Prices Mill Surgery
Patient Participation Group

Minutes of PPG Meeting 28th January 2013

In attendance:	Kate Kay, Chair Duncan Mann John Miles Sally Millett Marilyn Miles, NHP Chair Ros Mulhall, GP Paul Young
Apologies	Liz Green Winifred Page Betty Young

1. Welcome

Kate welcomed everybody to the meeting, and wished everyone a happy New Year.

2. Minutes of last Meeting

Sally noted that she was present at the last meeting, but accepted that she may not have signed the attendance sheet. Her attendance was therefore duly noted.

Matters Arising

Kate noted that at the last meeting, it had been noted that the practice were working with the Primary Care Foundation (PCF) to review the efficiency of the practice's appointment system, with a view to determining how well the practice coped with striking the right balance between short and long term appointment availability.

An audit of the practice's appointment uptake was undertaken originally in October, but this was felt to be potentially an unrepresentative period, given that a number of staff were away at the time – the practice had limited options in terms of the audit period chosen, and the practice was in the throes of migrating to a new clinical computer system, with all the disruption inherent in this.

Duncan explained that a further audit was conducted in December, and the practice are currently working with the PCF to number crunch the results.

Care for Vulnerable Patients

Kate noted that there had been a general agreement at the last meeting that we would invite the Village Agent, Aileen Bendall, along to a PPG meeting to talk about how the practice might best identify and meet the needs of vulnerable patients. Duncan noted that he had tried to contact Aileen, and that he hoped that this would be possible for the next meeting in March.

Living Wills

Kate suggested that a discussion about Living Wills might be best scheduled for the April 2013 meeting, which would give us time to research this area with a view to determining what was possible, and what was realistically achievable.

Community Services Consultation

Marilyn reported that when she attended a recent Health & Wellbeing Board meeting on the 21st January, there was little feedback on this area – presumably they are digesting the feedback garnered.

3. **Pharmacy Developments**

Duncan reported that the Manager at Lloyds Pharmacy has notified him of his resignation, with effect within about two months – he is taking up a similar post in Cheshire for personal reasons. It was perceived that Tom had brought some welcome stability to Lloyds during his limited time in post, so this is not good news. Similarly, George, the pharmacist, has also apparently given notice, within a similar timescale and it was understood that this may be due to travel arrangements – he apparently commutes in daily from South Wales.

It is understood that Lloyds intend to recruit a Pharmacy Manager to fill both posts – see:

http://www.pjcareers.com/job/8777/pharmacy-manager-nailsworth-gloucestershire/

Duncan noted that the previous Manager was responsible for the pharmacies in Nailsworth, Tetbury, Cirencester and Wotton – so it would appear that Lloyds have tried a number of models to try to find a solution that works well.

In this context Duncan noted that a number of practices have in recent years developed on site pharmacies, and it was perceived that it would be a useful exercise at this juncture for the practice to decide if this was a viable option.

If this were to be achieved, this would mean the relocation of one of the existing pharmacies to the surgery site, since it would be unlikely that a third pharmacy licence would be forthcoming from the Primary Care Trust, who have previously stated that two licences is an adequate number for the Nailsworth locality.

The main driver for such an initiative would be to improve the communication between the pharmacy and the practice, and the achievement of synergies through this that would result in a better service for patients.

John asked how the PPG could lend its weight in support of any moves by the practice to achieve this aim. Duncan noted that the PCT will shortly cease to exist, and the it was unclear as to whether the Clinical Commissioning Group (CCG) would take over the reins at a local level. He will make enquiries to confirm this. As it stands, however, the PCT would support a relocation provided both parties were amenable to the arrangement, and there were no well grounded objections to it.

Duncan confirmed that any development would be a new build, and if there was rapid agreement to a relocation, this might happen within perhaps 12-18 months, subject to planning consents. A lot would also depend on the state of the current leases operated by Lloyds. Marilyn noted that the landlords of the Old Market arcade were understood to have gone into administration.

In conclusion, it was therefore felt that whilst there was merit in exploring the concept of an on-site pharmacy, it was acknowledged that there would be a number of hurdles to overcome, and therefore no definitive plans could be laid at this time. Duncan undertook to research the matter further and will report back to the PPG at future meetings.

Editor's note:

A query to establish the process for consultation with regulatory bodies after the winding up of Primary Care Trusts in April 2013, resulted in the following advice:

- All primary care providers - GPs, Dentists, Optometrists, Pharmacists - will be commissioned and have their contracts performance managed by the NCB LAT.

- Medicines Management and all its issues will be responsibility of the CCG. Premises will be responsibility of NCB LAT.

- Pharmaceutical Needs Assessments and planning will be responsibility of the Health and Wellbeing Board i.e. managed by the Local Authority – see link below and a copy at Appendix 1:

  http://www.rpharms.com/promoting-pharmacy-pdfs/nhs-reforms---pnas-for-local-authorities---jan-2013.pdf

So it would seem that the HWB may have a leading role in sanctioning any relocation.

4. **Care Quality Commission (CQC) Registration**

Duncan noted that the regulation of Primary Care – GP practices – is currently the remit of the Primary Care Trust. With the demise of the PCT in April 2013, much of the responsibility for regulation will transfer to the CQC.

Duncan circulated a paper which outlined the role of the CQC, which has been responsible for regulation of Secondary Care (hospitals) and Care Homes for some years, and more recently (2011) took on the regulation of dentists as well.

Duncan noted that the approach taken by the CQC to regulation of all these bodies, including from April 2013 GP practices, was to apply a uniform set of standards (or what the CQC term "Outcomes"). There are 28 of these, of which 16 are deemed to be core standards.

This can lead to some anomalies – as Marilyn pointed out, GP practices may feel that **Outcome 5 – meeting nutritional needs** of patients is hardly relevant to them.

In total, however, there are a vast number of new regulation to which GP practices need to acclimatise. Much of the regulations relate to aspects of clinical practice that are already embedded, but where formalisation of existing good practice is the order of the day. For example, in respect of infection control, GP practices now need to publish an annual statement of compliance and make this public.

Each of the 28 standards contains a plethora of compliance requirements – for example, **Outcome 1 – Respecting and Involving people who use services** has 8 compliance requirements – so this results in the compliance guidance document issued by the CQC being 278 pages – a lot to digest and act upon.

Duncan noted that it had been widely reported in the medical press that two GP practices had already been served notice that their registration would be refused, thus effectively serving notice on them – though the CQC stated that that hoped to resolve any issues with the practice before the April 1st 2013 deadline.

It is understood that inspections will be carried out on a planned basis over a three year timescale – each practice will receive a visit annually, but this will not cover all standards, but focus on perhaps 5 of the 16 core standards each year – thus, all standards will have been reviewed within the three year timeframe. The CQC have indicated that practices will receive 48 hours notice of such inspections; this was thought to be problematic, as Practice Managers may we away on leave, but CQC have made it clear that their approach to inspection may differ from that undertaken hitherto – the emphasis will be on talking to patients and staff, rather than poring over policy documents. In this respect, it is probable that the PPG may have a valuable role to play in communicating their perceptions of the quality of services offered to the inspectors.

The CQC also have powers to undertake unannounced 'focused" inspections, particularly where they have concerns from "intelligence" gleaned from a disparate range of sources – which can include patients, other agencies in the NHS etc.

John asked if CQC compliance had implications for the patient survey. Duncan noted that patient feedback had always been important for the practice – it has been carrying out patient surveys annually since 2004 – but this will become even more important since CQC compliance specifically requires feedback from patients.

Kate noted that she had experience of similar types of regulation, and her perception was that preparation was key to success; though acknowledged that preparing patients was a more difficult task. She speculated about the prospect of publicising the role of the CQC, perhaps using the practice website – Duncan confirmed that it was likely that a host of CQC related information would be uploaded to the website in the coming months, not least because the CQC use this as the first port of call to check the practice's compliance. Sally noted however that we also do need to try to communicate to patients who are not internet savvy, by whatever means possible. An update in the Nailsworth News for example might be a good option – Duncan noted that the practice had placed several features there in the last year or so. Kate speculated that a feature could incorporate other changes to the NHS, such as the formation of Clinical Commissioning Groups (CCGs), and the likely impact of this change.

5. **Patient survey**

This had been discussed at the last meeting. One option would be to buy in an electronic feedback system – in the form of a booth in the reception entrance lobby. This would allow continuous feedback all year round, rather than an annual (and expensive) paper based survey effectively providing a shapshot at one point in time.

However, another option would be to use the funding available for this for the purposes of acquiring a patient call & feedback system in the waiting room – Duncan noted that many practices have such a facility, which is very useful in terms of keeping patients informed about services available in the practice (and wider NHS), and also providing a public health education role. This could also be used to publicise the work of the PPG, and the availability of the wealth of information on the website.

Paul noted that since we are collecting e-mail addresses and mobile phone numbers, we could use this mechanism to audit patient satisfaction. Duncan confirmed that the practice do indeed now have a significant volume of e-mail addresses, and this was indeed a feasible method of contacting a large number of patients – either with a newsletter or with satisfaction surveys.

The general consensus was that the waiting room system would on balance be the better investment, in terms of providing immediate benefits to patients in terms of feedback.

Duncan confirmed that it would be logical to use the same questionnaire as last year (Improving Practice Questionnaire, or IPQ), given that this allowed comparisons in terms of performance from year to year; like last year, there would also be an opportunity for the practice to construct a supplementary set of questions.

Kate queried whether the survey could incorporate, or be supplemented by, focus groups in the community. Ros noted that this type of feedback would however be harder to validate.

It was agreed that between now and the next meeting (7th March), we would via email develop some ideas in terms of the areas where feedback would be helpful. One area that was mooted was reaching out to the elderly and harder to reach groups – this had been an aspiration from the previous year's survey. Sally felt it was important to approach younger patients – an approach to Tracey, the local Youth Club leader might be a good way to develop this. Tracey also works part time for the Council in a community development role. Marilyn referred to the "pink handbag" leaflet ?published by SDC, giving guidance on how girls can keep safe. It was agreed that it would be useful to have the latter in the practice.

Other agencies worth approaching include Probus, the Nailsworth Society, Crystal Fountain etc. Marilyn noted that one possible outcome from outreach discussions might be the creation of interest and members of the community joining the PPG.

Ros noted that the practice do record information about patients who are housebound, and Duncan noted that the practice was doing work to improve the identification and recording of carers/patients who are cared for. It would be useful in this context to have Aileen present at the next meeting.

Action points: Duncan to liaise with PPG members re development of survey questions, and contact Carers Gloucestershire. Sally to approach Tracey to see what feedback might be obtained. Copies of the pink handbag leaflet to be obtained. Paul to consider how feedback from residents of Crystal Fountain might be canvassed. Kate to talk to Hanover & Concord. We may also need to consider sheltered accommodation such as Ringfield Close?

5. AGM

Kate noted that the PPG had not held an AGM since inception, and that this could perhaps be incorporated into the March meeting. It may be that as a result of the outreach work done in the next month or so, there may be interest in joining the group formally. This could perhaps be publicised on the website, and with some information in the waiting room. Marilyn noted that there are already publicity leaflets for NHP and the PPG in a prominent position in the surgery entrance lobby.

Ros gave her apologies for the meeting on the 7th March, as she will be on leave.

Action points: Duncan to circulate agenda with nomination papers as appropriate two weeks in advance of meeting.

6. NHS111

This is the replacement for NHS Direct, which has been in existence since 1998, and which provided telephone advice about health related matters for patients 24/7. It acts as a complementary service to the care provided by GP. The NHS Choices website explains the function of NHS111 in the following way:

When to use it

You should use the NHS 111 service if you urgently need medical help or advice but it's not a life-threatening situation.

Call 111 if:

- You need medical help fast but it's not a 999 emergency.
- You think you need to go to A&E or need another NHS urgent care service.
- You don't know who to call or you don't have a GP to call.
- You need health information or reassurance about what to do next.

For less urgent health needs, contact your GP or local pharmacist in the usual way. For immediate, life-threatening emergencies, continue to call 999

NHS111 is already up and running in some parts of the country, but is due for a "soft" launch in Gloucestershire in mid February 2012. It is understood that whereas NHS Direct was manned by trained nurses, NHS111 will be manned by non clinical staff who have received some training. Different computer algorithms to those used by NHS Direct will be introduced, so it remains to be seen how well honed the service is at launch.

For GPs, one key difference is that patients contacting NHS111 during working hours can be referred to GPs for action, with a one hour response time. Again, it remains to be seen how appropriate these referrals will be.

7. AOB

None

Date of next meeting

Thursday 7th March 19:30 at Prices Mill Surgery