The Family Practice Western College
Patient Participation Group

Resume of the meeting held 09/12/2019

Present:

John Plumb	
Gym Jarman	
Ann Nichols	
Jill White (Chair)	
David Shelton	
Kelly Williams (Operations Manager)	
Dr Rush (GP)	
Nick Benson	
Katherine Flint	
Olivia Lewis (Red maids)	
Maisie Bennett (Red Maids)	
Catherine Eva	

Apologies:

Katherine Turner	Penny Dobson
Keith Dawes	

1) JW welcomed members, Olivia Lewis and Maisie Bennett from Red Maids and a new member, Katherine Flint. JW introduced the guest speaker, Julia Martineau (Continuity of Care Project Manager), from One Care Ltd.

2) JW gave apologies for Katherine Turner, Keith Dawes and Penny Dobson

3) One Care Ltd. Presentation – Continuity of Care

The Project: Julia Martineau explained the overall aims of the Continuity of Care project. The project aims for patients to secure access to the GP who they know and trust – GP with an overview of the patients health care. The project is supported by Royal College of GP's, BNSSG Healthwatch, Nuffield Trust and Kings Fund and runs from January 2019 to December 2020 with evaluation in 2021. The Family Practice is in the first wave of the pilot which is designed to develop the process and toolkit for the practices which follow. Currently 30 Family Practice patients have been selected and written to – the sample reflects a broad demographic and includes patients with mental health issues and some with chronic conditions. Some have had over 15 GP consultations in the past 12 months and "cycle" between GP's. Eventually 400.000 patients will be involved in the local area.

 # please see below for attachments

Benefits: The current measure for continuity is that Patients see the GP at least twice. The potential benefits are that patients will take greater responsibility for their care (e.g. taking medicine) and that GP's do not have to "start at the beginning" each time they see the patient. It is possible patients may need to do fewer tests as a result of continuity.Continuity is most important for complex and long term conditions and less so for straight forward and one-off issues. Ideally families should be allocated the same GP so that they have the wider context for each patient, although it was noted that, in certain cases, an alternative GP should be available. Following discussion there was agreement that continuity was far more important for complex cases. Seeing a GP for a condition while it persists is beneficial (episodic continuity).

Resources: There is a trade-off between continuity and resource availability so, given the benefits are so strong, the aim is to target continuity on patients who are most likely to benefit. One of the aims of the pilot is to work out the best way to manage this by focusing on a small number of patients to enable testing and improvement of the service. Given that many GP's are part time it may be necessary for continuity to be provided by 2 GP's – this will be tested as part of the pilot.
Following discussion it was agreed that, in most cases, people would prefer to wait a short time for an appointment in order to maintain continuity with the same GP**.** This was supported by a small survey undertaken within the practice.

EMIS will be used to gather the data to monitor GP and Patient relationships and patients on the project are flagged on the software to help Care Co-ordinators manage appointments. Patients in the pilot will not receive preferential treatment with regard to appointments.

It was suggested that a progress update be presented to the PPG on 21.09.2020

Finally it was suggested that, at the appropriate time, the findings of the study be posted on the practice website.

4) Operation Managers Report – KW

a) Staffing: A new full time Care Co-ordinator has been appointed – Thomas Chriswick who starts on 10 December 2019.
b) Staffing: A new Health Care Assistant is to be appointed to cover 20 hours to support blood tests which are no longer available at BRI and Southmead.
c) Staffing: The Head Care Co-ordinator, Sue Sopel, is to step down from her role but will continue as a Care Co-ordinator for 3 days per week. Her position will be advertised during the week commencing 9 December 2019.
d) Did Not Attend (DNA): This has increased in November to 228 (October 148). Patients who DNA are telephoned with the aim of finding out the reason for DNA and to reduce monthly total. A breakdown of the demographic and age ranges and GP/HCA was requested.
e) Vaccinations: 1908 patients were vaccinated against influenza during this years campaign.

f) Photo Boards: These are up to date – they will need to be updated to account for the changes in reception.
g) Website: GP biographies have been updated but there are still some outstanding from the GP's and Nurses.
h) STEPS challenge: All staff were involved in walking 10,000 steps per day. There were 3 teams and 2 charities supported.

5) GP Report – Dr Rush
The Practice was experiencing some issues with access to medicine but is coping. There are several reasons for this along with BREXIT uncertainty.

6) Website report:
It was noted that there is still missing or out of date information about staff (see above).

7) AOB:

a) Detailed breakdown of DNAs was requested (see section 4d).
b) It was confirmed that there is an HCA available to undertake blood tests every day.
c) It was unanimously agreed that all staff and GPs worked very hard in the patients interests and a vote of thanks was passed.

Dates of next meetings:
09.03.2020
22.06.2020
21.09.2020
30.11.2020