UnityHealth

Patient Participation Group (PPG) meeting – 28th January 2020

Attendees: LM-F (Lesley Munro-Faure), SS (Stephanie Service), YH (Yvonne Hook), PM (Pat Mullan), JH (Jackie Highe), MW (Marion Wilkes), RH (Rob Holdaway), CC (Cathy Clark), IM (Ian McIntyre), MM (Monica Marshall), MD (Marcia Davis)

Venue/Time: Princes Risborough surgery at 2pm

No	Description	Action
1	**Welcome to our two new member and apologies** Ian McIntyre (IM) introduced himself as a new member to the PPG. He lives in Shabbington and is retired, but previously worked in the NHS for 31 years, latterly as a Director at Central and North West London NHS Foundation Trust. The following people sent their apologies for this meeting: Emma Lowndes, Jenny Asher, Jenny Edmans, Chris Poole, Brenda Jefford, Richard De Havillande.	
2	**Review of the actions from the last PPG meeting held on 5th November** **Action: SS to add QOF and QOF components to the next PPG meeting agenda –** done, point 8 on the agenda. **Action: SS to include in the next newsletter a reminder that patients can ask to see / speak to their usual GP for continuity.** – This is in the plan for the next newsletter (see point 6 on the agenda). **Action: SS to ask Sarah if she can produce a "quick guide to referrals" for the website and newsletter –** Sarah has agreed to do this, hopefully in time for the March newsletter. **Action: Possibly include note re. new ultrasound in next newsletter so patients know to request Thame** – this will likely go into the "Did you know…?" section of the March edition, space dependent. **Action: PPG volunteer in each of the 5 surgery areas to ensure newsletter is available in local "hubs" as well as the surgery itself.** – Discussed under point 6 on the agenda.	

	Action: SS to consider including additional question in the patient survey to gauge readership of the Patient Newsletter – discussed under point 7 of the agenda. **Action: SS to ask Dawn Ilsley to come to the next PPG meeting if possible to discuss her role and community pharmacy** – see agenda point 3. **Action: SS to check BP machine instructions in waiting rooms note that AF patients shouldn't use these machines.** This is the case at all sites except Thame. SS suspects this is because we share the machine with Rycote and it may have been removed by them. SS to discuss with Rycote Practice Manager. Karl. **Action: SS to put Friends and Family test results on the practice website** – this had already been done; see the bottom of the home page. **Action: SS to mention in the newsletter that patients can opt out of texts, but they won't receive any information at all from the practice –** this will go in the "Did you know…?" section of the newsletter. **Action: SS to research what other practices have done in the Wellbeing space –** SS noted that she had not yet had a chance to do this but that we now have a new Wellbeing Committee of 4 staff members, so she will ask them to look at this. **Action: SS to report back after 21st Nov and set up a sub-group meeting with Lesley Simpson** – this was done via email, and sub-group met with Lesley in December. **Action: SS to discuss the possibility of having a Carer's sub-group with EL and possibly agenda for next meeting** – not yet discussed with Emma. SS to send her an email about this. **Action: PM and JP to review the website (and other surgery websites) and suggest potential ideas for improvement** – PM explained that she had done this, but the email became corrupted and never sent. She will look to do this again when time. **Action: SS to ask website providers for any data on site hit rates and ensure we clearly link to NHS choices –** SS explained that she now has access to Google Analytics for the site. She will spend some time trying to create some useful reports; however, for the time being, here is a flavour of the data we will be able to see: In the last 7 days, we had 863 users, and 1.1k sessions (i.e. most people	**SS to provide an update on website data / reports available at the next**

	only went on to do one thing). The average duration of time spent on the site was 1m 28seconds. In the last 28 days: we had 3k users and the last 90 days: 8.7k users. In the last 7 days the most viewed sites were the "contact us" pages for the 5 surgeries (c.150 – 300 hits per site); online services (179); manage your health online (126); appts / online appts (109); and team/doctors (89). **Action: SS to find out if we are able to put the practice brochure on the website –** this has been uploaded and is under the "About Us" section. An amendment to last meeting's minutes were proposed by RH via email ahead of the meeting. He believes the minutes missed a quick but important additional dialogue about 'continuity'. In the section on Year of Care/Long Term Care, RH remarked that the issue of lack of continuity was made worse at Unity by the number of part-time doctors and on follow-up with patients there was also therefore greater risk of not delivering efficiently. Lesley commented that this would continue to be a big challenge in the future, but is not specific to Unity Health – part-time GPs is a national issue. SS has amended the minutes and will re-distribute along with the minutes of this meeting. Related to this point, RH showed a newspaper article titled: "Having one GP halves the chance of early death". He noted that whether Unity Health would dispute the statistic or not, the message remains that continuity is important. Nonetheless, he commented that he recalled when Mike Thomas came to talk to the PPG he noted that often there can be a benefit of a patient seeing a different GP to get a second opinion and/or as they might spot something that a GP who knows you well misses or discounts.	**meeting.**
3	**"Getting to know Unity Health staff"** Dawn Ilsley (Unity Health Pharmacist) and Safina Ashraf (PCN Pharmacist came to talk to the PPG. Dawn Ilsley explained that she has been a full time pharmacist for the practice for a year, and before that she was a part-time pharmacist and part-time reception. Her background is in community pharmacy, where she worked for 30 years for Boots. Her role is focused on improving medication safety. She deals with queries from GPs and patients alike. These could be to do with scripts, side effects or general worries etc. She also completes audits to check the prescribing processes followed by the practice and ensure that we are always following the latest NHS guidance. Safina Ashraf joined in November as the Primary Care Network (PCN) pharmacist. The hope is that this new role will enable us as a practice to	

	tackle bigger projects than we would have been able to do with Dawn alone. She is with us 2.5 days a week, and then spends 1.5 days at Cross Keys and 1 day at Haddenham. She has 12 years' experience in Community Pharmacy (also at Boots) and was looking for a new challenge. The PCN is supporting her to do a course that should lead to her being able to prescribe independently. JH: Do patients contact you directly? Dawn said that yes, they can do; she has a telephone call list (a bit like the GPs). The hope is that she is able to deal with some of the medication queries that patients have, thereby freeing up the GPs' time for other things. RH: Safina, have you noticed a difference working across the three practices? Safina said that the main difference is that we have Dawn already, whereas Cross Keys and Haddenham didn't previously have an in-house pharmacist. As such, the GPs still take the lead on medicines management and prescribing. Aside from that, she hasn't noticed a great deal of difference between the practices. JH: Do you spend most of your time talking to patients? Dawn said: Yes, although quite a lot of my time is spent doing admin – I deal with all the discharge and other clinic letters. As such, if there are any medication related actions on here, I process these. I am training up someone to try and help me with this, as some are relatively straightforward. This way, I hope I can begin to run some patient-facing clinics e.g. for patients who have lots of medications, trying to rationalise these. RH: Is your objective to do patient facing meetings? Dawn: Yes, I am for example working towards (with Dr Stamp) Atrial Fibrillation reviews that would be patient facing. RH: Would that be known/advertised to patients? LMF responded that we don't know yet as we haven't decided exactly what Dawn will be doing. SS asked Dawn what she liked best about the job. She said that it is such a good team and she loves working here. Her only regret is not joining sooner! She loves that she is able to see really simple things that improve the lives of patients. Safina noted that she was new to the role but that all the Clinical Directors were very supportive and she had been given a very good implementation/induction pack, and has been enjoying working alongside Dawn. PM: Will you do some of the basic medication reviews?	

	Dawn: We are working towards that, yes. There are certain groups of patients that I will be able to review safely (i.e. the less complex patients on just one medication). IM: Are you involved in the management of the cold chain? I notice this was a recommendation from the CQC report? Dawn: I'm not, although I was involved in the process that we carried out to rectify this issue. YH noted that on p.13 of the CQC report it says that patients should have steroids for 5 days. Two years ago she was discharged from hospital and they reduced her prescription down from 7 days to 5 days. She has just recently had a new prescription and it is for 7 days. Dawn said that she would look into this, and also review other patients too in relation to the this COPD medication. (SS to say that this has been changed for her, and thanks for flagging).	**Dawn to review Yvonne and other patients on this medication to ensure consistency of prescribing.**
4	**CQC inspection outcome and next steps** SS explained that the CQC inspect practices against five domains – their inspection focussed on three of these: whether the services we provided were safe; effective; and well-led. We received a Good against Safe and Effective and an Outstanding in the well-led domain: Some quotes from the report: "There was compassionate, inclusive and effective leadership at all levels." "Despite service delivery from five separate sites, there was collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences." "There was a fully embedded and systematic approach to improvement. Improvement was seen as the way to drive performance and for the organisation to learn." "Everything seems standardized" – the inspector explained that he felt that we had merged much quicker than other practices. In the feedback the CQC inspector gave on the day he commented that much of what we are doing in the practice is very innovative, and there is lots of continuous improvement. However, with some of the newer initiatives it is too early to evidence impact. He noted that all staff were very patient-focussed and outcomes-focussed. We were a strong team with a clear vision. SS noted that there were of course recommendations (although none of	

	which were mandatory). E.g. to continue to develop the cold chain processes for all medicines which require refrigeration; and develop the processes within the dispensaries to audit compliance and adherence to standard operating procedures). JH noted that the inspector called her to get her views about the practice. She told him that Unity Health supports patients very proactively. If there is something raised, they will find a way to accommodate it. She explained that the PPG was "not just a talking shop" and that the practice really does want to do the best by its patients, and listens to their views. MW noted that her experience of the practice over 30 years had always been extremely good. RH questioned what the wider patient population would think? Could we consider a question in the patient survey regarding how responsive the practice is to change or improvement? (See section 7 below). IM asked how staff felt about the inspection, and if they were worried or intimidated? SS noted that the CQC inspectors did not speak to too many staff members face to face, and instead asked for comments on confidential postcards which they collected at the end of the day. IM asked what we thought about the process - was it probing enough? LMF noted that this time the CQC brought a medicines management expert to visit Long Crendon and Brill (where as last time it was just a nurse doing the dispensary inspection). She also noted that all practices in Bucks now have the same inspector; he is therefore aware of which practices have issues before he even arrives. The inspection was indeed thorough – one example LMF gave was that the safeguarding lead had changed a couple of months previously and they wanted evidence that we had updated our protocol for this (which we had). In terms of the cold chain recommendation raised previously, LMF noted that we have fridges in almost every clinical room at all the sites. What the inspection flagged is that the fridges are under two separate lots of control; with most looked after by the nurses but two being looked after by dispensary. If the issue had been with one of the nurses' fridges it would have been different as we store immunisations in here. In the dispensary fridges, we don't store anything that needs to go in the fridge since we only store items for a very short time between ordering and the patient coming to collect them. LMF explained that the inspection was on Wednesday, and we were given until Monday to respond. In this time we identified anyone who had requested a prescription (that would have gone in the fridge) in the previous 28 days and contacted them, offering to replace any medications if they were worried. The CQC was happy that we had responded to the concerns.	

	LMF noted that we have spent a good deal of time since the inspection considering what have we learnt from it, and what do we need to focus on now. For example, in relation to chaperoning, not all the GPs were aware of who could chaperone (staff must have done the training and also have an enhanced DBS). We have now created a list such that all GPs know who can chaperone. Another thing that we are planning on putting in place on the back of the CQC inspection is a data set that we will monitor (quarterly) to gauge performance. We used to receive quite a lot of data from the CCG, but we receive very little now. We need to decide – other than QOF, the patient survey, Friends and Family Test and other data we review regularly - what would help us to "keep the finger on the pulse" of the practice, and flag if there are any issues that need addressing. LMF noted that, for example, in relation to bowel cancer screening rates – the practice is not involved in this, but we see the results of who does not attend. If our screening rates were low (which they aren't) we could then follow up with these patients to improve performance in this area. Is there a mechanism for staff to flag things up if they have issues? Yes. LMF explained that that we have regular site meetings, and we also have recently begun the "elephant in the room" initiative whereby staff can write down on here anything they are worried about and would like discussing. MD asked whether we monitored anything to do with carers. LMF stated that we're starting to look at this. We have also recently held two carers' events led by Carers Bucks, and LMF has a follow up meeting with them next week. We may consider proactively offering carers an annual health check, which is not something we have done before. MD noted that at the end of a carer's role there is also often a decline in health. LMF commented that we have a template to guide GPs as to what to think about in relation to end of life, but we will consider whether something should be added about carers. YH noted that there are 1,200 carers in Lord Williams' School. All were surprised by this figure, and would be interested to know the proportion of patients this is.	**If you as PPG members have any thoughts on potential key data sources you think we should include, please let SS know.** **LMF to review the end of life template.**
5	**Wellbeing sub-group update** SS updated the group on the status of this. Namely that we had agreed three dates for the first cohort of patients in April. Lesley Simpson will facilitate this (with c.15 patients), and RH, MW and JE will attend to learn the	

	content etc with a view to deliver future sessions directly to patients. There are three sessions: Eating for Health; Managing stress and anxiety; and Physical Activity. SS noted that there is a new PPG member (Sarah Buckley), who couldn't come to the meeting today but who is a young mum with an HR/employee wellbeing background; SS hopes that she may wish to get involved in this too. RH noted that it is a bit evolutionary at the moment as it's a pilot and that we will need to see how it goes. He noted that there is a lot of detail in the training slides (too much in his view). SS suggested he discussed this with Lesley Simpson. RH also noted that there is only so much time they could commit to this, and that he did not expect to arrange venues etc. SS noted the difficulty in getting the first date arranged and suggested RH, MW and JE start discussing possible dates for cohort two. Action: RH, MW and JE to agree on three dates for the second round of training. RH asked if there was any personal indemnification. SS said she would find out and report back to RH, MW and JE. RH noted that we need a longer-term plan for delivery. The hope is that some of the people being trained might take this on in the future. A query was raised as to whether this was a pilot or is being run elsewhere in the country. SS noted that Live Life Well is a new initiative and is about educating patients and giving them some tools to help manage their own health. This is not to be confused with Live Well, Stay Well, which is a healthy lifestyle service into which patients can be formally referred. MD noted that it will be interesting to see how many men engage. She went to a few of Lesley's chair-based sessions in Brill and it was exclusively women (with the exception of one man, who came with his wife). She noted that the venue selection could be key in trying to appeal to men – e.g. a sports / social club? Also, it will be important how the practice "sells" the project. IM noted that he thought young men would be receptive to conversations about wellbeing. MW agreed that there is a danger that the people who could benefit the most from it, won't come. We discussed the need for the information that patients are provided with to be as engaging as possible. It would be helpful to get input from the PPG members on this. RH: When the GP refers, what happens after that decision?	**Action: RH, MW and JE to agree dates for the second cohort of patients.** **SS to confirm re. personal indemnification.** **All to provide suggestions / comments on**

	The front end discussion with GPs will be important. SS noted in response that all the GP partners were very positive about the initiative. LMF explained that this will help their workload in the future, so it is a win win.	**the Live Life Well referral form/info.**
6	**Patient newsletter: planned contents for next edition** SS, MW and YH met to discuss the newsletter in January. The next edition is due to be printed in March, and we will aim for this to be 8 pages (we felt 12 was a bit too long). The main focus this time is likely to be on wellbeing and on pharmacy / meds management. In terms of wellbeing: we will advertise the new Live Life Well programme, as well as giving other advice to patients who aren't necessarily eligible to be "referred" to this. The pharmacy section will be an article from Dawn and possibly Safina re. their roles, and an article on medicines management – i.e. useful information for patients such as how to align their medication ordering so they don't have to come in to the surgery more than they need to etc. There will also be 1 page on the CQC report and the findings. MW and YH to read and consider what would be most interesting and relevant to patients. Other sections will be: a quick guide on referrals (as already discussed); the Did you know…?" section, with useful patient reminders; and then the back page will remain unchanged with surgery opening times and PLT dates. SS asked if there were any other ideas or if we were missing anything? YH noted that we will be mentioning in the newsletter the Thame Community Hub leaflet (produced by BHT) and where it is available. YH commented that the important point is that doctors have to recommend it. MW noted that previously some GPs (not from Unity Health) had been referring elsewhere despite the local facility being available in Thame; she hopes this is now resolved. MW also noted that in relation to cancer services, there is not yet a definitive list as to who can be treated there. SS asked for volunteers from the PPG to distribute a small number of newsletters to other locations in the main towns/villages. The following people have volunteered: Long Crendon: PM Thame: MW and YH Chinnor: RH (once back from holiday in March)	

	Risborough: JH (if available before 23rd March) Brill: MD has messaged JE to ask if she could do this. (Note: IM said that he'd be happy to do this for one of the surgeries if needed.)	
7	**Patient survey** SS briefly ran through the questions we asked in the last annual patient survey and asked for any suggested edits/additions etc. Q1: needs to change (such that we aren't just offering male and female as options on the survey). New Qu (after Q12): Do you feel Unity Health is responsive to your needs? Remove Q14 - Any concerns re. online access and Q26 – which offers the option of patients leaving their contact details to discuss further any concerns they have. We will also consider removing Q18 re. how patients with LTCs obtained their test results.. IM queried why we held the GPs to calling back in one hour (Q7). Is this too strict a deadline? LMF explained that this is not a national standard, but was the timescale agreed with the PPG previously. RH asked that we include a question that tries to tease out how often patients get to see the doctor they asked for. LMF noted that we would need to consider carefully the wording of this question as often patients just want to be seen as quickly as possible, and don't mind who they see. SS noted that we will consider adding a question (as discussed previously) re. whether patients read the Patient Newsletter to ascertain level of readership. RH asked if there was any possibility that the Newsletter could be given more prominence in the surgeries e.g. in a display piece next to the signing in screen? Action: SS to consider if this might be possible. We could then have a sign at the bottom once these are gone to say – "Unfortunately you have missed out on a paper copy of the Newsletter, but this is available on our website at…."	**SS to ask the LGBT Foundation what categories we should have.** **All to comment on proposed survey questions once SS distributes these.** **SS to consider positioning of newsletters in the waiting rooms.**
8	**Performance update: QOF framework and outcomes** LMF explained that the Quality and Outcomes Framework started in 2004, with the new GP contract. The aim was to standardize the care offered nationally in relation to some key areas that impact on patient outcomes. There are many QOF areas, but LMF picked out a couple as examples, showing these on the practice's clinical system:	

	Asthma: The first thing that is looked at is the number of patients on the asthma register. (Note: for everything we have to code patients against the national coding system). We then get points according to what we have done for these patients. E.g. to diagnose asthma we should have done some sort of reversibility test (i.e. if you were without your inhalers, does your condition worsen). All asthmatics should have had a review in the last 12 months. Also, it asks us about the smoking status of all of our asthmatic patients from the age of 14-19. LMF noted that every disease group possible lobbies to be included in QOF, and the selection process is extremely thorough. Atrial Fibrillation (AF): The first thing that is looked at is the number of patients with AF. Next, the CHA2DS2-VASc score, which assesses the patients risk of stroke. Then, if this score is above 2, the patients should be on anticoagulant treatment. We are assessed against all these criteria and given points based on how we have performed. The more work involved, in theory the more points available. The total number of QOF points this year is 485. We are currently on 431 points, but there are two more months until the end of the year, and we will be very disappointed with anything less than practically 100%. IM asked what QOF is used for. LMF responded that it is about quality of care (but also payment). LMF explained when QOF first came out prevalence was not considered. E.g. if you had only 5 diabetic patients and you controlled their condition perfectly, you got all the points available; where as if you had 1,000 patients with diabetes and you didn't control them all perfectly, you didn't. This was changed by the end of the first year though and now it is worked out against a national average. RH asked: How does the practice organise itself to achieve the QOF points? LMF said that we know that we need patients to come in for their annual reviews in their birthday month if they have a long-term condition, and we have worked hard to educate patients to do this. RH: Is there a reminder? LMF responded no, it is the patient's responsibility, and it is clear in their plan when they need to come in. We do call in certain patients though e.g. dementia sufferers. RH: How does payment work? LMF explained that we get c. £140 per patient, we get the practice's rent paid, and then we also get money for QOF achievement. These are the main income streams for the practice.	**LMF to review percentage of income obtained from each source.**

9	**Surgery updates and business** A new social prescriber has started across the PCN (Nina Scott); she is currently being inducted in Haddenham. SS will invite her to the next PPG meeting to discuss what she'll be doing as the work is likely to tie in heavily with the PPG. She will be with us approximately of the time (as we make up half of the PCN in terms of patient numbers). We recently held two Carers' events at Brill and Risborough surgeries, led by Carer's Bucks. These were a success, and the feedback was that everyone was very pleased with them and it was a great opportunity to meet other people in a similar situation. C.12-15 people came to each one. There will be a military veteran's coffee morning on Feb 8th: 10-11am. SS noted that she had followed up with the Lead Receptionists in relation to the (relatively) poor result we achieved on the GP Patient Survey re. whether patients saw their named doctor. They explained that mostly patients do ask if they want a particular doctor, and will often wait quite a while to do this. It is in the Appointments protocol that we book in with same GP, where possible. Some patients specifically say that they don't mind who they see and that they just want a swift appointment.	**SS to invite Nina to next PPG meeting.**
10	**Bereavement pack for patients** JH wanted to talk to the PPG about something that has come up at the PCN meetings she attends. She explained that there was a bereavement pack available at Haddenham surgery; however, it had very little in it. As such, the PCN asked her to review this to see what could be useful to have in here. She has submitted a report to them, which they have agreed upon. She has suggested that there is a generic list of organisations alongside their contact details (a directory), with one sentence on each explaining what they do. This would not just be emotional support, but also practical support such as how to organise a funeral. Then there should also be a local list of resources too, based on where patients live. JH noted that the new PCN social prescriber has agreed to own the generic list, but wondered if someone from the PPG wanted to own the local list? It would involve a bit of work creating it in the first place, and then just checking e.g. six monthly that it is still up to date. PM commented that the registrars and the county council give out a bereavement leaflet. SS noted that it would be worth reviewing this to check the directory would be complementary and/or supplementary to this. LMF commented that she thought Nina (the social prescriber) should own	**SS to discuss**

	both the general and the local list. In so doing, she could contact PPG members to find out what they know in terms of any local groups, to make sure we capture all relevant knowledge from within the group. LMF also commented that we should explain what our role is as the practice for bereaved patients. JH noted that there is also a Carer's pack, which is full of brochures but lacks a "directory" type resource, as above. She wondered whether Emma Lowndes might want to get involved with. PM noted that we should refer to the carer's support group information sheet we included in the last Patient Newsletter.	**with Nina owning the bereavement pack and to liaise with Dr Furlonger over what the practice's role is in this.** **JH to discuss Carer's pack with EL.**
11	**AOB** SS mentioned that the Local Age Concern group in Bernwode have a £2k fund that they'd be happy for us to spend on any new equipment for Brill surgery in case the PPG had any ideas. None were given (Brill members had left). SS noted that at the last meeting there was a suggestion by one of the group to put the names of the PPG members on the website. A couple of members have said that they're not happy about this, so we will leave this. The PPG email address is available for any questions which PM continues to monitor (although there have been no new emails in three months). SS asked if there were any questions / concerns / suggestions from the group as to how the meetings are running? PM noted that she thought the group was starting to function a bit better. RH agreed that it was improving. JH commented that there is always a bit too much on the agenda. SS noted that she will endeavour to share any information with the PPG before by email where possible to reduce the need to discuss certain things in the meeting itself.	**SS to try to shorten the agenda next time to ensure we don't overrun.**