost immediately after the transfer that the standard of patient care dropped significantly. One of the major problems was that patients were unable to book appointments. The SSP reduced the number of doctors on duty at any one time, and failed to get locum doctors in to cover periods of annual leave, despite having said that this would be arranged. Due to the deteriorating working conditions, GPs started to consider resigning from their roles with the SSP and had contacted the BMA about the poor conduct of the SSP and standards. This caused further problems given that we were already short staffed. Patients wanted to book appointments with their regular GP but were unable to, so the burden was overloaded to locums or me as a nurse. The effect of this on me and the other nurses was an increase of work load and responsibilities and the creation of major clinical risks. The number of patients we were seeing increased, including the variety of ailments that we were treating. This was a serious clinical risk as we were dealing with issues that we were not trained in. Another issue was that patients could not get reviewed for repeat medication. The nurses, including myself, would try to sort this problem to support the patients as best we could by either seeing the patients ourselves or sorting out medication as patients could not get appointments to see a GP to review medication, so could not get repeat prescriptions and were running out of medication. When the appointments situation was at its worst, patients would have to call many times before the phone was answered and they would be queuing outside Princes Park from before the practice opened.
SSP are using locums much more extensively than LCH ever did. This extensive use of locums increases my work load as a Practice Nurse. In particular, locums do not know the staff, procedures, referral systems or where things are kept at Princes Park. Therefore I often have to pick up on their shortfalls. For example they leave unlabelled specimens in the utility room which I then have to sort out. This creates a huge overloading of work when I am already very busy given the lack of staff. Locums do not have the same commitment to Princes Park as regular previous staff did. A prime example of this is that I asked a locum to label a specimen that he had left out in the utility room and I pointed out to him that an unlabelled specimen would have to be discarded and thereby delay the care delivered to the patient. The locum replied to say “I am a locum and I don’t care”. I reported this to the Practice Manager at Princes Park in May 2014 on an incident form as a totally unreasonable working practice to have. Instances like this make it clear to me that SSP are simply not interested in providing an adequate level of care to patients. Whilst I did expect some level of transitional period following the transfer, it now appears that SSP just doesn’t have the capacity or the will to run Princes Park properly.
When the transfer was confirmed shortly before it actually took place, at least two of my GP colleagues resigned from Princes Park. Following the transfer, these GPs were not replaced by SSP, despite the need for the same level of clinical staff which we had previously enjoyed.

Following the transfer, and in particular following my colleagues’ departures, which left a shortage of clinical staff at Princes Park, we struggled to provide continuity and quality of care to patients. In particular, SSP only employed locum doctors as opposed to replacing permanent GPs. This created huge problems with continuity of care for patients.

My workload increased significantly following the transfer, as did that of the other GPs. The locum doctors who came in to Princes Park had no idea about the regular protocols and processes at Princes Park. This meant that even jobs which are considered simple to GPs, such as medication reviews and requests, were becoming problematic and left incomplete. This also resulted in an increase in the workloads of the reception staff and in turn it mounted on the regular GP’s workload.

The GPs at Princes Park had weekly meetings to discuss clinical issues, significant events, management of complex patients and clinical governance issues. Nurses, the Practice Manager and a member of the reception/admin team would also participate in the meeting. My colleagues and I would regularly highlight the issues we were facing and the inability to deliver quality of care due to the lack of continuity and inappropriate referrals to secondary care. We would strive to find methods to improve the standards. Minutes of these meetings would usually be taken which I understand were forwarded to SSP’s management team. The issues were therefore clearly highlighted but were never addressed in any way.
In addition during this the period my colleagues and I made various requests to SSP’s Head Office in an effort to obtain additional clinical support. Finally, in around October to November 2013, SSP began to provide regular locum doctors to Princes Park. By this point, it was absolutely vital that something be done to ease the burden on the remaining staff but I do not think SSP took sufficient action to support us. As I have mentioned, locums are unable to provide the same standards of care to patients as regular GPs therefore standards were continuing to fall and the working environment was becoming increasingly difficult.

In addition to the problems with staffing levels, my colleagues and I also wrote to the Medical Directors of SSP, the Drs Pitalia on several occasions to highlight other concerns at Princes Park.

I felt that all of the changes to Princes Park began to affect me personally and my ability to work to the highest standards which my patients needed. There was no attempt to provide any in-house training for the staff, as we had previously been used to, except for mandatory CPR training. This was despite several requests for training during our practice meetings.

I also consider the changes to have had a detrimental impact on the patients. Some of the patients would have to rebook appointments if they wanted to see regular GPs because in the first instance they were seen by a locum. On a few occasions patients complained to me about the standard of care offered by locums because they were insensitive to the patients’ problems and refused to deal with more than one clinical problem. Whilst I can understand that the locums were under pressure given the time allocation for appointments, I consider it essential that patients are made to feel comfortable to talk about all of their problems. This was not happening.
Following the transfer to SSP in April 2013, I noticed a substantial change in working conditions which created a detriment for both me and my colleagues. The main changes which created significant detriment to me personally were the falling standards of patient care, the severe deterioration of staff levels and the burden placed on me as a receptionist, to deal with an impossible administrative working practice.

Princes Park is a very busy and demanding practice. A lot of the patients of Princes Park are vulnerable and often English is not their first language. This requires the staff to be very committed to the patient group in order to properly provide the service they require. Prior to the transfer, I very much enjoyed my employment and found my role to be very fulfilling. I enjoyed helping patients in my capacity as a receptionist and it was clear that my colleagues, including the Claimant were also committed to the same goal.

The situation got so bad that there would be occasions where Princes Park opened at 8am and all the appointments would be gone by 8:10am. There were articles in the local press regarding this situation. In addition several patient concerns are raised in the survey.

When the lack of appointments was at its worst, patients would be queuing up outside Princes Park at opening time. SSP were well aware of this situation but took no constructive action to resolve it. Instead, SSP instructed me and the other reception staff to attend to one patient in the queue followed by one patient on the phone. This was very difficult and frustrating for both me and the patients. It was particularly hard when a patient in the queue would hear me book an appointment on the phone and then if that GP was fully booked and I wasn’t able to offer them an appointment as well they would say “I’ve just heard you give one out”. It was understandably frustrating for the patients but there was nothing I could do to help them. I felt that only SSP could take steps to resolve this situation, but they just didn’t.
There was a lack of continuity for the patients, they would want to book appointments with their regular GP but when the GPs had left, I was only able to book appointments with locums. I felt that SSP had given absolutely no consideration to the patients’ needs and instead shifted the burden of their complaints on to me. There were several occasions where I received verbal abuse from patients to whom I was unable to offer appointments. This was very difficult as I could see why they were annoyed but I couldn’t offer to help. I really felt like I was letting them down. In addition, patients expressed how they felt sorry for me and my colleagues because we had to deal with the situation created by SSP.
Bill Esterson MP criticises company responsible for managing surgeries in Sefton

Sefton MP Bill Esterson has criticised the performance of a private health company which is responsible for running surgeries in his constituency.

Mr Esterson has told the Herald that constituents have complained to him about appointment delays at surgeries in Freshfield, Hightown, Thornton and Parkhaven, which are run by SSP Healthcare.

Mr Esterson said: “At Hightown, patients have told me of the surgery being shut when it is supposed to be open and about difficulties with staff at the surgery on top of the difficulty in seeing the doctor.

Now at Thornton, at Freshfield and at Parkhaven, my constituents have told me about the use of locums and of the delays in getting an appointment. The surgeries at Hightown, Freshfield, Thornton and Parkhaven are run by all SSP Healthcare, who took over running the practices from the Primary Care Trust. SSP Healthcare promised to me that they would employ permanent GPs at their surgeries when they took over but this appears to be taking a very long time.”

Mr Esterson also claimed that the Government had ‘washed it hands’ of the problem after he was told that the matter was for NHS England.

He added: “One patient told me that the GP practice that she has attended since 1978 is now falling apart as good doctors have been replaced by locums. It has taken her two weeks to get an appointment for blood test results and
her experience is typical of what you are telling me. The difficulties in seeing
the same doctor, the attitude of staff and the state of the waiting room are all
issues which have been raised with me.

“The problems with seeing a GP, which so many of you are experiencing, are all
part of the reorganisation of the NHS which the coalition government pushed
through with the Health and Social Care Act. Tomorrow (Friday) my Labour
colleagues and I will vote for the NHS (Amended Duties and Powers) bill, which
aims to stop the worst of the Health and Social Care Act, including the
privatisation of services.”

A spokesman for SSP Healthcare said: "National changes in the health service
required NHS England Merseyside to begin a procurement process for 20
practices in Liverpool and Sefton in 2011. The advertisement followed the
principles of OJEU, which meant that bidders could tender for these practices
from all over the UK and Europe.

"A number of surgeries across the country currently face closure. Smaller
practices are at higher risk and probably need to work in different ways if they
are to remain viable. It is the commitment and hard work of dedicated staff at
SSP Health which has supported the ability of a number of such smaller
practices in Sefton and Liverpool to remain viable and avoid closure. There is a
national shortage of GPs. In addition most doctors now choose to work only
part-time in general practice.

"SSP Health offers flexible working and innovative solutions to support
retention and recruitment of doctors. SSP Health strives to ensure patient
access is available for all those in need of clinical care. Sharing care across
groups of practices is something that SSP Health successfully pioneered many
years ago. This is now being replicated in many parts of the country and widely
recognised as an effective solution to improve access for patients. All SSP
Health surgeries offer a mix of same day and pre-bookable appointments to
suit patient needs for urgent and planned healthcare. The number of
appointments available at each surgery is defined by NHS England. This is
calculated objectively using a nationally agreed formula which takes account of
the special needs of patients in each practice. This includes factors such as
deprivation and age plus patients resident in care homes, in need of additional healthcare. Prior to the procurement, a number of private and other providers were running 11 GP practices in Liverpool.

"The PCT was running 9 GP practices in Sefton. All these previous providers including Sefton PCT were funded at significantly higher levels than the fixed price at which these practices were advertised and contracts awarded to SSP Health. Each practice is now funded at levels consistent with other practices across Merseyside. NHS England is responsible for measuring and monitoring the quality of services delivered by all GP practices in the country.

"SSP Health practices, including Hightown, Freshfield, Thornton and Parkhaven, have regular contract reviews with NHS England. It is important to note that every SSP Health surgery is delivering services as expected by the contract held with NHS England. As part of the national inspection programme, some of the practices have satisfactorily passed additional reviews by the Care Quality Commission (CQC) and Healthwatch.

" These independent inspections include detailed assessments of appointments system, access for patients, staffing levels, quality of services and administrative systems and processes. CQC is responsible for the mandatory registration for all practices in the country and is responsible for ensuring that the provider delivers services in keeping with the standards laid out by it. SSP Health is working with Healthwatch and NHS England to develop patient participation groups in every practice NHS England uses an objective measurement for the quality of services provided by GPs nationally. This is the Quality and Outcomes Framework (QoF), implemented in 2004. SSP Health has developed significant experience in implementing systems for QoF to ensure that the maximum number of patients with conditions such as heart disease and asthma are seen at the surgery for their health reviews. This methodical approach achieves better health outcomes for patients and SSP Health consistently delivers high levels of QoF performance every year since 2004. This was part of the evidence used by the commissioners to make the decision to award contracts to SSP Health. SSP Health has achieved higher levels of health outcomes for our patients in."
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
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<tr>
<td>APMS Contract</td>
<td>Alternative Provider Medical Services – a type of contract between commissioners and outside contractors who provide GP services</td>
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<tr>
<td>ASA</td>
<td>Advertising standards authority</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group. A group of local GPs who have responsibility for commissioning hospital services. Have some responsibility for quality and improvement of primary care services and increasingly involved in co-commissioning primary care services</td>
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<tr>
<td>Clinical Governance</td>
<td>A framework through which a practice endeavours continuously to improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission – responsible for checking that GPs (and other health care providers) are meeting national standards</td>
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<tr>
<td>FOI</td>
<td>Freedom of Information - The Freedom of Information Act 2000 provides public access to information held by public authorities. The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland</td>
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<tr>
<td>FESC</td>
<td>Framework for procuring External Support for Commissioners (UK)</td>
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<tr>
<td>GP</td>
<td>General practitioner or family doctor</td>
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<tr>
<td><strong>KONP</strong></td>
<td>Keep Our NHS Public. Local branch is known as KONP Merseyside</td>
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<tr>
<td><strong>Locum</strong></td>
<td>A locum is a doctor who temporarily fulfils the duties of a regular GP. Most are employed by larger agencies</td>
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<tr>
<td><strong>NHSE</strong></td>
<td>NHS England – Since April 2013, NHS England has taken on many of the functions of the former primary care trusts (PCTs) with regard to the commissioning of primary care health services, as well as some nationally-based functions previously undertaken by the Department of Health. There is a local area team for Merseyside</td>
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<tr>
<td><strong>PCT</strong></td>
<td>Primary Care Trust – The organisation responsible for commissioning many NHS services prior to April 2013. Until 31 May 2011 they also provided community health services directly. No longer exists</td>
</tr>
<tr>
<td><strong>PMS contract</strong></td>
<td>Personal Medical Services. Similar to APMS, but the main use of this contract is to give GPs the option of being salaried.</td>
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<tr>
<td><strong>PPHC</strong></td>
<td>Princes Park Health Centre</td>
</tr>
<tr>
<td><strong>SSP</strong></td>
<td>SSP Health Ltd. A private healthcare company. Directors are Drs Sanjay and Shikha Pitalia, who own all shares</td>
</tr>
<tr>
<td><strong>TUPE</strong></td>
<td>the Transfer of Undertakings (Protection of Employment) Regulations 2006</td>
</tr>
<tr>
<td><strong>Zero hours contract</strong></td>
<td>An employment contract between an employer and a worker, which means the employer is not obliged to provide the worker with any minimum working hours, and the worker is not obliged to accept any of the hours offered</td>
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Princes Park Health Centre: The destruction of community based GP services

Report available on: www.labournet.net/other/1502/konp1.html

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