MINUTES OF ACOMB PPG MEETING
HELD AT ACOMB ON WEDNESDAY 16th MAY 2018 AT 12.30PM

Attendees YMG:	[redacted], [redacted], [redacted] (part)
Attendees Patients:	[redacted], [redacted], [redacted], [redacted]
Apologies:	[redacted], [redacted], [redacted], [redacted], [redacted], [redacted], [redacted]
Facilitator:	[redacted]
Note Taker:	[redacted]

RE-STRUCTURED PPG

The main item to be discussed was the recent vote patients took on the new re-structured PPG which would see the site meetings rolled into 4 joint meetings a year. Of the replies received 28 members were in agreement to the change and 2 were against.

Why are you having a mass meeting I want to keep it local to Acomb?

[redacted] and [redacted] explained that it was the aim to make the meetings more focused and productive and each site would continue to have opportunity to raise local issues at the meetings.

[redacted] also said that often issues raised across sites were similar and patients may be interested to hear this and if issues were different members from other sites by be able to offer support of ways to improve.

All members would be given opportunity to offer items for consideration for the agenda of the new meetings.

Surely it's management's job to sort out issues from individual meetings?

People will feel whatever I say no-one will take any notice, we want to get the system improved if you have a mass meeting will you take no notice.

[redacted] needs to be here to discuss this. I am incensed that he is not here to talk about this and explain his decision.

[redacted] explained that unfortunately [redacted] had been called away to attend another meeting and sent his apologies. Although the email had come from [redacted] about the restructuring of the PPG, staff agreed that it would be beneficial for staff and patients to hold combined meetings of the PPG going forward.

I do not like meetings to start late – we make the effort to be here on time and management should be here.

[redacted] apologised for the delay and tried to explain that it was unavoidable due to another meeting overrunning.

I do not like that I don't have access upstairs except by the lift when I can get it working – why is this place like Fort Knox? At my previous practice there was a sign which showed your name and which room to go to that worked why don't you have a system like that

[redacted] explained that engineers had been out to give us a quote for a new lift and that this is being looked into.

It just needs a new button not a new lift that's easy to sort.

[redacted] advised the meeting that we have a duty of care for our patients and employees and we need to secure access into areas that patients can't access without being escorted. Many of the rooms upstairs are administration rooms that hold patient records and that confidentiality must be protected.

Why don't you have a system where people can knock on doors?

[redacted] and [redacted] both replied that I'm sure you would agree that if you were sat in consultation with your doctor or nurse you would not appreciate someone knocking on the door and interrupting you.

I used to work in health sciences at the University where we had a very similar system as you are very vulnerable to people just wandering about so do understand the security issues.

Why is it like a prison most people are terrified when they come to a doctor – they need reassurance.

[redacted] informed the meeting that the second waiting room requested by the GPs had been removed as it was confusing for patients so we did listen to patients when issues were raised about not knowing where to go.

[redacted] also said that if she were visiting a doctor she wouldn't be happy if someone locked the door, the locks we

have are locked from the outside but not if you are in the room.

You are setting the wrong impression for patients.

[redacted] offered to look into patients having better access to the upstairs consulting rooms but consideration would have to be given to staff safety and confidential data held.

You don't have enough signage to say this is the way out.

[redacted] stated that she would look at putting new signs in that make it clearer where patients should go.

Why did I have to travel across York for an INR appointment – couldn't you just fit me in. Why do I have to continually come in to make an appointment why can't you just put all the appointments on for the next 6 months!

I agree it is possible to get appointments quickly or for three weeks in the future but not in 2 or 3 days.

[redacted] advised that we have a team of schedulers who create the appointments on a 4 week rolling system. We are unable to add appointments for the full year as we don't know what sessions clinician will be working. Although we try and offer a phlebotomy clinic every day at each site if a Health Care Assistant is on leave sometimes we are unable to cover their clinic with another member of staff and patients might be asked to attend another surgery.

I tried to get an appointment for my husband which the doctor had specifically asked us to do and the PCC was most unhelpful. I had tried to call, couldn't get through and come down to the surgery to be advised to call back the next day at 8am. When I called back the PCC again told me there were no appointments for 3 weeks.

[redacted] asked if the patient could determine exactly when this happened they would be able to speak to the PCC involved. [redacted] expressed her disappointment and that appropriate training would be given.

[redacted] explained that the PCCs had a signposting sheet directing them to the most appropriate appointment for a patients' condition and unless it was on the patient record that they should be seen urgently the PCC had followed the sheet correctly.

[redacted] stated that it may be that there are appointments available but only a GP or Nurse can book into these so the PCC would not have been able to offer an appointment. After speaking to a GP if they feel it appropriate the patient is seen they have appointments they can use.

[redacted] also said that the signposting sheet was devised by GPs and Nurses and was not expecting the PCC to make a clinical judgement.

Is there not Urgent Care information online? It seems antiquated that you have to make up something that could already be there produced by the NHS. Why can't other patients come to your Urgent Care Clinic

[redacted] said that if we opened up our Urgent Care Clinic to other surgeries there would be no appointments available for our own patients.

[redacted] stated that although we referred to our same day appointments as an Urgent Care Clinic other surgeries would probably offer the same service for their patients but it may not be given the title Urgent Care Clinic.

You get paid 35p per patient to have a PPG what happens to that?

[redacted] and [redacted] told the meeting that PPGs are not funded.

Post Meeting Note – please see attached extract from the NAPP website explaining that the 35p payment ceased on 31 March 2015:-

Important changes to the GP contract* - Patient Participation Groups a contractual requirement in England

From 1 April 2015, it will be a contractual requirement for all English practices to form a patient participation group (PPG) during the year ahead and to make reasonable efforts for this to be representative of the practice population. Having a PPG is already the norm for most practices and is expected for CQC inspection. The practice must engage with the PPG including obtaining patient feedback and, where the practice and PPG agree, will act on suggestions for improvement. Practices will be required to confirm through the e-declaration that they have fulfilled these requirements. The change will reduce practices' PPG workload as reporting requirements (set out in the previous optional "enhanced service" clauses) will be withdrawn.

The practice PPG will need to enable the involvement of carers of registered patients but who themselves are not registered patients.

Since April 2011, having a PPG has been an enhanced service i.e. an optional clause in the GP contract which

attracted extra funding – currently 35p per registered patient. This will cease on 31 March 2015 and the associated funding will be reinvested in "global sum" i.e. the standard contract. This change follows feedback from practices that excessive monitoring and reporting required for the enhanced service has detracted from the purpose of patient participation.

I recently took my grandson along to an appointment at Water Lane where we saw [redacted], a paramedic, who was fantastic and picked up on something that was missed by another OOH clinic in the area.

Where is the young man that was at last meeting? Isn't he doing the training for PCCs?

[redacted] explained that our Reception Manager had left and had not been replaced. Training will continue with our PCCs taken over by the [redacted], our Head of Operations with support from the Site Leads.

What kind of training do you do?

[redacted] reported that training could take various forms including presentations, role play or online.

Have you considered when you do role play to video it and play back it would help with training.

[redacted] said that we don't but it is something we could consider for future training sessions.

The big problem you have with the PCCs is time, they don't have time to talk to patients so you've got to have someone who knows what they are talking about. Everyone wants to be treated as an individual so needs time.

ACTION	COMMENT	PERSON RESPONSIBLE	TARGET DATE
Investigate the possibility of having easier access to the upstairs consulting rooms		[redacted]	
Add new signage to give patients clearer directions for patients		[redacted]	

DATE OF FUTURE MEETINGS
Wednesday 6th June at 6.30pm at Tower Court
Tuesday 4th September at 6.30pm at Water Lane
Wednesday 5th December at 6.30pm at Acomb
Tuesday 12th March at 6.30pm at Tower Court