Patient Participation Group (PPG) meeting – 5th January 2022

Attendees:
LM-F (Lesley Munro-Faure, JH (Jackie Highe), RH (Rob Holdaway), JE (Jenny Edmans), MB (Matt Bateman), PM (Pat Mullan), MW (Marion Wilkes), LT (Lorna Taylor), (YH) Yvonne Hook); RC (Richard Clemmow); RDH (Richard De Havillande); Brenda Jefford (BJ); John Pettit (JP); Emma Lowndes

Location/Time: via Zoom at 10am

No	Description	Action
1	**Welcome and Apologies** Apologies were received from Monica Marshall, Cathy Clark and Louise Smith.	
2	**Practice update** <u>Covid clinics</u> LMF explained that we had been doing the booster COVID clinics from October and had planned for these to finish at the beginning of December. However, there was then a national call to vaccinate all adults by the end of January (then changed to end of December). We quickly arranged a lot of clinics but several between Christmas and New Year had to be cancelled due to a lack of demand. Part of the problem was that the Prince Risborough clinic was not on the National Booking System until near the end of the clinic provision; we also believe that many people had already gone elsewhere for their vaccine. We have currently paused clinics as there is a lot of capacity across Buckinghamshire; however we don't know if we will be asked to do the 4th boosters, if these happen. We have done 45,000 vaccines altogether in just over a year. PM noted that this was amazing given everything we have had to cope with in primary care and as a practice, and that patients were very appreciative of the efforts and said how well organised it was. RC asked what % of our patients were vaccinated. LMF explained that it depended on the cohorts: 100% of our patients in care homes are	

	vaccinated; 97% of our over 80s; well over 80% of the over 40 year olds. However, the percentages reduce as you go down the cohorts. We have not yet done the under 16 year olds as a practice. Nationally they are also starting to look at the under 11 year olds. RC asked what the plan was for the 4th vaccination for vulnerable people. LMF noted that given we aren't currently running clinics, she would suggest going to other sites. <u>Flu clinics</u> Our last flu clinic will be at Brill surgery on 12th January. We are targeting via text the last few people who are still wanting to get this vaccination. <u>Long Crendon Surgery</u> The planning permission has all gone through since the conditions were met (including having 'a spade in the ground' by the end of December 2021). However, the Parish Council has not yet obtained the funding required. They have an agreement with the CCG in relation to rental income; however they need the capital for the build. LMF explained that once this is in place the CCG might allow us to open Long Crendon surgery in a limited way, whilst the new Wellbeing Centre is being built. <u>Thame Health Hub</u> Unity Health and Rycote are still in discussions with the developers in relation to the land opposite the Chinnor Rugby Club in Thame. The developer is still keen to move things forward but there is still much to do/agree if this is to go ahead (LMF thinks they are going back to planning in the Spring). New health properties are extremely complicated and we are not currently the CCG priority in terms of a new build. <u>Unprecedented Demand</u> Nationally primary care is still the busiest it has been in a very long time. Our clinicians are working extremely hard, but it also puts pressure on all of our staff, especially reception. LMF asked that if there was anything the PPG could do to encourage patients to be kind to reception that would be helpful. MW noted that she was pleased that the staff in Thame recently got an award through the Thame Business Awards as she feels it was very well deserved. RC asked if things had got worse for reception recently? LMF said that it was primarily patient's frustration that they can't get what they think	

	they want/need. She went on to say that the issue is that our receptionists will just leave if patients continue to be rude; and then this will mean patients are even less likely to get the level of service they expect. JH noted that a lot of the patient angst when talking to reception is out of fear and anxiety. The key thing is to continue to communicate with patients as much as we can. RH asked: what is the biggest current impact on patients of this unprecedented demand? LMF noted that there were two main impacts: 1. Difficulty in getting appointments due to the overwhelming urgent/acute issues that we are currently seeing. 2. Reduced capacity to do longer-term patient care provision. <u>QOF and PCN Targets</u> LMF noted that some of these targets have been relaxed during the pandemic in order to allow practices to cope with running COVID clinics and staff absences caused by COVID. However, we are trying to continue to deliver as many of the long-term condition checkups etc that we can as we feel this is extremely important for clinical care. <u>Uncertain environment</u> The environment in which the practice is operating currently is very reactionary. It is therefore difficult for us to plan as every time we do, things change again.	
3	**Review of the actions from the last PPG meeting held on 13th October 2021** • LMF to publish information on the website re. LTC recalls – to be rolled forward since this work has been paused again nationally. • SS to arrange initial meeting with website working group – to be rolled forward. • SS to review the data to see if age of respondents had an impact – nothing of significant impact to warrant further discussion. • SS/LMF to discuss potential review of appointments system with the Partners – rolled forward since this PPG meeting is the pre-cursor to that. • SS to share figure with PPG once 2021 accounts are finalised – this related to the patient numbers per GP. 2021 accounts are not yet finalised, but this figure for the practice in 2020 was 2253 per WTE (versus the national figure of 2253 per WTE). • SS to feedback to GPs comment re. video consultations - done • SS to discuss with Lead Nurses re. communicating to patients a	**LMF to publish information on the website re. LTC recalls** **SS/LMF to discuss potential review of appointments system with the Partners**

	fall back date for next year – this related to the long-term conditions work which is currently paused. • SS to ask PPG members for comments on key areas to be included in patient survey action plan – done on 27/10/21. • SS to send around link to national patient survey results – done on 27/10/21. • SS to circulate some more info on PCN team and roles – done on 27/10/21.	
4	**Patient survey action plan** SS noted that she had done an initial draft of an action plan for the patient survey based on the 12 key themes identified (set out in the last slide of the powerpoint discussed in the PPG meeting on 13th October). The first 5 priority areas relate to the appointments system, and in the responses from the PPG members by email, it seems that this is what the PPG members feel is most important to patients. SS asked for there to be an open discussion to ascertain the views of the PPG on the appointment system. This will then be fed into a Board (and/or Partner) meeting to inform the final action plan. SS set the scene explaining that, ideally patients want to be able to call up on the day and get an appointment for an acute/urgent issue; they want to have access to pre-bookable appointments in the future for something less urgent; they want to see the GP of their choice; they want that GP to give them a 30 minute timeframe within which they will call back; and they want to be able to book online or email in queries. SS asked - where does all of that sit in the balance of things? In other words, what is most important to patients do you think? MB asked if/when we would be going back to triage calls being within 1hr of the patient's initial call. SS explained that this had been extended to 2hrs during the pandemic as what were previously triage calls had changed to telephone consultations (as far fewer patients were being seen face-to-face), which take much longer. As such, the GPs cannot get through their call lists as quickly as they used to. MB noted that we therefore potentially need a plan for the short-term (during the pandemic) and then a longer-term plan where we could aim to return to the 1hr call back timeframe. LMF noted that this would not be possible if	

	telephone consultations became a more permanent change. LT said that she thought the triage system was fantastic and, because it was deemed sufficiently urgent she suspects, she had twice recently been able to see a doctor that day. MB noted that some of the frustration is in getting a triage call, and the need to call back on the next day if all the slots are taken. This leads to the surge of calls at 8.30am that the telephone triage system was set up to prevent. SS noted that currently due to the very high demand for urgent/acute issues, sometimes the call slots were all booked up from early on in the day. Each GP working a full day has 12 triage slots. Once the afternoon is half full (i.e. each GP only has 3 slots left), reception then ask any patients calling for an appointment whether it is urgent for the day. If not, they are asked to call back another time. Once all the triage appointments are filled for the day, reception ask any patients calling in whether it is an emergency for the day. If so, it is booked in as an extra; if not, the patient is asked to call back another day. JP commented that the pressure from COVID and the ability to book appointments is all connected. The PPG understands that and is accepting of the situation, but not all patients are (and are frustrated due to having been cooped up since the start of the pandemic). He thinks the triage system is excellent and can't see how it could be made any better. He thinks that we need to communicate with patients that there is a lot of organisation/admin that takes place behind the scenes ahead of a patient actually talking to a clinician. Patients are generally only interested in themselves and don't have an awareness of the pressures on the practice e.g. certain consultations may be very complex and take longer than 10 minutes, hence a GP running late for example. EL noted on the Zoom Chat that she thought communicating a number of things in the Newsletter was a good idea, but she would also suggest using social media, especially the Unity Health facebook page and local facebook groups. In terms of reception, JP feels that they need to counselling – to illustrate that they are appreciated, as this doesn't always come across. EL noted in the Zoom Chat function: "On reception staff not been treated	

	kindly - perhaps it's time to let people know in the recorded telephone message that reception staff will simply put the phone down on you if you can't be civil.." RDH commented that for him personally, he wants to speak to a clinician but he doesn't mind if it is a practice nurse, paramedic of a GP. Could reception divert to other clinical staff aside from GPs? LMF noted that this is where the Care Navigation training will come in, since currently the GPs do all of the triage. However e.g. medical queries should go straight to the pharmacists; urgent care should go straight to the ANPs or paramedics (LMF noted we are about to employ an in-house paramedic for urgent care which should help). We need to get reception to understand all these other roles and to utilise them better. Also, sometimes patients push back/disagree with reception, but they need to have the confidence to say that, for example, the nurse is the best person for the patient to see about their dressing or long-term condition. The GP needs to be employed later on in the process, to make the most of their specialist skills. RH suggested that we should explicitly explain that the receptionists will be triaging patients' calls. SS noted that we say this in so many words on the current recorded message. We agreed as a group that this could be re-worded to be more direct. JH suggested: we will ask you for a description of your problem in order to "help you best" and to direct your call to the most appropriate person. BJ said that she has always been impressed with the speed of the GP call backs. However, she asked why patients calling in when we are full could not be put on a waiting list or booked later on in the week. SS explained that then we would be booked up for the whole week by the end of Monday. JP commented that the issue is that in calling back the next day, you fall once again to the back of the queue. SS agreed but noted that she was not sure what the solution was. LMF explained that before telephone triage was introduced in 2013, face-to-face appointments were all full, yet a lot of them were with things the GP didn't need to see at all. This is where the triage system is helpful, as it ensures those that need to speak to a GP most urgently can; and it is why online booking reduces efficiency. BJ also queried how and whether a patient could insist on being seen if following the triage call the GP didn't feel the patient needed a face-to-face review. SS explained that it should be a joing discussion between	**SS to agree new wording for recorded telephone message.**

	the patient and GP and therefore should not get to the point of insistence. LMF added that sometimes the GP knows that seeing the patient will not change their diagnosis, but it is up to the GP to convince the patient of this so that they are reassured. JH commented that this is where seeing your own GP is preferable as you would be more likely to trust them if they said you did not need to be seen. JE commented that there are patients who are at the opposite end of the scale and don't contact the GP as they don't want to be an inconvenience and they know how busy we currently are, and that the consequence of this delay can be very serious. SS asked what we could do about this? JE said that we could communicate to patients to remind them that they are important to us, and we are here to see them. EL commented that a lot of this is education of patients, whether it's the 'worried well' or the people ignoring symptoms that do require a GP appt, and everyone in between. A twice a week update on social media would also go a long way on spreading the word, by word of mouth off social media too. Is there anyone in the practice that is a Facebook whizz and can be given a little training on the messaging you need on the site and in local groups? The pandemic has made more people more attentive to facebook for local info. EL also offered to provide any help on the communications-side. RC asked whether it might be possible for a clinician e.g. a paramedic to do all of the triage calls? SS explained that it would need a lot of resource as currently we have 10 receptionists working at any one time. LMF explained that the purpose of the Care Navigation is to do that first level of triage – e.g. to the paramedic/nurse/physio/GP/pharmacist etc. RH noted that from the patient survey it is clear that the triage system is the most important thing to focus on, and that it needs some fine-tuning.	**SS to consider regular facebook updates to communicate with / educate our patients.**
5	**Newsletter** SS asked the wider group for ideas for the next issue (due to be published in March), as well as thoughts about how we could increase awareness / readership. She noted that we already text all patients a link via their mobile phones, and vertical displays in reception haven't worked in the past and now there are even less patients coming in to the surgery. We could and should use social media more to advertise it.	

	RC noted that we should ensure that the link we send via text is formatted such that people can easily view it on their phones, as this is not often the case and yet this is where most people are likely to view it. MW noted that it was clear we needed to focus on behaviour on both sides (practice and patient). We need to include short, snappy articles that have information that is most important to patients. Some articles in a Q&A form might help. MW noted that one bad experience from a patient is shared like wildfire in local groups. SS suggested that we could include some compliments from patients to negate these messages. It was suggested that it would be useful to set out in the newsletter the range of clinicians that are available to patients (aside from GPs) – e.g. PCN staff, physios etc to make patients aware.	**SS to discuss this with website provider and ensure it is possible.** **SS to give MW/YH contact details of patient who was happy to write compliment in newsletter.**
6	**"Getting to know Unity Health staff"** Laura Twomey, Dispensary Manager talked briefly about her role: she has been at Unity Health for four years; there are eight dispensers in the team currently, most of whom are part-time; it is an extremely busy job, with lots of patient interaction. Laura explained the process briefly and therefore why it takes 4 working days to turnaround a script – first it needs to be authorised by the GP, then the medication needs to be ordered, delivered, dispensed, and then checked. This is not a quick process, and we had to increase our turnaround times from 3 to 4 working days during the pandemic and have not been able to reduce these since the demand for medication has not allowed it. Laura noted that our suppliers are often delayed, which means that orders are then late (currently they are struggling with drivers). As such, she reminded everyone to put their medication requests in in plenty of time to ensure there were no issues. She also asked that patients considered bank holidays and practice training days (PLTs) as we are closed during these and therefore the turnaround time is extended. This was something that the PPG thought could be included in the newsletter. Laura also discussed the dispensary call lists – that is, reception can note that a patient wishes to discuss something with the dispensary team and they will call them back within the day. The reason that we have this	**MW/YH to include the rationale for the 4 working days turnaround in the newsletter**

	system is to reduce the amount of disruptions to the team, as this can lead to errors. MW asked why we only dispense to Brill and Long Crendon patients. Laura explained that legally we can only dispense to patients that live over 1 mile away from a pharmacy. BJ asked why the manufacturer on certain medications (e.g. high BP tablets) changes so often? Is it a matter or cost, or suppy? Laura explained that we are completely reliant on our suppliers and they sometimes change the brand and we are therefore not able to get the old brand. Laura explained that we do try and keep the cost to the NHS down by ordering generically in Buckinghamshire (i.e. generics rather than brands) since there is often a very significant cost difference despite the medication being exactly the same. It was queried whether the dispensing team could answer questions on medication interactions. Laura explained that they would always refer back to the GP, but that they can act as the middle person in order to do this, and indeed that they are happy to as it makes their jobs more interesting and expands their knowledge. This query could be written down the repeat prescription request; in the comments box online; or by calling reception and asking to be added to the dispensary call list. PM noted that generics do seem to vary and if we were to get feedback that one brand didn't suit a lot of people, would we be able to change this? Laura explained that there is often some flexibility within the generic brands. She gave an example of some patients being allergic to yellow food colouring which is used in some drugs; these patients therefore have a specific brand. Laura noted that as long as they know the reason why and it is valid, they are usually able to source an alternative. Laura noted that the team dispense c. 10,000 items a month, which is a very large number. As such, of course sometimes there are errors, but that by reducing interruptions the rate of these is generally kept extremely low.	
7	**AOB** **1. Care Navigation training** SS explained the background to this and that some of our receptionists are concerned that despite the training they will receive and the	

	"rebranding" to Care Navigators, patients still won't listen to them and have confidence in what they are advising them to do / who they are advising that they are best to speak to etc. SS asked if there was anything we could do to educate patients to help address this concern? RC commented that being explicit with patients was the most important thing – saying that they have been trained as Care Navigators. We need to communicate as effectively and efficiently the demands on the practice and what has been done to make it run as smoothly as possible, including the introduction of other clinical roles. JP: What do people think receptionists do? He noted that they are possibly perceived as a hindrance, when in fact they are pointing patients down the best path for their problem. SS replied that she thinks many people do not realise what a difficult job it is, and they think that reception just answer the phone, book appointments and take messages. JH commented that they are often considered to be the "gatekeepers". Again it was noted that communication is key – if patients knew the full job of a receptionist, they might be more understanding. SS noted that we could possibly do "A day in the life of a receptionist" in the newsletter, potentially in a Q&A format, so it is not too text-heavy. PM suggested that we change the recorded message to say that you will be put through to a Care Navigator (rather than receptionist). JH commented that the language in everything we do as a practice needs to be as simple and direct as possible. No jargon or 'sales' speak. She also suggested that we call the Newsletter something else, to make it more attractive to potential readers. RH noted that the confidence required is two-fold – confidence from reception due to the new knowledge learned in training, but also confidence from patients, that the care navigators they're speaking to have the required knowledge. LMF noted that sometimes she hears reception apologising for the system: "I know this is not really what you want, but this is all we have…" This needs to change as reception need to really believe in the system since they are the ones guiding the patients through it. The message	**SS to organize content on the receptionist role for the newsletter.** **MW/YH to consider an alternative name for the newsletter.**

	must be positive: "This is what I can offer you today!" MB feels that reception need to be supported and helped to grow. He asked whether they might have questions for the PPG that might help them in their role? SS suggested that in the next PPG meeting one or more receptionists attend and there is an open Q&A session to see what support the PPG can offer them. JH noted that she thinks reception are the most patient group of people. She suggested that they could tell the PPG what their biggest difficulties are in order that these could be discussed and problem-solved as a group. MB suggested that reception are involved in the design of any tweaks to the appointment system, to ensure their buy-in. **2. Website** SS suggested that the working group (Richard C, Richard DH, Jackie and Lorna) meet ahead of the next PPG meeting. She thanked those PPG members who had already sent in some comments about the website and suggested that one of the working group took ownership of looking at some other practice websites in order to inform the view of how ours could be improved. **Ideas for future PPG sessions** SS asked the group for ideas for any topics for future PPG sessions. **Volunteers** PM noted that the volunteer community was so successful in helping with the COVID clinics and wondered whether there might be the opportunity to volunteer with other admin-type tasks for the surgery? SS said that this was a lovely idea, and we would discuss and consider what might be feasible.	**SS to agenda a reception session at the next meeting and ensure staff can attend.** **SS to arrange a website working group meeting and someone from the group to take ownership of researching other practice websites.** **SS to consider what tasks volunteers might be able to help with in the medium to long-term.**