Written evidence submitted by Neil Spooney (FGP0376)

This submission is made by me, Neil Spoonley, living in Shropshire. I am retired and have moved from France back to the UK in 2020 and feel that my submission may be of interest. I would like to see that all Medical Practices are services that their Patient Communities are openly proud of, which seems not to be the case at present.

The outpouring of praise for the NHS is dominated by the hospital element and obscures the fact that the gateway for most people to NHS services is their local Medical Practice, for whom, I feel, there would be far less praise.

My contribution is small but I would like to encourage a really serious reform of the way the Medical Practices operate and that they should be much more respectful of the communities they serve. In that way we can all then be openly proud of them.

Part 1: Practice-Patient Community Interface

A Medical Practice is a good example of a complex, non-fee-earning, quasi monopolistic service being delivered to a bounded or defined community. For many years of my life I have directed very successful services with a similar definition in academic and research fields. I learnt that within such a service there must be excellent communication, both ways, between the principal components of the service.

In a Medical Practice this means that the Management must work well with the Clinical staff, but of particular importance is that the Practice overall must have an excellent informed relationship with its users, i.e. the Patients. Without the latter the Practice can turn inwards, becoming opaque as opposed to transparent, capable of absorbing resources without benefit, resistant to change, defensive, and unresponsive to the needs of the community of Patients.

This lack in some, or maybe, many Practices implies that there is no obligation within the rules of the NHS to ensure a demonstrably adequate interface with the Patient Community for every Practice. This need not add to cost and can be managed at a medium level in the organisation, with senior overview and subject to regular inspection/evaluation.

Such an interface requires that the Practice maintain a regular information flow to the Community so that their input to the Practice is informed and constructive when meetings or other exchanges take place. The flow could include performance data, staff and working practice changes, modifications to the range of services etc. This approach will engender respect and support for the Practice even in the most difficult of times.

I ask that the Committee recognise the role to be played by local Communities in shaping local Practices to meet their needs. This need not conflict with NHS overall as much of it is concerned with the attitude of the Practice. It is my belief that without adding the Patient dimension many investments into a Practice will not have the effectiveness that is desired.

I want Patient Communities to be openly proud of their Medical Practice and an NHS instruction to effect this change would go a long way to rebuilding any trust that might have evaporated.

Part 2: Non-Clinical Staff and Resources

There must be a wide range of Medical Practices, but I would like to present the profiles of two; one in England, and the other in France, both of which I have experienced in the last few years. They are situated in small towns, in largely rural communities, providing a wide range of services, and with occasional visits of specialists, with the only significant difference being their served populations.

	England	France
Local Population	Env.10,000	Env. 4,000
Nearest large Hospital	30 mins. drive	25 mins. drive
No. of Doctors	7 part-time (equiv. to 4 full time)	4 full time
No. of Nurse Practitioners	2	4
No. of Nurses	5	
No. of Physiotherapists		2
No. of Managers	7	
No. of Coordinators	2	
No. of Receptionists	10-12	2
No. of Office Areas	40-50	12-15
No. of Sites	2	1
Open Hours per Week	42.50	49
Walk–In services	None	Early every morning
Accident & Emergency	None	For minor situations

For two very similar Practices there is one glaring divergence and that is the resources consumed by the non-clinical aspects of the Practices.

There is a difference in the non-clinical staffing levels, by a factor of 8. Very roughly there are 2 non-clinical staff per clinician for England but in France it is 0.25. Perhaps there is some fundamental difference between the National Health Systems to enforce this difference, but it should be

challenged. It is also possible that the above example is rare, but even if that is the case one wonders how it was allowed to happen.

The objectives of the non-clinical staff are:

- *To provide a sympathetic, friendly, and efficient gateway for patients to access clinical services, and*
- *To create, support and maintain an environment that permits the effective and efficient use of the clinical resources in the interest of the Patient Community.*

But, why should an English Practice be so heavily burdened by non-clinical staff in order to deliver a similar service? Can the cost of this extra burden be justified? This raises questions of budget allocation, audit, oversite, and accountability. Who would authorise the complement of non-clinical staff? Who establishes norms for Practice management? How are the Practices audited against targets and norms? There are so many questions that deserve answers, including 'who really cares?'

The Inquiry should explore appropriate staffing levels, budget allocation, oversite, and audit procedures to ensure that funds and staffing levels are focussed on the delivery of service to the Patient Community, maintaining a reasonable balance between non-clinical and clinical resources.

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