Stoke Rd Patients Participation Group

Minutes of meeting held on 19th April 2012

Attendees: -

Paul Holliday (PH) – Chairman
Carol Gardiner (CG) – Joint Secretary
Doreen Dyer (DD) – Joint Secretary
John Alderman (JA) - Guest Speaker
Mollie Edwards (MO)
Joy Merrell (JM)
Peter Badham (PB)
John Coopey (JC)
John Grayson (JG)
Mike Otter (MO)
Jaswant Gangotra (JG) – Consultant
Dr Jim Moore (JM)
Dr Tim Hardwick (TH)
Lester Pygott (LP) Practice Manager
Jane Tillotson (JT) Reception Manager

Apologies: -

Jill Hogg

1) Paul welcomed everyone to the meeting and gave particular thanks to Mike for arranging with John Alderman to come to the meeting as our 'honoured' guest speaker.

2) Minutes of the meeting held on 26/01/12 were agreed.

3) John Alderman had previously sent a resume of the work which had been done by the Winchcombe Surgery PPG and Paul acknowledged the achievements which they had made. John then went on to elaborate how they had managed to do this.

The surgery initially set up a 'comments system' which could be accessed via e-mail or on paper. It was through this that the Surgery changed their practice.

They established a few projects from the comments/suggestions they received which included a television in the waiting room to provide information about both local and national issues, better signage; a Minor Injuries Unit (MIU) was developed and more latterly they have set up a triage system which is run by a Nurse Practitioner in order to free up some of the GP's valuable time so as they can concentrate on patients with more complex issues.

John was keen to inform us that his PPG recognised that the emphasis was to take the practice to the community and this was done by arranging various health sessions, two of

which were held in the local library. One was a Ladies Evening which covered Nutrition and Healthy Eating whilst the other topic was around Mental Health issues and dealing with Stress.

The third session concentrated on men's health, so therefore a Men's Evening was held in the Working Men's Club which was much less formal and a pint could be had by those who so wished.

All of the meetings had a guest speaker and was supported by 2 of the GPs.

Their patients are now in a position to be able to monitor their own blood pressure.

The PPG undertook another survey in September 2011 and found that the Portakabins, which went some way to replace the Out Patients Department of the Winchcombe Hospital, were being underused and the lease was coming to an end. They also realised that there was no direct bus route from Winchcombe to Tewkesbury Hospital. These were highlighted to the PCT and they have now invited some of the PPG members to a meeting with themselves to discuss services in Winchcombe.

The PPG have a regular spot on Radio Winchcombe and they also set up a stand at the annual Winchcombe Show. They also organised a local Fitness Club to help support them and they provided a rowing machine and made a 'who's fastest' competition.

The Virtual PPG is now taking off on-line however they found that it is not attracting the younger population so they are looking at ways to address this.

They are also looking at what they can do for the local children and this is proving to be challenging.

The other challenge is keeping the PPG going as it has proved to have benefits to both the surgery and patients of Winchcombe and therein lays its success. John also recommended that the chairperson should only have a year in office.

John then took questions from the members.

3.1) PB – Could the Stoke Rd PPG compare data with Winchcombe PPG to establish any trends/patterns? John couldn't see why not.

TH – How often do the PPG meet? - Monthly.

What was the outcome of the 3 events?

1) Men's reluctance to go to GPs.

2) To put information out there and was attended by 2 GPs.

3) The biggest feedback they received was that it was all done very informally.

Where did they advertise their Health Awareness sessions?

- In local shops and via E-mail.

Money is now coming to the PPG via advertising.

CG – How many are in your PPG and what would be the most appropriate number?

Membership started with 12 and is now down to 8 however the most ideal number would be for the group to be 10.

John went on to say that the PPG is now a body in its own right and that it has a treasurer and secretary.

JG commented that we need to look at strands to provide better healthcare.

Paul thanked John for giving us such a good insight to how Winchcombe PPG operated and came to some fantastic outcomes. John remained with the group for the rest of the meeting.

4) <u>Matters arising</u> -

Paul acknowledged that the Terms of Reference had not been properly discussed and agreed. He read out a sample of the Terms of Reference (Appendix 5) which could be adopted by the group however as time was limited at this meeting it was decided by all that this would be an item for the next meeting.

JG commented that we needed a framework to operate from.

Paul asked the group if he thought that the group needed a vice chairman in order to share responsibility. It was decided that this was sensible. CG nominated Peter Badham. It was put to a vote and unanimously agreed.

5) <u>Membership</u>

A long debate took place over the subject and lots of ideas were brought to the discussion.

ME suggested that any potential PPG member should provide a profile of themselves, as we have all done.

It was agreed that the chairman or vice chairman would ask the candidate to provide a profile. This would then be circulated to the PPG members and after consideration of appropriateness they would then be phoned by the chairman or vice chairman and be invited to the next meeting.

It was agreed that in the event of a candidate being declined, it should be communicated in writing by the chair.

6) <u>Results and discussions of the Questionnaires</u>

Lester went over the results.

ME commented that it demonstrated that demand clearly outstrips supply and it is increasingly going to get worse. In order to release the pressure perhaps the appointment of a Nurse Practitioner (as Winchcombe have done) would be beneficial, but realises that this may not be a long term solution.

JM stated that at the last CCG meeting it was highlighted that this was a national problem. Triaging for the GPs would swallow up routine appointments and therefore they couldn't give continuity of care to the patients. They are intending for their nurses to undertake triaging.

TH stated that the patients' problems were phone access to the surgery. He felt that the results of the survey gave him a sense that overall the surgery was doing a good job and the feedback about the nurses was equally good.

JG said that when a patient turns up for their appointment the GP has no idea whether it is for a simple or complex problem and that the allotted 10 minutes to see a GP may not be long enough. Timing and waiting is a national issue. He stated that the patient nowadays has a very high expectation and the GPs work extremely hard over longer hours and get physically and emotionally drained.

PH commented that 10 minute appointments are potentially not realistic and was there another way around this problem?

JG stated that this would have an impact on others if they were made longer.

TH agreed that strategies around timings of appointments needed to be looked at again but in the meantime if a patient is taking too long they would have to be seen the next day or phoned.

JM highlighted that Bishop's Cleeve has a high demographic of elderly population who have complex needs and that he offers a 15 minute appointment in those circumstances.

PH suggested that a 15 minute appointment would appear more realistic as it would assist harmonisation and expectation.

JG made a comment that patients don't know how long they are going to have to wait if the GP is running behind time.

JA said that in Winchcombe when a patient 'books in' on the system it informs them how long they will have to wait to see their GP.

LP informed us that the surgery has a new computer system and that he will look into whether this can be hooked into the computer software.

ME asked if there was some budget allocation if LP was not successful with the computer system.

JG said that it is not good when waiting to see a GP but when you are with the GP t is good and makes up for the waiting. He commented that we need to inform patients when/why GPs are running late.

JG suggested that the community needs to be aware of the pressures of waiting times and the stress it causes to both patients and GPs and that perhaps a presentation could be considered.

JC pointed out that patients see themselves in isolation.

JM stated that when she helped patients with the questionnaire no-one complained of waiting.

JM informed the group that GPs get remunerated if their surgery is in a deprived area. As Bishop's Cleeve is described as being in more of an affluent area they do not get recognised and rewards are not granted. Some mornings patients who are to be triaged may have to wait up to 60 minutes.

JA stated that as there is something visual/moving in the waiting room the patients are more sympathetic to waiting and towards the GP.

PH commented that we need to match expectation with reality.

LP agreed with the community issues and waiting times. Politically the surgery has to provide a 48 hour access to a GP therefore more resources are needed for the Duty and Triage GP so the needs are not taken away from the routine capacity and continuity of care. However, LP also pointed out that some patients don't mind which GP they see whilst lots do.

A comment was made about how we get the message out to the community and an action plan needs to be considered of how we can help to support the GPs.

PB noted the percentage of change from this year's survey to the last one performed in 2008. He asked how the patients are allocated and if they had a choice.

Apparently patients have told Peter that they accept that they can't always get to see their own GP but it doesn't mean to say they like it. Is there a cascade system?

JM stated that in certain circumstances they do hold a core list of patients, they have a cascade/buddy up system for palliative care patients but as he and Dr Hardwick are the only full time GPs this can be difficult to do for non-palliative patients.

TH pointed out that some surgeries do have their own personalised patient list and only see those patients but Stoke Road hold a group list which means that any patient can see any GP.

TH thanked those who went to the surgery to help with the survey and stated that they got their quota much quicker than had they not been there.

As the survey's results showed that telephone access was low PB asked if a dedicated phone line for appointments and repeat prescriptions would be appropriate? JT highlighted that they had done this in the past and was not successful. PB suggested that perhaps patients could ring his pharmacies for repeat prescriptions and then he could ring the surgery. Nothing was accepted or agreed at this stage. PB also said that he would push 'Pathfinder'.

PB spoke about Greyholme's new surgery which is going to be built on Homelands 2. He stated that if the PPG spoke to the PCT, Stoke Rd Surgery may be able to gain a percentage of the funding which would potentially be available.

Action – Paul and Peter have agreed to contact the PCT.

Paul acknowledged that from tonight's meeting there would be various items to discuss, consider and an Action Plan made before the next PPG meeting, therefore he suggested that a sub-committee of two or three members should be set up and he asked who would like to volunteer for this. Mike Otter, Peter Badham and John Coopey offered and a meeting will be held at the surgery on Thursday 17th May at 19.30 hrs.

LP would like to publish the results of the survey by the end of April and PB and PH stated they would help him with the Interim Report.

There was no time for AOB.

Date of next PPG meeting – **Thursday 31st May at 19.30 hrs. at Bishop's Cleeve Primary School.**