Patient reference group meeting Minutes
Thursday 5th March 2015
5.30pm

Roger Stead opened the meeting with a brief summary of the previous meeting, for the benefit of those attendees who were not present. There had been a presentation, at the request of a member of the group, outlining the way in which General practice is funded through the NHS. This had prompted a very useful, but lengthy and in-depth discussion which subsequently meant that the other agenda items were not able to be addressed adequately. Consequently, today's meeting has been scheduled to focus on those items not discussed at the previous meeting.

Roger explained that the Practice is required to meet certain criteria in relation to a Directed Enhanced Service for patient participation. This is a service commissioned nationally by NHS England and is funded separately to the Practice's core contract. Funding is linked to Practice achievement of different components as detailed in the Service specification. One of the group members requested details of exactly what funding is available and what the specific components are. These are set out below.

Practices will receive an overall payment of £0.36 per registered patient based on its achievement of the following components.		
Component	**Payment calculation**	**Actual payment***
Patient Group and Practice to review patient feedback at a frequency agreed with the Patient Group and reach agreement on priority areas.	30% of total funding	£1,179.90
Practice and Patient Group to develop an action plan for implementing changes based on at least 3 priority areas	30% of total funding	£1,179.90
Practice to implement improvements and publicise actions taken to Practice population	40% of total funding	£1,573.20
Total funding available for achievement of all components		£3,933.00

*based on a Practice population of 10,925

All members had previously received a copy of a document summarising patient feedback form a range of sources including NHS Choices website, the Friends and Family Test, two Practice patient surveys and the most recent National patient Survey. At the previous Patient group meeting there had also been a summary of patient complaints and suggestions received in the past year.

There followed a general discussion about the feedback and the group's own perceptions of the Practice. It was felt that the feedback is generally positive, and the group echoed this, emphasising in particular the Walk in and Wait surgery which has improved access to a GP. There were, however, some areas that the group felt

could be prioritised for potential improvement, such as disabled access, access to appointments, and information & education.

There were some comments about difficulties with making an appointment with a specific, named GP. Roger acknowledged that this can sometimes be a problem and briefly explained how the surgeries are managed. Each day there are a combination of routine surgeries, a morning Walk in and Wait surgery and an afternoon duty doctor. The rota is scheduled so that the Walk in and Wait sessions and Duty Doctor sessions are shared equally amongst the GPs available each week so that each GP should only do one of each, allowing them to be available for routine bookable appointments for their other sessions. As most GPs are part time this can sometimes limit their availability, particularly if other GPs are absent, e.g. on annual leave or sick leave. Some GPs, usually a Partner, are also sometimes required to attend meetings, for instance to discuss and plan services for the wider community of B&NES. Again, wherever possible, these are rotated amongst the relevant GPs to minimise individual GPs unavailability. Roger emphasised that the Practice's primary priority is always to ensure that as many appointment slots as possible are available and that every effort is made to maximise the GP availability at the Practice.

The group also discussed the difficulties with making routine appointments in advance. Sometimes, at the end of a consultation, a GP may ask the patient to make a follow up appointment in four week's time, but there may not be appointments available on the system, requiring the patient to telephone back at a later date. Roger explained that it is the Practice's aim to try to have appointments available for between 4-6 weeks in advance, although he accepted that this is not always achieved. A specific action was agreed for the Practice to prioritise this target and to monitor and report, via a noticeboard display in the Reception area, achievement.

The group suggested that perhaps the Minor Illness Nurse could be promoted more so that patients are more aware of what ailments she can treat, and what prescriptions she can issue. This was agreed as a specific action.

The Group felt that is useful for patients to know which GPs and Nurses are working on specific days so it was agreed for a board to be displayed in the Reception area showing who is 'on duty'. This was agreed as a specific action.

The groups also felt that an 'organisational structure' chart on display would also be helpful for patients to understand which staff are employed by the Practice and which are provided by outside organisations. This was agreed as a specific action.

It was suggested that an additional disabled parking space could be made available in the front car park. As the route between the rear car park and the main front entrance includes a rather seep hill, it can be difficult for disabled patients to access the Health Centre from the rear car park. A further suggestion was for access through the Lower Ground floor Health Promotion Room could be made available for disabled patients, perhaps via an intercom system to the Reception desk. It was agreed for the Practice to consider these two options as an action.

Roger Stead agreed to draft an action plan to circulate to all Group members for comments and approval. The draft action plan is attached as appendix 1.

Following the discussion of the action plan, the group discussed the Patient Reference Group's purpose and role. Roger Stead felt that, for the Practice, the primary purpose of the group is to act as the voice of the wider population. The group accepted this although it was noted that the members may not necessarily be representative of some groups, e.g. younger ages, minority ethnic groups etc. and there was some discussion about possible strategies to recruit from a wider cross section of the Practice population. It was suggested that promotional posters could be displayed in businesses in the local community, e.g. newsagents, shops etc. It was also suggested to make the recruitment to the group more prominent on the Practice website. There was a further suggestion to schedule the meetings at different times of day to try to make them more accessible to other groups, e.g. non-working parents of school-age children. Roger agreed to add these suggestions to the action plan as additional action.

Members of the group commented that they felt the role of the group is to support the Practice, to put forward suggestions for improvements and development and to be consulted on any service changes the Practice may be considering. Roger Stead agreed that this would be very useful. In terms of meeting frequency it was suggested that regular quarterly meetings would be most practical with additional meetings as and when required. Roger agreed to circulate a list of possible dates for the next 12 months.

The group also emphasised that they think it would be particularly useful if one or more of the GP Partners could attend the meetings. Roger noted that this had already been discussed with the Partners and they had agreed to include this as an action on the action plan, but noted that it may not always be possible for a partner to attend as it will depend on dates, times and individual partners' availability.

Roger Stead thanked all of the members for their valuable input and closed the meeting.