**Bridge Cottage Surgery**

**Patient Participation Group**

**Annual General Meeting Minutes**

***20th February 2023***

Chair: Ian Skidmore

Present: Jan Jacklin, David Bell (DB), Jaqueline Pountney (JP), Carolyn Clark, Ian Skidmore (IS), Roger Aubrey, Neil Burns (NB), Sue Fletcher, Dr Kunal Chandarana (KC), Debbie Crossley

Apologies: James Young, Sara Otty

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| **Item** | **Notes** | **Action** |
| Nominations for Membership | Standing down from PPG are: Roger Aubrey, Ian Skidmore and Sara Otty |  |
| Nominations for Officers | No nominations for Chair, Vice-Chair or Secretary |  |
| Election of Officers | DC has agreed to act as Secretary, producing Agenda and typing Minutes  Currently no Chair or Vice-chair | To be discussed at next PPG meeting |
| Minutes of the last AGM – 21/01/22 | Minutes were agreed as correct |  |
| Presentation from Practice – Dr Chandarana (KC) | KC began by thanking the PPG for all their hard work and stated that they are a valuable conduit between the Practice and patient population and that the Surgery understood how difficult it has been during COVID.  KC explained the pressures being faced by the NHS and primary care with the backlog from COVID, an ageing population needing more input and the recent strikes. COVID and strep-A spiked around Christmastime and although this has declined, levels are still higher than historically. As secondary care struggles, more work is often diverted to primary care.  Over the last 12 months the Surgery have audited the appointment system. In response, the system has been changed and most recently more advanced face to face appointments have been offered with same day appointments focusing on minor illness/emergency issues.  Demand has increased and to meet this demand the Surgery have recruited more GPs and now have more clinical hours.  The clinicians are concentrating more on Long Term Conditions (LTC) as during COVID focus was on the most urgent/high level needs. During COVID patients either chose not to come in for bloods requested or were unable to have bloods done at the Surgery when phlebotomists from the hospital were reallocated. Since April we have tried to get all reviews done ie. cervical screening, LTC reviews etc. Audits are regularly done for those on high-risk medications which need blood monitoring, non-attenders and high risk cancer referrals.  KC mentioned that support from the PPG to encourage patients to attend for LTC reviews and screening when invited. Educating patients to use the most appropriate clinician for their problem including community pharmacies. The community pharmacist can refer back to the Surgery if necessary.  NB – suggested an education campaign including posters and website update to inform and encourage  DB – stated that, with the workload of pharmacies currently, he would be concerned about talking to a pharmacist within a reasonable time.  KC replied that the NHS are pumping more money into pharmacies and other services to support patients and surgeries. Although he did understand that their workload had also increased.  KC explained the reception booking protocol used to triage patient to the most appropriate clinician. It is understood that online booked appointments bypass this triage so may not be as appropriately booked.  JP – asked whether it was more appropriate for a nurse to triage rather than a receptionist.  KC replied that any clinicians would need time to assess and then time to book into for an appointment, hence using 2 x 10 minutes rather than just the one appointment. The reception protocol has been developed by KC and the Partners with pathways to follow. Patients are encouraged to provide a reason for their appointment to ensure the correct clinician is booked for the problem. KC encouraged anyone to provide feedback of any instance where distress or harm may have been caused to enable us to amend the protocol if necessary to make it robust and safe going forwards.  Going forward the NHS will continue to struggle with the backlog, ageing population, and lack of clinicians.  KC once again thanked the PPG for all their hard work over the year. |  |
| Report for the year 2022 | (IS) – In the past year we have had seven meetings, 2 face-to-face and 5 by Zoom.  My personal preference has always been for face-to-face as it allows more personal interaction between attendees, but Zoom has worked well when we have been restricted by Covid and personal availability.  This short report is not a list of all the things that have happened in the year, such as the new phone system and the revised booking system but a note of those where the PPG been involved. It is also not a list of complaints.  During the year while still under restriction and the use of downstairs for vaccination we could not reactivate our monthly information tables, this can be an objective for 2023.  Sara Otty has continued throughout the year with her very valuable monthly information pieces in the Parish Magazine and more widely. As she is stepping down a challenge will be to keep these going. Thank you, Sara, for all your hard and focused work.  The PPG also needs to think about other means of communication to the patient population in 2023.  We had intended to audit our performance during the year but soon realised that the abnormal condition of the past two years could not give a valid picture. This year could be different. The same applies to the practice survey we intended to run with the Practice. The tools are available to do this at some point in the coming year.  The PPG had significant input into the revamped Information and Services sheet during the year, thus making it more informative and understandable.  One of the concerns throughout the year has been and continues to be the relationship of the Practice to the PCNs to the North and South of us and the effect that not being a member of either might be having on the availability of some services to the patient population, for example social prescribing and first point physiotherapy advice. We realise that this is a matter for the Practice Partners, but it is perhaps natural for us to wonder if we are missing out.  Patient feedback has led to more advance bookable appointments being available.  The Practice has several new receptionist staff and we have suggested that empathy training and advice on dealing with unwell patients should be part of their training.  Practical matters raised recently include Waiting Room ventilation, Communication via Systmonline and design of consultation areas to allow better face to face discussion.  A challenge for the forthcoming year will be to ensure that the newly available patient record access, now active, is understood by patients and used by them to their benefit. This will be a major communication challenge in which the PPG should participate.  Finally, I should like to thank the PPG and the Practice staff for all their work during the past year and indeed since the PPG started. I am standing down because I must reduce my outside commitments, there are others on that list too. In particular, I should like to thank Debbie Crossley, in a potentially difficult position as the interface between PPG and Practice. Her advice has always been sound and delivered cheerfully, reminding me on more than one occasion that the mountain I see before me is in fact a molehill. Thank you, Debbie, and thank you all both present and absent. Good luck in 2023.  DB – gave thanks to (IS) for his chairmanship over the years | Actions for PPG to consider –   * Monthly newsletter * Yearly audit of PPG * Patient Survey * Patient Access to records education |
| Question Time | (IS) questioned whether not being in a PCN was detrimental to patients  KC replied that the Partners have thought long and hard and been in and out of PCNs since they started in 2019. The PCN contract was set to run from 2019-2024. The new contract is currently being negotiated but has not yet been circulated to Practices. The PCN contract states that if a practice chose not to opt-in to a PCN, services would still be provided to the patient population by another PCN.  By being part of a PCN, you potentially have more say in the ARRS (additional roles ie, physio, social prescriber, pharmacist) who are recruited. However, the level of Partner time involved in meetings and roles for the PCN is extremely high and takes away from patient time.  Other practices struggle to recruit Doctors and Nurses and therefore rely more on the ARRS staff. However, we have used ARRS as an addition to our clinicians and have been able to meet patient demand. The PCN providing services to our patients provides clinical pharmacists and when they have recruited a social prescriber/first point physio our patient will have access to these.  (JP?) – who runs the PCN  KC explained that each PCN has a Clinical Director who reports to the ICB (Integrated Care Board – which used to be the CCG). Funding comes from NHS England and the income goes to the PCN.  (JP) – Do you think patient population will increase with local new builds  KC responded that our population levels have been fairly static over the years. With the recruitment of 2 new GPs in the last 12 months we can meet demand.  KC stated that we do not know what the 2024 GP Contract will contain as this is currently being negotiated with the BMA who, working with the NHS target to tackle health inequalities going forward, are asking for a levelling up rather than levelling down. We don’t know what the funding formula will be like, whether QOF (Quality Outcome Framework) or whether more funding will go to socially deprived areas. KC also informed that the CQC (Care Quality Commission) will be inspecting ICSs from April 2023 and publish their views. |  |
| Any other business | None |  |
| Next Meeting | TBC – 6 weeks between meetings | DC to audit to agree day/PM for best attendance |