Minutes of Mountwood PPG Meeting at 2pm on Thu 01 June 2023

Present: Shannon Hanbury, Susan Smee, Mary Egan, Mary Perkins, Stefan Sieradzki

Apologies: Colin Berthelsen, Dr Liz Hermaszewska

Susan Smee informed the meeting about documents Colin had left with her prior to the meeting.

These were annotated by Colin and were to be discussed at the meeting.

Unfortunately most members needed to leave the meeting by 4pm.

As a result discussion of said documents was postponed to the next meeting of the PPG.

A large part of the meeting was taken up by a briefing from Shannon H.

More about that below.

The leaflet drafted by Simon met was approved by members with only minor changes.

These are set out below:

- on folding in half the back pages of the leaflet are upside down

- *Any patient registered .. is a member* is repeated on the top & bottom of first half page in a slightly different form of words

-Under *Who Are We,* second bullet point replace *Any members* with *Members*

- If this was acceptable to the practice and to encourage PPG participation it was felt that it might be helpful to include a phrase along the lines of “*join PPG to actively help shape the way the practice is run for the benefit of patients*” although this might be misleading regarding the powers of the PPG

The next meeting is set for the 6th of July 2023..

This should allow Dr Liz H to attend to urgent matters on her return from holiday prior to the meeting.

Shannon shared the following details for practice going forward following their strategy meeting.

Unfortunately the surgery has no control over changes to PATCHS, except for when it is open.

From next week the practice will run a pilot on behalf of PCN, Mondays & Tuesdays only.

This trial will involve PATCHS being available 4hrs am and 4hrs pm.

The on-call doctor with registrars will assist the reception team.

The idea being to close as many PATCHS forms there and then.

Also the doctor will assist with phone calls.

Some new process pathways could be developed.

If successful the pilot will be extended to all days and other practices in our PCN (=Primary Care Network).

Eastbury surgery will be the central hub for triage with the new process.

This should help filter out those requests which do not require a GP appointment.

It has worked in other practices albeit with a different demographic to MW.

And the volume of forms at one such practice was lower than in MW according to Shannon,

Our pilot might take a while to bed in and the increased volume of forms was unknown.

Shannon also commented on MW practice having patients who saw consultants privately and then went back to the practice expecting to be dealt with via NHS and the practice. This meant that MW had more to deal with compared to surgeries in other areas where patients did not do this. In this context members reflected that there was a rising tide of opinion that NHS was almost pushing patients to seek private treatment to relieve pressure on the NHS. And yet often the same doctors often work both privately and for the NHS… not ideal.

In response to members’ comments Shannon indicated that going back to the old ways of being able to ask for and see your own doctor was no longer viable due to increased demand and the decreasing number of experienced GPs although the practice is very positive about the great

 registrars coming on board who contribute to the growing overall number of doctors available. Shannon also expressed the view that a change in society – older family used to live with younger members and advise on some basic medical matters avoiding unnecessary GP visits – which is now adding to practice workloads. A further demand on GPs was the need to provide medical input at meetings e.g. PCN meetings. Heightened anxiety amongst patients in the context of Covid was also a factor.

Members commented on how long it takes to get through PATCHS and how it then drops out sometimes and you have to start again. Shannon responded that increased PATCHS capacity should help with this issue.

Shannon also mentioned improvements in the medication review data system which will now allow for more automatic processing of repeat prescriptions. Also a huge increase in the number of medications on the (permitted) repeat prescriptions list should help. Synchronizing multiple medication renewal for a given patient should also help. All of the above should speed up processing and free up GPs from a tedious admin overhead in approving repeat prescriptions.

Other improvements included training up phlebotomists to do HCA (=Health Care Assistant) work such as ECGs, B12s, immunizations, dressings. These and other initiatives to increase skills of current staff, such as nurses should help with handling more tasks in the practice. It should potentially also allow better co-ordination of blood test appointments with other follow up tests that HCA can do.

The timeline for seeing full benefits of improvements was quite lengthy e.g. 3 years for nurses, Shannon thought. With GPs the timeline was more difficult to gauge. However small incremental improvements should be evident sooner.

The increase in portfolio working by GPs (gaining experience in areas of medical interest outside the practice) will mean less opportunity for patients to have “their own GP”.

Shannon explained about the new ICB (=Integrated Care Board) which will comprise primary care, secondary care and social care with a single pot of funding for the entire ICB. This might result in moving some work from secondary to primary and paying the latter less for the same service.

Integration of IT systems is also an issue leading to confusion (caused by different codes in different systems) for admin staff who need GP expertise to unravel ambiguities since interpretation is involved.

Another issue – surgeries are expected to rigidly adhere to KPIs (=Key Performance Indicators) to get paid. This is not always realistically possible or even necessary e.g. taking the weight of an anorexic patient every time when this is stressful for them and is not a clinical priority.

Shannon mentioned that the local MP, David Simmonds will be visiting the surgery next Monday. Shannon felt it would be beneficial for him to see how busy the surgery is. The lamentable and counterproductive politicisation of health care was discussed.

Regarding use of social media such as Twitter was met with a largely negative reaction by the members. Although some practice partners were in favour, Shannon added that such use might lead to unforeseen consequences e.g. increasing number of patients due to increased profile and a predictable one e.g. more work for admin staff. Twitter might help target younger members to hear about PPG and help disseminate information about initiatives such as monthly talks about healthcare, arguably.

Shannon mentioned the new - not yet released - surgery website and promised to give access of a demo to Colin provided the surgery agreed. All members were keen on seeing the demo.

Shannon suggested IT training for monthly sessions to train patients in online tools related to the surgery e.g. PATCHS. Shannon felt she could provide a member of staff for an hour or two and this could really help with patients’ acceptance of PATCHS etc. Members reacted very favourably to this idea.

Working with local charities such as Live at Home to help inform members was also thought to be a good idea.

Members enquired about lights in the lift and Shannon responded regarding difficulties in funding and finding affordable electricians and other contractors. One member passed contact details for an electrician to Shannon.

Members felt that the information provided by Shannon was detailed and interesting and focused on explaining the current strains and stresses for the surgery. On Colin’s return to the next PPG meeting, however, members felt, some discussion with the practice i.e. Dr Liz of patient issues, including results of the patient survey was still very much in order.

Members reminded Shannon of the date of the next PPG and asked that she lets Dr Liz know the date as well (6th July).