Date of Meeting	Monday 16th February 2015
Time of Meeting	6:15 pm
Place of Meeting	De Montfort Surgery
Attendees	Liam O'Reilly, Charmain Taylor, Steve Haswell, Claire Deare (Business Manager)

AGENDA

Welcome and Introductions

Claire thanked everyone for coming, and introductions were performed.

Minutes of last meeting on 26th January 2015

The minutes were agreed as a true record of the meeting.

Matters arising:

- *Increasing student membership within PPG*

Claire explained she had look through the membership list of the current PPG and that three of the patients listed are university students. She wondered what would motivate students to get more actively involved in the running of the practice. She noted the university has both nursing and pharmacy students.

- *Update on funding changes following meeting with commissioners on 29th January 2015 to discuss impacts of PMS review on De Montfort Surgery*

Claire explained that she and the partners had met with key team members from:

- NHS England (the team that hold the practice's NHS contract to provide NHS GP services)
- The Local Medical Committee (the local arm of the BMA)
- Leicester City Commissioning Group (CCG) (the body responsible for commissioning secondary care and community services. From 1 April the local CCG will also be responsible for co-commissioning GP services, jointly with NHS England)

The meeting had been arranged in response to NHS England's directive that PMS (Personal Medical Services) contracts were being reviewed in line with national guidance, and PMS practices have three options:

- Move to the GMS contract immediately
- Remain in a PMS contract and participate in a PMS review- requiring practices to justify their premium funding
- Move to GMS over a 6 year period, allowing practices time to plan for the loss of PMS premium

She had delivered a presentation spelling out the issues moving from a Personal Medical Services contract to a General Medical Services contract, in terms of reduced funding. Under the rules of the PMS review NHS England had specified practices choosing to remain in the PMS contract would need to demonstrate what they are delivering over and above the GMS core contract.

Claire had outlined some of the services De Montfort Surgery provides which are not part of the 'core' GP contract:

- Expertise of a GP with Special Interests (GPwSI) in sexual health
- Obstetric and gynaecological ultrasound scanning for pregnant and non-pregnant women
- In house physiotherapy and chiropractor appointments
- Management of patients with complex mental health needs
- Management of patients with complex musculoskeletal needs
- In house acupuncture for management of chronic pain

She had also explained that the national funding formula (Carr Hill) does not reflect the workload created by patients in the age 15-44 banding. 86% of De Montfort Surgery's patients are aged 15-44.

The formula takes the number of patients and then weights patients based on age, sex, deprivation and other factors. This formula then calculates a 'weighted' patient number and practices are paid so much per 'weighted patient' each year for delivery of core GP services. Currently that payment is £73.56 per 'weighted' patient.

On 1 January the practice had 16,826 patients registered, but the formula weighting would fund the practice for 13,244 patients. Currently this basic payment is 'topped up' by a premium payment. It is this premium payment that at risk.

This issue is further compounded by higher than average turnover of patients. Around 45% of patients are students, so we have a lot of patients registering at the beginning of the academic year, and leaving at the end of their studies. Some students also register elsewhere during the longer vacations and re-register when they return to Leicester.

Currently our PMS funding formula calculates the practice's funding once per year. The GMS formula would re-calculate the funding level every three months, meaning that over the summer while the number of

registered patients is lower, we would receive even less funding. Although the GMS funding formula does allow some extra 'weighting' for 'list turnover index', it by no means rewards the workload of patient registration.

It was recognised by everyone who attended the meeting that the practice had valid reasons for remaining in the PMS structure. However, due to changes with commissioning primary care from 1 April (control will move from NHS England, to joint control between NHS England and the CCG), no one was able to guarantee the practice's current funding level.

The practice has to make a formal choice by 2nd March.

Claire explained to the members of the group, that the partners and she were still undecided about how to proceed. She felt the practice has a strong business case she can put forward as to the value for money the practice provides for the 'premium' funding.

However, she has real concerns about whether or not the joint commissioners will guarantee the funding level in the future. The CCG is still developing its five year commissioning strategy, and is genuinely unable to give the practice a clear answer at this time.

She also has concerns that, although the PMS contracting route will continue to be available in the future, and is underpinned by legislation, governments can impose contract changes, and can give notice on the PMS contract at any time. A move to GMS would be de-stabilising, but would at least enable the practice to plan.

However, if the practice does move to GMS, it will have to reduce the range of services it currently provides, as funding will be reduced. Claire estimates it will be somewhere between 14% and 20% of the practice's current core PMS income.

She agreed to let the PPG know what decision the practice makes.

Post meeting note from Claire Deare, the practice's business manager (17.03.2015)

The practice opted to remain in PMS and participate in a review.

We are advised that this review will take place sometime between April 2015 and March 2016.

While we are in this period of uncertainty, we have decided not to recruit any more permanent clinical staff into the team, which means we will not be recruiting a permanent doctor as we had previously agreed and communicated. Instead we have engaged the services of a reliable long term locum doctor who has been working for the practice for the last 6 months, and who is not seeking a permanent position at this time. This means we will be able to maintain the planned number of appointments without committing to employing a permanent member of staff. This decision will be reviewed again as a priority after the PMS Review is complete

This was not a decision that was taken lightly.

Draft Patient Feedback Action Plan

Claire explained that NHS England requires practices to complete a specific 'PPG Reporting template' to qualify for funding for having a PPG. From 1 April having a PPG will become a core component of the GP contract. She had partially completed the template and brought it in draft form for the group to discuss and amend as they thought appropriate.

Claire shared the results and comments received via January's Friends and Family test (reports are published monthly on the practice website), and the result of the month so far in February. We have received nearly 300 responses, which was well in excess of the number of patients who completed the Local Patient Survey in the previous year. The group was happy to accept the Friends and Family test as a reasonable gauge of patients' experiences, along with other sources of feedback discussed at the meeting in January (feedback report is available to view on the practice website).

We discussed the actions the practice has taken to improve the patient experience in response to feedback from last year's Local Patient Survey in addition to other feedback received over the year, and we talked about what actions we will take over the next 12 months to address themes of dissatisfaction.

The three key themes that have emerged are:

- Pressure on the appointment system
- Doctors running late
- Phone lines being busy at 8am when the practice opens

There was a long discussion about increasing the amount and range of online transactions available to patients. Claire felt this would be a sensible option, to try and reduce the number of phone calls the practice

receives. Prior to working in the NHS she had worked in the financial services sector, and had noted in that sector a move away from using human beings to relay simple, transactional information to customers via a call centre, e.g. their account balance, or the amount due on their most recent statement.

She recognised that the health sector is not directly comparable, but with the rising demand for NHS services that is widely predicted, she feels we need to explore different ways of working. She has discussed this with the doctors, and they have some concerns about the practicalities of increasing online access to patients' medical records, although they do not object to the idea per se, as well as the security of online information.

The practice also needs to be mindful to verify the identity of patients when registering for online services- currently they can book and cancel appointments and order repeat medication, and from 1 April they will be able to see their 'My Summary' information, which will detail medications, sensitivities and allergies.

Claire expressed that she has been slightly frustrated in how late in the financial year guidance and training has been rolled out to practices- she and her team are attending Patient Online training on 24 February, to find out what additional elements of the patient record can be accessed online in the clinical software.

There was a discussion about testing out additional functionality with a small group of patients before rolling access to the wider patient population. The doctors are concerned this could create additional workload, e.g. patients querying historic information recorded in records before the patient was registered at the practice.

It was agreed in May to recruit a group of 20-30 ‘test’ patients. To be discussed further at the next meeting.

PPG Reporting Template Sign Off

The group accepted the revisions to the template discussed, and those present were happy to sign it off.

Next Newsletter

Agreed to include an item about patients booking one ten minute appointment per problem, and a reminder about cancelling appointments if patients are not able to attend. (Despite efforts, the ‘Do Not Attend’ rate remains around 8% of all appointments, which is a huge waste of resources and may be one of the reasons some patients feel it is difficult to get an appointment).

Staff training

Claire sought the group’s agreement to close the practice one afternoon per month for staff training. She explained that we are very busy throughout the day, and we open two evenings per week, and it is increasingly difficult to find the time for both the clinical and the administrative staff to have ‘protected’ time for important training and updates. These events will be referred to as ‘Protected Learning Time’ (PLT).

This would be organised through the Clinical Commissioning Group, and arrangements put in place for patients requiring medical treatment during the PLT so the reasonable needs of patients would be met. It

would be advertised on the website and in the waiting room, well in advance.

Those present were happy for the practice to go ahead with this.

Any other business
There was no AOB

Date of next meeting
Monday April 20th at 6:15 pm, here at the practice.