Minutes from the PRG Meeting held on 12th June 2013 @ 2.00 pm

Present: Philip Smith, Adie Salter, Jane Dixon, Leanne Edwards, the Chairman and 5 PRG Members

1. Items Arising from Last Meeting

The Chair and members confirmed that all actions points were completed and up to date.

2. West Cheshire Clinical Commissioning (WCCCG) Group Update

Philip showed a document which displays the new structure of the WCCCG, in view of the recent changes. He explained how the current structure has is now very complex as recently job roles have been changing. The Practices hope that this is not something that will affect the patients as it is organisational factors that have been affected. Many of the more experienced and senior staff within the former PCT have retired. We do not have the previous points of contact that we could rely on for their knowledge and expertise.

Most patients have the perception that the GPs have all the decision making power regarding service provision and commissioning, which is not the case for Primary Care services. The group agreed that they believe most patients think that the GPs get to decide what the practice spends their overall budget on.

Every GP Surgery within the county has to be a member of a Clinical Commissioning Group. The Clinical Commissioning Groups report to NHS England and their local Area Teams (in our case NHS Cheshire, Warrington & Wirral Area Team). GP Practices remain as independent contractors to the NHS. The changes in the structure will mean there is a change in who we send reports and data to and who is in charge of verification of quality/ payments for the services we provide. For the first time the Local Authority will be commissioning some services (Cheshire West and Chester Council).

3. Current Performance Update

Philip explained that between the 37 West Cheshire practices £5million was saved on the prescribing budget last year (2012/13), without any adverse effect on patient care. This has been done through strong teamwork within the practices between GPs, Medicine Managers, Community Teams and the Management Team. The practices are not, however, able to use this £5million saving on other areas as it has been used to reduce the WCCCG deficit down from £15 million to £10 million that was left at the end of the year (2012/13).

Consultations at this Practice have increased by approximately 19% in the 8 years (up from 54,600 in 2005 to 64,800 in 2013) year. The patient list size has risen from 11,200 to 11,700 in the same period. This is set against the same level of 11.5 FTE GPs and Nurses and 12 FTE members of the Reception Team (excluding managers). All Practices in WCCCG are reporting large numbers of new patients in the past two years that are overseas visitors. These consultations often take up 20 minutes due to the language difficulties. These patients also often present with multiple issues. This new group comprises of equally both women and men in their 30s and 40s (with many consulting up to 12 times per annum). The usual UK resident male patient type of that age group has a very low consultation rate (<3 consultations per annum). The NHS currently provides resources for an average of 5 patient consultations per annum.

There is currently acute pressure on all Primary & Secondary Care services, Accident and Emergency and the new 111 service. GP practices are also under great pressure on patient access

< 48 hours. GP Practices are largely paid on a capitation basis and not by activity or per consultation. The Practice estimates that we need ¾ of a GP extra to meet current demand. In addition to that for every GP, 2.2 members of staff are needed to support them. As all GP Practices are currently facing significant budget cuts we are not able to fund this increased need for clinical resources.

We are carrying out a local patient survey over a two week period which started this week. So far, we have received good results but it is evident that patients feel there needs to be still more appointments. This is a (national) resourcing and funding issue as detailed above.

It was explained how patients should always be able to get an appointment within 48 hours but that often the patient will only see a particular GP, so this GP may not be available. If an urgent appointment is required the patient will be able to see a GP or Nurse Practitioner. Most days we have appointments for on-the-day still available up until about 9:30am. On Mondays and the days that follow a Bank Holiday appointments are heavily protected, due to high "on the day" demand. Currently the BMA is reporting that, nationally, 38% of UK patients are not able to book a GP appointment in 48 hours or less.

Patients are offered an appointment in a Nurse Led Clinic if appropriate. Most patients are happy to see a Nurse Practitioner/ Advanced Nurse Practitioner, especially if they have been seen in this clinic before. The Receptionist will ask the patient (using a standard Practice algorithm) what the problem is regarding, in order to "signpost" the patient to the most appropriate clinic. A minority (<10%) of patients are not willing to give a reason. These patients will be booked into a GP appointment.

A member of the group asked a question about the Anti-Coagulation Clinic which is run by the Phlebotomists. Philip explained that we are paid a small retainer (approx £1k p.a. which does not cover our costs) to provide the service. However the patients have the choice of whether to be seen here at the practice or at the Countess of Chester Hospital. We do not get paid for our patients who are seen at the hospital. We have recently improved the service by having both Phlebotomists on duty on a Wednesday morning to meet demand. We get no increased funding to cover this new resource.

Another member asked what happened to the Minor Injury Clinic. Philip explained that the £26,000 per annum central NHS funding for this service was withdrawn for Chester City Practices 3 years ago. Practices were advised that they could either treat the patient but without receiving a payment for it, or send them the Countess of Chester Hospital. As a practice we have decided to continue to see patients (unpaid) with minor injuries. The average patient Minor Injury attendance at A & E costs £98, which is then billed direct to the Practices.

4. Virtual Group

The Chair gave a history of the group and explained how it became evident that the group was only attracting patient within a certain (older) demographic. As other age groups etc. may be unable to attend a meeting it was decided to try to expand the dynamics of the members of the group and a Facebook group was set up which now has 31 members. A member of the committee manages the Facebook group and if the number of patients joining increase, then extra time may be needed to manage this.

We currently have a notice and leaflets advertising the PRG and the Virtual Group. Last year we specifically targeted ethnic minority groups (by mail shot and MJOG text campaigns) but without success. We will try again this year and approach >100 patients in ethnic minority groups to join the PRG or Virtual Group.

Other PRGs have used e-mail as a way to contact patients.

5. Local Patient Survey

Philip circulated a copy of the patient survey which is currently being handed out to patients. The Reception Team will give out 300 surveys over a two week period. Philip stated that as long as we have 200 surveys (> 1.5% is the Ipsos Mori Poll standard) returned this will be a good representation of the practice. It is part of a Direct Enhanced Service to carry out a local and nation patient survey. In the local survey which we are currently carrying out, we are asking questions on areas which we did not perform very well on in last year's survey. These areas were GPs giving the patients enough time and also involving them in the consultation and their own healthcare plans. We have deliberately made the survey only one page long so to encourage patients to complete and return the form.

Philip has found that adverse feedback is often vague/ unspecific, which does not help in addressing any problems. Philip explained how we needed more evidence of any specific problems in order to assess whether there is a training or resourcing need.

The Chair suggested that if people did not feel they could answer the question with one of the multi-choice options, they write a note at the bottom of the survey to explain their thoughts.

At the next meeting in September 2103 Philip will share the results of the survey with the group.

Philip explained that national the patients groups will now be known as a Patient Reference Group instead of Patient Participation Group. The new Patient Participation Directed Enhanced Service (2013/14) requires Practices to form and work with Patient Reference Groups. PRGs had had several tiles over the last three years but PRG is now the formal (national) title.

6. New Consulting Room

Philip reports no progress in the new consulting rooms. This matter has been ongoing since February 2011. The Health Visitors room is currently used only 10% of the time. This room would be ideal for turning into 2 new GP/ Nurse consulting rooms. As the District Nurses re-located to Health Lane Surgery in August 2012, their room is now empty and the GPs have proposed that the Health Visitors move into this empty room in order for their room to be used as consulting rooms. In principle all Heads of Departments at the former Primary Care Trust (PCT) is happy with this move. We have not received any confirmation that it can go ahead and we are pursuing this monthly. Philip has been asked by the Partners this week to write again to the head of NHS Property Company Limited to say that we are going to go ahead with the move. The PRG Chair, has also written to the Director of NHS England (Cheshire, Warrington and Wirral) to support this move.

7. Pharmacy

From 26th July 2013 this practice will be able to send prescriptions to a patient's pharmacy of choice, electronically. This new system is known as Electronic Prescribing System revision 2 (EPSr2). Patients will request their medication as normal and then collect it from the pharmacy instead of having to collect it from the surgery and then go to the pharmacy. If a patient is seen by a GP and issued acute medication this can also be sent electronically to the pharmacy and will be ready when the patient gets to the pharmacy. When the patient collects their medication they will be given a list of their repeat medication, as normal, so that they can order their medication when it is next due.

61% of staff time (nationally) is spent on prescriptions so this will save a lot of staff time within the practices.

This will be a better system as far as we are concerned as it will enable us to audit a prescription; there is no paper to go missing. We will know exactly what stage the medication request is up to and with whom (i.e. Reception Staff/ GP/ Medicines Manager or dispatched to the Pharmacy).This will significantly reduce the queues at reception as both patients and pharmacies will not need to visit the surgery for repeat prescriptions.

Patients are being given the choice to use electronic prescribing, so if they wish to carry on collecting their prescriptions from the surgery they can do so.

Philip is still in discussion (since January 2012) with the pharmacy to renew the lease. We are very keen to keep the pharmacy within our premises for the benefit of our patients.

8. Circulation List

The practice is sent a lot of NHS information papers within a day which is now routinely sent by e-mail. The NHS has a clear policy of being paperless as far as possible. This reduces costs and increases efficiency and speed of communication. Some of this information would be interesting to members of the group and the Chair suggested that members might like to be sent this information. The only way that it would be able to be sent is by e-mail. These e-mail addresses would only be used for this purpose. Philip will send the information to Clive who would then send it on to the PRG and Committee members.

The Chair asked that anybody interested in receiving information provides their e-mail address to either Clive or the Practice Secretary, who will then pass on to Clive.

9. Recruitment

Recruiting new members to the group has always been an issue, in order to get a wider dynamic of patients. This is a common problem nationally for PRG Groups.

It is often difficult to get people of different demographics but we have to be able to prove that we have been trying to attract new members. Our current average age for the PRG is 70.

One of the easiest ways to contact patients is electronically and the practice have the facility to text patients, via MJOG (our text messaging service), which is at not extra cost to the practice as we pay a fixed monthly bill (£60) for the service. Adie will send out a message to invite patients to joint the PRG.
Clive has also arranged to have a notice board in the Waiting Room for the PRG and has placed a notice to recruit members for this group and the virtual group.

- Adie to arrange a MJOG campaign

A member of the group who is also involved with the Countess of Chester Hospital (COCH) meetings shared that the only way in which they recruit members, is by actively speaking to patients in waiting rooms etc. She suggested that the meetings are held at different times as many patients who will fall into a different demographic will not be able to attend a meeting during the afternoon. The group agreed and suggested alternating the start time of meeting between 2pm and 5:30pm.

Different PRGs around the country have a range of activity, some doing nothing and some being very involved. By looking at the patient survey results we can look at what can be done to provide a better service.

Some PRGs only hold an annual meeting and Philip suggested possibly having 2 PRG meetings a year and quarterly committee meetings. Philip suggested having a meeting during the summer at

say 5.0pm and a 2.00pm meeting during winter in the afternoon. This rota had worked well at several local Practices.

A member of the group asked for a brief summary of what was discussed during the committee meetings and it was discussed that a brief set of minutes could be made available to group members. The Chair shared how the committee will be loosing a member later in the year so they will be looking for a volunteer to fill this place.

- Chair to arrange for members of the PRG that wanted to receive minutes of committee meetings to have copies. Members are to approach the Chair.

A member of the group shared the dates of other WCCCG and COCH meetings that are being held in the near future that members might be interested in attending. All of these meetings are held in public but are not public meetings.

Board of Directors Meeting is on the 2nd July at 1:15 at the COCH Lecture Centre in the Education and Training Centre

COCH Council of Governors Meeting is also on the 2nd July at 5:00 at the Lecture Centre in the Education and Training Centre

Further information on these two meetings can be found at http://www.coch.nhs.uk/corporate-information/board-of-directors/public-meetings.aspx

The WCCCG Meeting is to be held on 18th July between 9:00-12:00. Venue to be confirmed

The WCCCG allows 15 minutes at the start of the meeting for members of the public to ask questions; it is appreciated if questions are submitted before the meeting, but not essential.

Further information can be found on this meeting at http://www.westcheshireccg.nhs.uk/

A group photograph was taken to be sent to the Chester Chronicle with the new defibrillator which has been bought through patient donations and a donation of £1,000 from the British Heart Foundation.

Meeting Closed: 3:30