Hill Surgery PPG Meeting: 18th March 2024

Attendees: David Standen (DS) Chair

PPG Members: Andrée Stevens (AS), Tom & Jan Kelly (TK & JK), Anne Bird (AB), Angela Stewart (AS), Sharon Jackson (SJ), Peter Wallace (PW),

Hill Surgery: Dr Linda Parker (LP), Dr Naomi Konu (NK), Julie Holloway (JS)

Guests: Hill Surgery Action Group (HSAG), represented by Nick Andrews (NA), Maxine Green (MG) et al.

Meeting Started: 17:00

1. The chair opened the meeting officially at 17:05 when most of the members had joined. In the welcome the chair reiterated that the meeting is being recorded and before it will allow you to unmute and speak, you must accept and click the OK button.
2. **Chair's Apology:** (not from minutes of meeting). *I would like to apologise to any members who had difficulty accessing the meeting. I am uncertain why the prompt to accept the terms was not displaying on your screen. If you would like to do a test meeting with me, please email me and I will set one up so that you can test and familiarise yourself with how to get on. The telephone number for the meetings is always in the message containing the link, which can be used if you cannot get on with your computer.*
3. **Apologies**:
4. Debby, from the HVA, who is on a borough council meeting. No other apologies were received.
5. **Minutes of the previous meeting:**
   The chair made an apology for the lateness of sending the minutes. This was due to a technical failure in the recording of the last meeting and so it wasn't possible to get the transcript. The chair reported that he had to do most of it from memory. The chair thanked the Hill Surgery Action Group, who had provided their minutes to assist in the process.
6. As the chair will now be hosting the meetings, and is technically minded, this should not happen again.

8. **Matters Arising:**
9. HSAG membership. At this point there were no members of the HSAG on the call. The chair explained that the most we could offer them, because it's a conflict of interest, would be an associate membership.
10. The chair asked if there were any comments on this.
11. AB commented that she was new to the PPG and hadn't been aware of the HSAG. She expressed confusion over why there are two groups. AB said that she had seen an e-mail and it appears that there are about 200 members who may wish to join the PPG, but that it would be quite ridiculous.
12. The chair agreed that we could not accommodate a meeting with that many people online.
13. AB asked why there are two groups, the PPG and HSAG?
14. The chair explained that Nick Andrews (NA), who is the chair of HSAG felt that strongly that he wasn't getting the service that he was expecting from Hill Surgery after the Harold Road merger, and he posted on the Next-Door neighbour's group about his concerns. Lots of other people commented and so he formed the HSAG, and people joined the group.
15. The chair explained that their goals are aligned with ours and that they are not making a protest. They're trying to essentially do what the PPG is doing. However, the PPG is an official recognised body of volunteers, whereas the Hill Surgery Action Group isn't. The chair said that he feels it is right for them to come along and observe and participate in PPG meetings.
16. The HSAG representatives arrived late and were welcomed to the meeting.
17. The chair continued that they could have voting rights as it stands.
18. AB gave thanks for the explanation.
19. **Election of Officers:**
20. The chair moved to item 4 on the agenda and explained that we have a couple of vacancies for Vice Chair and Secretary and asked for volunteers to fill those positions. There were no volunteers.
21. **Policy Documents:**

    The chair referred to the policy documents which had been circulated and said that we have a proposal from Tom Kelly. The chair gave way to TK to explain further.
22. TK said that we have two issues. The first is confidentiality, which TK was uncertain why there was such emphasis on this. By and large one wouldn't expect the PPG to

become involved in the issues that might involve confidentiality, like staff records etc. Concerning. The PPG guidance previously circulated doesn't address confidentiality, so this may be something to investigate further.

23. TK made a proposal for a temporary confidentiality clause to get us over the hump for the next few months. TK proposed, as the meeting is recorded, that we give a verbal assent to confidentiality at the beginning of the meeting.
24. TK continued, now addressing his proposal for a working group to examine and decide on the functions of the PPG. For example, the issue of confidentiality.
25. LP raised her hand and commented that she had not read the current version of the confidentiality agreement, but pointed out that you do need to think about these don't want your own individual e-mail addresses publishing to all in sundry.
26. If patients approach you with problems. You do not want to be sharing the specific details of those patients, medical issues.
27. You may be coming across information which has a confidentiality element to it, which you weren't necessarily expecting, particularly when you've been in the surgery, and you've been doing surveys.
28. LP expressed that we do need a confidentiality policy because of the type of information and because of things we may be coming across as part of what we're doing.
29. The chair agreed that it makes perfect sense that there is every possibility while putting stuff up in the notice boards. If you go into the surgeries that you could be approached by a patient
30. DS said I think we certainly do need a policy, but I don't necessarily know that the one that is mentioned in the policy documents is the right one for us, and that more thought on that is required.
31. TK commented that we should explore the proposed temporary confidentiality statement that he suggested.
32. TK – Presently we don't know and haven't decided what our functions are, and that's why I've suggested that what we need a small working group to sit down and work through this and then report back to the larger PPG group.
33. TK – It is very difficult to do have this kind of discussion over a Teams call. A smaller group can take these issues apart, sit down and think about what we're going to be doing.

34. JK directed TK to the guidance, which states that a core group of a maximum of 20 members should meet face to face at least three times a year. That the group has a formal structure of a of a chair, vice chair, secretary and if need be, a treasurer.
35. TK questioned if we have got an active patient participation group. We've got a group of people who meet once a month.
36. HSAG agreed.
37. TK – Suggested that we may have had one at Beacon Beaconsfield and Harold Road before, and that we are in the process of trying to set one up, but this is a new surgery with a new group of patients.
38. The chair agreed and mentioned that he had seen the guidance documents which say what the Constitution of the PPG should be. He agreed strongly with Tom's proposal.
39. Further, I do think that we need to know exactly what it is we're supposed to be doing before we can fulfil that function, and that a smaller group should sit face to face. We used to do face to face at Beaconsfield, and we used to hold it at the Shankill surgery in one of the rooms upstairs.
40. COVID caused these meetings to stop and so we went online.
41. LP – Commented on face to face that the time of meetings was prohibitive as a lot of our patients did not want to come out late in the evening, particularly in winter. That meant that a lot of our older patients felt that they couldn't carry on doing this. People who work find it very difficult to find the time during the day, whereas if you've got time with an online meeting, that's fine.
42. LP explained that both LP and NK are between patients, and fitting this meeting in, so could not necessarily leave one site to visit another for a meeting.
43. TK said that we wouldn't need a doctor or a representative from the surgery.
44. LP commented on the disgruntlement going on, and with so many changes we are trying to attend the PPG meetings to make sure that we know what is going on from the horse's mouth, because there's so much disinformation being put out, that it's important that you hear from the partners what is going on.
45. LP invited questions as she may have to dip out to see patients and may not be able to stay to the end of the meeting.
46. The chair explained that he has now received the slide pack information from the call Centre and will circulate this. **AP > Chair to circulate call centre information**.

47. The chair suggested that we skip items on the agenda and move to the questions from HSAG, so that we can let LP and NK go.
48. HSAG - The first item on the HSAG list - Is the action group welcome to join the future PPG meetings?
49. The chair confirmed that there had been no objection and that the HSAG had raised questions and contributed positively to the meetings.
50. HSAG asked about voting rights (discussed earlier in the meeting).
51. The chair responded that the HSAG (as an organisation) can attend as an associate member, but this does not include voting rights. The matter is complicated by the potential conflict of interest between HSAG and any potential role as a PPG member. Although HSAG is broadly aligned with the goals of the PPG, your goal is to achieve action and change and that could present a conflict of interest which just wouldn't work out.
52. The chair repeated that he was perfectly happy to have HSAG come along as associates as that's not presenting a problem.
53. HSAG - Several members have applied for membership of the PPG but have had no formal reply from surgery. Who controls that membership application?
54. The chair replied that he didn't know and asked JH if she could answer the question.
55. JH advised that there was a problem on the website and that the applications go to an inactive mailbox and disappear. JH reported that the IT support are creating a new email address, which she will have linked to the form. **AP > JH to notify PPG when new email is working and how to access applications.**
56. JK reiterated that we don't have a PPG. Beaconsfield had one, Hill surgery does not yet have a PPG.
57. Chair's response (not from minutes). *When the Beaconsfield and Hill surgery merged, members of previous PPG's were invited to form a new one. This took place and there was a face-to-face meeting, at which a chair was elected. After some email traffic, that chair resigned, though the members continued to communicate by email. When the internet meetings recommenced, the existing Hill Surgery PPG had no obvious leadership. I was nominated by AS to be the point of contact. I retained that position until the following meeting, where it was necessary to formalise the PPG. I self-nominated for the position of chair and was seconded. There were no other volunteers for any other positions. As far as I am concerned and the surgery agree, this is a valid PPG.*

58. HSAG - Do you have an application team?
59. JH reiterated that the e-mail address that's linked to the website is not working and that the IT people are working on it.
60. LP - The emails should go straight through to the PPG, the Harold Road site and the Beaconsfield Rd site, PPG's have been merged to then reorganise themselves into their new entity when the surgery merged.
61. LP - The Hill Surgery patient participation group, has had a long association with the partners at the Beaconsfield site. They even came to court with me when we were trying to fight, getting evicted from one of our surgeries, so we expected things to carry on in the similar cooperative vein that they had previously. Now, unfortunately, as I've been telling everybody for quite a while now, we have been hamstrung by the IT fiasco's and their cancelling the PPG e-mail addresses is just another one and a long line of problems that we've been dealing with.
62. HSAG commented that the reason behind forming the HSAG was because we couldn't get on to the PPG, and is there not an opportunity for the group to be a member? Why is there a conflict of interest?
63. The chair replied, although you are aligned, you are a separate entity. You have your own committee, and you are a unified group that although you may all be patients and technically entitled to join the PPG, you're a separate cell. If you all wanted to come on board as PPG members and dissolve the Hill Surgery Action Group, that's fine, but I don't see that happening.
64. HSAG – No, not now. Until there's an effective PPG, I think we'll continue to communicate what people through our site, and then then we'll dissolve if we need to.
65. HSAG asked LP to confirm that the application for the PPG goes via an e-mail address to the PPG.
66. LP – Confirmed this as correct. There should be a secretary for the PPG who has access to the e-mail address and then will manage e-mail communication through that. That's what always happened in the past.
67. TK – Commented that we haven't got a secretary. We haven't got a vice chair, we have not yet agreed how we are running this PPG, this new PPG.
68. HSAG – From our point of view, as members of the Action Group, that one will apply for membership of the PBG we'll just have to wait until you have sort yourself out.

69. The chair confirmed that the problem is that there is an online web form which asks you for information to fill in when you submit that web form, it goes through to an e-mail address, but that e-mail address is dead. Once the new e-mail address is set up for PPG applications, the web form will be attached to that and any applicants will then be sent through to our secretary, which is probably going to be me until we elect somebody, or we get a volunteer.
70. HSAG suggested that they could email me personally. There was some discussion and, although the chair had no objection, it was decided that this was not a good idea.
71. HSAG said that the PPG is looking for a vice chair and a secretary, but nobody can apply for it.
72. TK - We are actively seeking in the PPG to have representatives of groups with interests, be they people with hearing disabilities, disabled, and there are groups of those people that we've accepted that they can send representatives. Voting rights for those kind of groups does not necessarily present a conflict of interest and it would seem to me that the Action Group is in a very similar position.
73. TK commented on whether they should have a seat as individuals, in the same way as somebody representing, a disabled group.
74. TK suggested that we don't have a PPG as envisaged in the guidance, and whatever may have existed previously, the situation is that we have no constitution, we have no idea of the activities of what various representations on the group should be and what I'm suggesting is the first thing we need to do is get those clarified, and a small working group could do that.
75. AS – explained that the Beaconsfield PPG has been going for a long time. It continued when it merged with Little Ridge and again with Fairlight Road. The PPG just evolved and yes, we did look at all the Constitution and all those bits again. AS commented that there are members on the current PPG for whom this is the 4th time round. The constitution that we had previously was perfectly valid and we would simply amend it as needed to in the light of the new group.
76. There was a brief debate on this point.
77. AS pointed out that we can build on that old constitution or change it as the group decides.
78. TK asked who is the secretary and who's the vice chair? If you've already got a PPG?

79. The chair replied that we have not had any volunteers or nominees.
80. HSAG asked if HSAG could sit as one representative on the committee?
81. The chair responded that he did not have a problem with HSAG attending meetings.
82. HSAG asked about having a vote as they represent 225 patients of the Hill Surgery and that they request 1 voting right on behalf of that group.
83. The chair replied to the question. As TK mentioned, we do have other representative groups that attend the PPG, such as HVA. The original constitution only allowed for full members of the patient participation group to have voting rights. Associate groups were allowed to attend the meetings, but they never had a vote.
84. HSAG - Concerning engage consult, there's some concern that it doesn't allow the full functionality and of what used to be on patient access, but we're not quite sure if that's the case or not. Could anybody clarify that?
85. JH - When the merger happened, we had to stop access because of a GDPR problem, some of our patient records were linking to the incorrect documents. Access is being restored on an individual basis, but they must apply for it. We've, got to check every single individual record. It's not going to be something that's quick.
86. The chair clarified, as JH mentioned when the Harold Road surgery closed and Beaconsfield took it over, there was a problem merging the database of records. Consequently, that presented a GDPR issue, and so all the patients that had access through either patient access app must go in and get new passwords issued to them. That way they can be certain that they are accessing the correct record.
87. LP added a link to the chat on how to use engage consult.
88. HSAG asked, “Does the NHS app provide the full functionality of engaged consult?”
89. LP clarified that they are two completely different things. Engage consult is an online consultation platform where people put their information in and they instead of talking to a GP or coming in face to face, they can have an online consultation.
90. LP - The NHS app where you look at your medication, you order your medication, or you look at your blood tests. There is no doctor input into it unless we have made a comment on your blood test. There is no interaction with the doctor. It is literally just you can have a leaf through your record. The online consultation app is another way of accessing the surgery.
91. LP put a link to a YouTube video from engaged consult into the chat. The video shows you how to use it, showing how triage questions, very similar to the questions that receptionists would ask you when you phone, to screen out people who are

having a heart attack or a stroke and all the urgent stuff. It then goes through a series of questions for information gathering that we might need.

92. LP - We still get people using it to say I need an appointment with somebody and cited examples of people mentioning “hay fever acting up”, “repeat prescriptions”, “my back pain's getting worse”, “could I have an appointment with the physio” and “can you send some medication or something?”
93. LP mentioned that people ask for medical certificates etc. and that doesn't require too much interaction, but that half of the time we end up phoning people to get a bit more information or calling them in because what they've tried to put through the online app isn't suitable for online consultation.
94. LP - It's another way of accessing the surgery and a lot of people who work find this convenient, because it can be put through sort of 24/7.
95. HSAG – Is it working properly now?
96. LP - If there's capacity, the engage consult should be. We're getting stuff coming through all the time.
97. HSAG suggested that it's only during those hours is it only between 6:00 and 11:00.
98. JH clarified that it does not have unlimited capacity.
99. LP clarified that the surgery has limited the time.
100. HSAG rephrased, “I'm not asking about the hours that they actually operate”.
101. LP Clarified that the time is unrestricted, but the number of requests has a restriction. If we didn’t, we'd have 1000 requests through, and it would take us about a month to try and wade through it all.
102. LP - It's set at having an additional GPS worth of consultations and people also send admin queries through there as well or medication queries. The timing is helpful, so if a patient gets sick at 3am, they can jot it all down and it's ready waiting in our inbox when the girls come in at 8:00 o'clock.
103. HSAG thanked LP and JH for the clarification.
104. NK clarified that Harold Road did have a functioning PPG at the time of the merger, so met quarterly**,** and corrected the chair, who had earlier used the term collapsed in respect of the Harold Road closure (minutes corrected). The chair apologised for this error.
105. HSAG returned to the NHS app, explaining some confusion over access engage consult directly through the NHS website, requesting consultations etc via that route.

106. The chair said that the best way is through the Hill Surgery website, and the engage consult button.
107. HSAG suggested returning to an agreement from the last meeting and going through it with somebody at the practise so that when people ask us, we are giving them the right advice. It's no good us saying go on, engage, consult and they don't understand how it works. HSAG agreed to add a link to the video shared by LP on their website.
108. LP added that the training video is quite long but detailed. The biggest problem with engage consult is the rigmarole of registering. It's what everybody complaints about.
109. LP clarified that many people use the engage consult every day.
110. HSAG confirmed that they have use it and it works. HSAG asked if registration can be done in practice or just online?
111. LP was not sure but thought that it was through the website.
112. HSAG thanked LP.
113. SJ suggested that we need an IT expert to help with the videos.
114. The chair explained that he is an IT expert, and that this is why he has taken over hosting the meeting so we can be sure that we get the recordings and everything else sorted out. He clarified that he has offered services to the surgery and will be happy to help them out if there's anything that comes up that's technical.
115. The chair said that he would help create some training videos.
116. JH mentioned two guides that are on engage, and that NHS have put them on themselves, on all websites for of all GP surgeries and they are directly on that link.
117. HSAG asked about a statement on the surgery website that says, “We endeavour to offer a patient a GP appointment within 48 hours”, but with a current appointment strategy the surgery only give appointments within 24.
118. LP confirmed this.
119. HSAG asked if there will there be a new coaching charter for the Hill Surgery?
120. LP confirmed that we have a contract which we work to. We are offering most of our appointments on the day because people are phoning up on the day. Things can be left to the following day, and we have a limited number of appointments which are we pre book in advance, particularly when people are phoning in later in the day. They will often be put through as a routine.
121. LP - Most of our clinicians have a few appointments which we use for pre booking later in the week. As we explained at the last meeting, we get a lot of demand on a

Monday, so things are often pushed through till later in the week when there is less demand so although we're not allowing people to book six weeks in advance, like in the old days, when 10% of the patients used to forget to turn up with the appointments that they pre-booked for the doctors.

122. LP - We do have a limited number of things which are available in advance, and doctors will also book in their review appointments.
123. LP clarified that the nurse appointments are bookable in advance. Apart from the emergency, we hold some emergency on the day. Appointments for emergency dressings and things like that.
124. HSAG suggested that, because everyone demands a GP when in fact, they probably need a nurse practitioner or one of the healthcare assistants. Is there any way that we can have a list of services offered by the surgery on the site? They commented that Anita had a really good experience today seeing a nurse practitioner at Beaconsfield.
125. LP confirmed that calls are triaged into the appropriate nurses because different people have different skill sets, so those are already available. I'm sure we can produce a table of the sort of things which the nurses can do. Our nurses deal with all our chronic disease management. If you have diabetes or if you have asthma or COPD, the management of those conditions are generally done by the nurses. The doctors are there often for the acute things coming through. We've got physiotherapists, we have a diabetes specialist, nurse consultant that comes in. We have a whole team of different specialists and they're not necessarily all doctors.
126. HSAG thought the list would be a good idea.
127. LP quipped that most of those that called for a doctor were asking for sick notes or repeat prescriptions. LP confirmed that the surgery deal with 150 or more admin tasks a day for things which do not require a wasted GP appointment. Although it may feel like we're restricting capacity, we are probably dealing with two or three times as many patients as we used to in the old days, when if you didn't get through between 8:30 and 8:35, you just got told to phone tomorrow and that could go on for days until you manage to get through.
128. LP - In time, whereas now all the calls are triaged, everything goes on to a cancellation list, and if we can squeeze you in somewhere, if you're old, if you're sick, if you're young, if your palliative care you will be squeezed in somewhere. If you

want to talk to me about a medical certificate for something that you've had for the last 10 years, that just goes on my admin list.

129. HSAG thanked LP and pressed the question on what measurement of quality control? Returning to the question about to patient charter, should the GP appointment time be changed to 24 hours or realistically, can it stay at 48 hours?

130. LP - It depends on what's needed. We're trying not to book a lot in advance because that means we got less on the day. The problem of booking in advance, it is often for a review that could be done over the phone. It's for a review of something which obviously wasn't acute because you're not phoning on the day for it. If we're booking something which is relatively far in advance, then it's something that we know about.

131. LP - The problem is that if we're getting 800 calls, I don't know what people are phoning in with. People are sort of coughing up blood or you know, they're collapsing or there's some disaster that's happening. I have capacity to deal with those.
And the routines, I'm afraid generally are being farmed out to the nurses and nurse practitioners because we just have far more demand and demand from much sicker people now than we would have been in the past. Unfortunately, if you go to A&E, you've probably got a 12 hour wait, so a lot of people will be phoning us for emergencies and we must be able to triage them, see them deal with them and if necessary, admit them.

132. HSAG - If a patient wants to go and look at the website and sees what the Patient Charter tells them about their appointment when they would expect to see AGP for 48 hours is a bit confusing.

133. LP explained that the Patient Charter is set by the government, whereas the surgery is working to a ‘patient contract’. A contract to provide medical care for my patient group that are registered. It's nice to be able to provide unlimited access when people want it. And if that's three days in advance, that's great, but we are juggling demand that will always exceed supply. If there are things which if you phone in and say I've got this problem, I prefer to be called between these two times or on this day we will try and accommodate it. What we're trying to do all the time is to clear what is coming in today because we do not know what is coming in tomorrow.

134. HSAG agreed and thanked LP for explaining thoroughly.

135. LP clarified that, I'm not going to guarantee to see you next week because your hairdresser's appointments tomorrow and then you go into the podiatrist and then you're going out for lunch. This is unrealistic.

136. HSAG asked LP about that mission statement and patient charter, is that something all UK GPs must have from the government on their website or are you able to give a surgery patient charter?
137. LP stated that our mission statement is to try to provide the care that we would want for ourselves. It's fleshed out very slightly, but that we will always try and give you what you need and what we would like for ourselves. If you are very sick, if you are dying, if you have got very serious medical issues, we want to be there for you. If you're wasting our time and screaming at us that you want controlled drugs and you don't like the fact that we've we're limiting these and you're kicking off in the waiting room, we're not going to be looking at that with a very sympathetic eye.
138. HSAG responded that the reason that we're getting so many complaints is that this looks as though it's set in a stone. It doesn't say we will endeavour. It doesn't say we will try. It says we will. And I think a lot of the complaints that we get is because it clearly says we endeavour to see you on the same day you will see a GP within 48 hours. I think we can go around in circles here.
139. LP - We have got quite a lot of capacity compared to a lot of surgeries, and we are providing over and above what we are mandated to supply and that doesn't include all the admin, the tasks, the, doctor who makes all the phone calls for the blood tests and everything else. We could very easily go back to a situation where we say fine, OK, do you know what everybody gets 15-minute appointment, I will give you this many appointments if you want a sick note. If you want to discuss your results if you know everything you have to book an appointment.
140. HSAG felt that this was not what they were asking.
141. LP - That would take our capacity down by about a third, so to about 1/3 of what we're offering now.
142. HSAG felt that the website needed to set realistic expectations, and that this is why a lot of people are saying you're not delivering. You are delivering, you're delivering where you need to deliver.
143. The chair explained that he has looked at some other surgeries websites and the charter is the same for all of them, and that it is mandated by government whether they meet it or not.
144. LP - This is from NHS England. We have no control what these people put on our websites; what they suddenly decide they're going to do. We came in this morning to find that the electronic referral system has been changed overnight and we hadn’t

been informed. OK, so now if you're being referred, you're going to have to go online and book your own appointment unless we do it for you. OK. Now that's great if you can use a computer, if you can read the letter that we're sending you and you have the equipment, the time, and the understanding for it.

145. LP - The secretary came in and said, were you aware of this? We also suddenly found that another one of our add-ons has suddenly started downloading documents to us. Well, we've had to stop that because we don't have a process for dealing with this. And we said we didn't want this because there we have established processes for dealing with documents so that they get looked at, they're coded, they're processed, their medications are sorted out. We can't just ad-hoc, receive this stuff into people's notes.
146. LP - The NHS is a very large and unwieldy thing. We are slightly at the mercy of them. NHS Digital, NHS England, and anybody else that wants to make changes to things, and we're not always consulted, and we don't often get advanced notice on these things.
147. HSAG thanked LP and moved to their next agenda item. HSAG has spoken to Jackie Halton about patient numbers, which HSAG had attempted to capture from various sources including CQC. HSAG asked is it just over 20,000, almost 21?
148. LP confirmed the number as 20,825 patients.
149. HSAG asked is this corrected or has there been duplication of registration, and how does this impact the funding that is paid on per patient head. HSAG asked if this was an inflated number?
150. LP - No, because this was a quirk of the merger because some patients just randomly got assigned twice. We knew how many patients we had.
151. HSAG thanked LP for clarifying that number.
152. LP clarified that Harold Rd had about 12,000 patients and we had about 10’500 from before the merger.
153. HSAG suggested that from the funding question. You only ever had the correct amounts.
154. LP confirmed this. However, your figures on the funding are incorrect. If I could get the amount of funding that you're saying that we're earning per patient, that would be fantastic. I'd be able to pay the electric bill.

155. The chair added that unfortunately, it does seem to be of a disconnect regarding the amount of funding per patient. There are a lot of theories about, some suggesting £180 pounds and so on.
156. HSAG asserted the figure to be £163.
157. LP - I'd love that. Do you know that would be amazing.
158. The chair said that it has been asserted based on calculations and random figures that this is a £5 million surgery.
159. LP confirmed that this was not the case, but that it would be fantastic if it was.
160. The chair added, in fact the amount is considerably less, I believe it's under £75 per head.
161. LP - It's not very much, but the thing is, this isn't like profit. I can't go to Sainsbury's with this. This is what I pay for my staff with. This is what I pay the electric bill with. This is what I pay for the call answering service with and it just about keeps the lights on. We employ a lot of people. And that's what pays for the nurses, the doctors, everything that's coming in and out of the building. LP confirmed that this money is not going into the pockets of the partners.
162. HSAG questioned where the £163 comes from as their research suggests an average of £163?
163. LP - I have no idea. I mean that that's not what we get paid for a GMS contract and…
164. HSAG - No, it clearly says those different levels, but it's certain averages out.
165. LP - Well, it also depends on how many additional services you're running. GP practises which are running violent patient schemes, they get paid more for that, they're running drug detox schemes, so they'll get more money for that. Although I have to say a lot of these additional services have been pulled recently and that money was subsidising the employment of nurses, physiotherapists, paramedics to go visiting people because there just isn't the money in the system.
166. HSAG reported that they have now gone live with a website. MG organised this, but it's a website that is open to all new applicants to the Action Group and then as we grow it, expand it. It will offer ways in for people who have specific problems like disabilities, who need to talk to. We'll get some advice on disabilities, but not specific health problems.
167. LP - If there are patients who have disabilities that we don't know about, then they need to tell the surgery because we have specific access routes for our deaf patients

for our patients who are blind, which are not open to everybody else. We're not going to advertise them because I don't want them being abused by other people. But we do have several people who are profoundly deaf, who we give special access to via different routes, because that's the only way they can access appointments and we will organise the BSL interpreters and things for them for their appointments, and they're given much longer appointments because obviously it's quite difficult doing a consultation if it must go three ways.

168. HSAG said that it had been approached by people with deafness problems who find it extremely difficult to get into the surgery and make themselves understood and are suggesting that we provide some sort of advice line to help them with that.

169. LP - What they need to do is bring in a piece of paper with their name and address and date of birth on it, state quite clearly what their disability is. We have people who are wheelchair users, who can't necessarily access all the sites. There are some people who have different problems. We will try to accommodate them at the best site that enables them to get in. For example, you can't really use a wheelchair very easily at the Fairlight Road site unless you've got about three people to push you up the hill.

170. HSAG - We intend to assist people in getting to the right place in the right way. We're not sort of offering any health advice.

171. LP – If they have a problem, they need to tell us about it because we have many of our patients have problems. Also, if there's somebody that is speaking for them, if they have a son/daughter or somebody that helps. all we need is a documentation to say they've agreed to this and then we will be able to organise their appointments for them or if they need a particular way of accessing. We are not advertising what the access route is because we will have people abusing it.

172. LP - We had to shut down the paramedic telephone line because we had too many people that kept phoning up for rubbish abusing the paramedic lines. We've had to go back to one of the other paramedic lines. We had somebody phoning up the paramedic line to book, demanding a home visit for their wife, for an ingrown toenail.

173. LP - You just don't understand how people can do this. You have to say some. Look, this is the line for paramedics and for the Hospice and the hospital. You must get off this line and they won't.

174. The chair said that he knew of a person who called an ambulance because they're suffering acid reflux, and the ambulance had to attend the property and eventually

ended up taking them into the hospital because they refused to allow them to leave. That's just a complete waste of resources, and if somebody else had needed that ambulance, say for a heart attack at the time and died because the ambulance was tied up with somebody having acid reflux. I just think that's disgusting and people do misuse.

175. HSAG - This is where the PPG should and could be helping educate patients so that the guys that are at the clinic and the surgery can get on and do the day job. This is why I think we need a proactive PPG and that means that people have got to volunteer to join your PPG and volunteer to take on some of the workers. Right now, it's all down to you by the sounds of it. We've got members, but you haven't got the committee.
176. The chair agreed and said that he was the one stop shop.
177. AS contributed that she has connections with the deaf community, and they should be going to the Sussex Deaf Association. There are social workers who always come if they haven't got a relative or a friend that can help them. And I don't understand why they're coming to you (HSAG) rather than through to the social workers or the people that they're supposed to call.
178. AS – I don't understand why they are coming to you when there is the Sussex Deaf Association, and these are things that they would know or if they're the deaf groups, who are very much together, and they know these things. There might be someone who's maybe newly become infirmed, and maybe they don't know about these things, but anyone who's profoundly deaf, that they meet in associations, and they would know that.
179. AS - One last thing I want to say to the group is that if you've got all these things that you need to say come and join the PPG, we need you.
180. HSAG - We've been trying to, I cannot emphasise enough, ask Jackie Halton how many reminders she's had. We've been trying to join we don't want to be working separately. Our Constitution reflects yours.
181. The chair drew a line under the problems applying to join, as this has been covered extensively earlier, and when the e-mail address is sorted out, the obstacle will be removed.
182. LP - One thing I would like to say is that there have been quite a few posts on your social media platforms for the Action Group, which are quite inflammatory, and the staff are finding quite intimidating, and we have even had an incident last week with

somebody creating a nasty scene in the surgery, intimidating one of the members of staff. It was a very minor medical issue which didn't need an appointment which has a very structured process around sorting it out and I think some of the people who are following you on your website seem to feel that being part of the group (HSAG) entitles them to preferential treatment and to behave in an anti-social manner.

183. LP – Unfortunately, this person turned up to the surgery and was screaming at the receptionist, she's using a lot of choice language, and she was telling the receptionist that she was a member of the Action Group and expected to be dealt with. Doctor Dann, who's trying to deal with another patient, got called away to try and deal with her and get her out of the waiting room.

184. HSAG - We do know of this and there's been a response from us immediately today and it very clearly says that if you go on to the website and David's now got the link to the website, we have a code of conduct. It clearly says on the limitations on terms of membership that it is a forum. It does not give anyone priority. That is very clearly noted. I know Jackie Halton wants to look for an external way of managing this. We have been no control over the behaviours of these Members, what we do have control of is our own code of conduct and our own terms of reference, and I'm hope you'll have a chance to look at those because they are very much aligned with the PPG. We do not condone abusive behaviour, nor do we say that membership gives them priority and in fact, I did ask David today to make sure that that is noted, and he's been properly saying that because it's no good keep writing to us. Saying that, if this member said she was a member of the IRA, there's nothing that we could do about it.

185. LP - We have dealt with it as with our usual complaints process and told her what that is.

186. HSAG thanked LP and asked for the patient’s details so that they could take the person off their membership list.

187. LP declined as this is a patient information confidentiality issue.

188. LP - We've dealt with this. She has been told in no uncertain terms that you don't behave like that in the surgery. You don't upset and interfere with other patients care on the auspices that you are an Action Group member. Behaviour like that will not be tolerated.

189. HSAG - Our hands are tied. It's not very much we can do other than that and we support you 100% on that. We've never ever encouraged that. And the fact the

reason we put the website together is to take it away from the social media platforms so that we can have intelligent conversations with people who deserve a response and ignore those that do not deserve a response. So, we will be taking it away. It will still be there for things like the Minutes, but we will work through the website. That's absolutely the reason we put the website together so quickly.

190. HSAG - We could see it escalating on social media, but I think the thing is, and please be aware that there is that frustration out there and we're trying to help with that and to get the service that people are requesting from you.
191. LP - The problem is that quite a lot of people behaving badly on social media, people don't seem to realise that this is a published medium which is visible to all. With a couple of 100 patients that is 1% of the patient population.
192. HSAG – I totally get that. Our frustration was more that we had tried endlessly to support with the PPG, and I applied online. I've applied in writing I've handed it in to the Harold Road surgery, this is sort of the frustration came out that we formed the group, so please be aware that it's not been done so antagonise or cause problems.
193. The chair noted this and said that he didn't see the Action Group as adversarial, and much like the PPG as the 'critical friend' that is there to act as a sounding board. These are ideas that we think might be useful. Something that we can look at as a project, increase the awareness of engage consult, all things that aid the surgery.
194. HSAG - Absolutely. And just as patriotism made us as patriots because the pressure, if we can take the pressure off the surgery, then our frustrations will also go away.
195. The chair agreed and said, "We're all the same sheet, I think".
196. LP asked, are you taking down some of the inflammatory posts that people are putting up? I don't know whether you're able to do that because there was something early on.
197. HSAG said that it does and reported that someone had posted an awful response recently and had tried to message them at 4:00 in the morning, really going for it. HSAG has deleted her post and reported her to next door, so that was taken off very quickly.
198. LP - We did have some earlier posts, which said that they were going to wait for management and accost them well, that crosses the line to stalking and harassment.
199. HSAG denied any knowledge of this and asked if it was a Facebook post?
200. LP thought it was on next door, quite early on.

201. HSAG apologised without reservation.
202. LP - The problem with all this social media stuff, is that you don't know where it's branching out to.
203. The chair agreed and expressed concern for the members of staff. If any of the members of staff see that, it's just an extension of the abuse they used to get on telephone lines. It's important that we remember that everybody that works for the surgery is there to help patients and help make sure they get the healthcare they need and they're all people.
204. LP – Actually, I don't pay them enough to take the abuse that they take. I can tell you that now so.
205. HSAG - You have our word. If we if we saw any inflammatory posts, we would remove them. But we don't. We're not in the business of trying to escalate problems. HSAG asked for the chair to minute that, if there's any post that you want taken down, let us know. But I haven't seen and would not allow that to come on there. Absolutely not.
206. PW - It occurred to me that with the Action Group, could not their committee members apply to be PPG members and therefore they anything that comes up that they that they get notified of the phone call at 4:00 o'clock in the morning? They can then bring up to the PPG as a PPG member.
207. The chair indicated that is the aim broadly, that once we've got the PPG application process corrected on the website, we we'll get them on board as proper members, and we can work from there.
208. HSAG suggested we could even take over the HSAG website at some stage and make it the PPG website. It's up, it's got a constitution. It's got terms of reference. It's got e-mail addresses. You can add whatever you want to add on there. You can put minutes on there. It can link to the practise website. We wanted it off social media.
209. PW - I was thinking in terms of the Action Group members could in fact then become officers within the PPG.
210. HSAG - We've just been told that can't happen because there's a conflict of interest.
211. PW – No, not if you are an individual acting as a PPG member, if you are the PPG secretary not HSAG. Your lines of confidentiality within the PPG group and so long as you observe that, I don't see there's any problem.
212. HSAG - That's why we applied.
213. LP - Well, we've just sort of established unfortunately.

214. HSAG - I think we're going round in circles. Once we've seen that the PPG is running effectively, we'll join it.
215. PW - The other thing I think that David said right at the beginning, which I think is important is I think we should have or a number should have a small group have a face to face meeting to try and out iron out some of these problems and establish at the PPG Committee, which is a combination of the Harold Rd people, patients and the PPG that you all obviously already had. Beaconsfield Road to get us into one solid PPG rather than the main, I think we've got a mismatch of people.
216. The chair agreed with Tom's idea of a small working party and suggested that Nick or Maxine from the Action Group should be involved in that working group.
217. The chair interrupted that the time was getting late and that he needed to circle back to an item on the agenda.
218. HSAG refused this as they had not finished their agenda items.
219. HSAG - We've just got a couple of things that are still on our agenda, and we had one member questioning doctors who work from home. They wanted to know how much access doctors had to data on their home computers. A member had asked because during a call the doctor had said that they couldn't access records from home.
220. NK - I think that's a broad question. Probably we need to take away. There are a few different reasons for that, depending on what they asked for, it may be with engage the primary care network had access to people's records, but they might not have been able to see the hospital results, for example, because that's on a slightly different system. It depends on what platform she used to ask for the appointment as to which doctor.
221. HSAG - She was contacted by the GP. It was that it was one of these GP follow-ups, who'd phoned her, and she got told then that she had no access to her records. Although others here in the group, obviously GPs, have spoken with us and have got access to the records.
222. NK - I think we need to take that one away to answer that. Generally, the GPs who are working remotely have an NHS laptop that has access, with a smart card, to our clinical system, but there are different systems that link into that. For example, imaging is on a different system. Blood test results on a different system. Letters from the hospital or a different system which link in. They may not have all the functionality depending on what it is.

223. HSAG thanked NK.
224. HSAG - Finally on the agenda, one of our committee members has taken a sample to Beaconsfield Road at 9:15 in the morning. They got a call a couple of weeks later to say that the results were negative, only to subsequently be told that there is a problem with the sample, despite getting a letter with a negative result. Then phoned the surgery to find that it hadn't in fact been processed because it got to the clinic late. It was a bit of a worry because they've been told it was negative and then they got told that they needed to provide another sample. It had been left at Beaconsfield Road on time.
225. The chair directed the question to Doctor Parker.
226. LP – There is a difference between dipping at the surgery and processing by the lab because we have a strict process. We're not going to send you a text to say it's negative unless it's been dipped. Sometimes there's a problem that there isn't a clinician at the site that can do it, but that that's quite rare. Normally what happens is it gets dipped. You either get antibiotics or told it's negative based on the dip. It then goes to the lab, who hopefully grow it, but they may decide not to process it if there's absolutely nothing in it, they may drop it, or there may be a problem with the sample. If it's not processed for any reason, chances are if it's, if it said processed, that's probably the lab end of it.
227. NK added, there are several different steps that can happen in the surgery and going to the hospital.
228. HSAG - The public is concerned with being told it was negligent and then being called back in and I don't know how that happened.
229. NK - As she was told it was negative, she got a phone call. Again, we probably need the patient details to look at this further.
230. HSAG - That's what we advised her to do was to write, list the complaint and you know, step by step and send it in. And I believe that's what's being done.
231. NK - Perfect. The other thing we see sometimes with samples is it gets tested for two things. One thing may be OK on a sample and we're getting the results separately. So, we may say one part. So particularly with swabs for example, we may test for two different bacteria or common infections. One comes back before the other, saying it's negative, but it's been tested for something else so that can happen with swabs. You might be told one thing's negative and then, there's something that's been picked up later.

232. HSAG felt it was a problem with communication. Whoever it needed to be. If that was the case and I absolutely take that on board, then that patient should have been told test one is negative. We're awaiting test two. It's just communication.
233. LP - We'll get a result through about 2 weeks later to tell us. Oh, we did extended culture on this, and we came up with something bizarre. You know the problem is that this stuff goes straight onto your records. We've got people phoning up immediately to say, I can see my sample. Is it all right? I haven't even looked at it yet. It's all very well having these things available on the app, but then it doesn't necessarily give you the right answer.
234. HSAG agreed.
235. LP - Because they might have dipped and it's OK and we'll put it through for extended culture or something. You don't get the final result until later. So sometimes slower is better because it doesn't confuse everyone. The point of dipping things beforehand is we get an idea as to whether we should be treating with antibiotics now or waiting.
236. HSAG - Thank you very much. I think we I think we've cleared everything. I can wait until next time. OK.
237. The chair returned to item 6 on our original agenda, which is the call centre presentation. I have the data now that's been sent to me. I'll share that with everybody later. As we've run out of time, I think I'll just have one item which is Sharon, who is leaving us and given her resignation. Sharon attended this evening. It's very kind of you to come. Thank you very much for your time on the PPG and it's very much appreciated.
238. The chair extended the best wishes of the PPG in respect of the care of her husband.
239. NK echoed the thanks of the surgery.
240. The chair set the date of next meeting, 22nd of April, 5:00 o'clock and concluded the meeting, with thanks to all who attended at 18:40.
241. HSAG asked the chair if he wanted to put an entry meeting in with Tom?
242. The chair agreed to do so.
243. HSAG was keen to avoid having to wait until the next PPG.
244. The chair agreed and would be in touch to arrange this before the next meeting.