Minutes of MVPPG Inaugural AGM at Manor View Practice 7pm 25 June 2015

Richard Beeden (RB) as chair of the Manor View Patient Participation Group (PPG) Steering Committee opened the meeting by welcoming those present (10 patients plus 3 from the practice). He then introduced himself and the other two members of the Steering Committee, Joan Manning (JM) and Colin Stodel (CS). A welcome was extended to Dr Davis (DD)and Dr Gos (DG) from the Practice plus Liz Webb (LW) the practice manager.

Apologies were taken from: Susanne Tomlin, Gill Tattle, Brian Richards, Ruth Waxman, Richard McHale, Jill Macey, Brian and Linda Springer; Bill Stephens and Radhika Biswas.

There were general comments that there were problems with emails and patients claimed they did not receive the newsletter and information on talks. LW would speak with the Web provider

RB then gave a report starting by outlining why the Steering Committee was set up to bring about the transition from a patient representative group (PRG) to a patient participation group (PPG) and what the differences between the two are as summarised in the table below.

PPGs do things. They:	**PRGs give feedback. They:**
➢ are patient-led	➢ are practice-led
➢ are autonomous & proactive	➢ are mainly reactive
➢ respond to local needs	➢ are top down and target-driven
➢ have a wide remit taking a long term view on continuous improvement through participation	➢ have a narrow focus on feedback
➢ are developed from the 'grass roots' through a mutually agreed relationship with practice	➢ have been developed since 2011 to meet targets in an optional clause in a GP contract to qualify for extra payment
➢ can be face to face or virtual and provide community outreach	➢ are often only virtual

RB went on to speak about why, given that the PPG was patient lead a constitution and terms of reference were necessary to give it legitimacy to represent patients. He explained that a little later the meeting would be asked to adopt the previously circulated draft constitution and draft terms of reference both based on the advice from the National Association of Patient Participation (NAPP) to which the MVPPG was affiliating.

RB then touched on the issue of the membership of the PPG and the committee ideally reflecting the diversity of the patient body which currently it does not suggesting that there were communication issues. One immediate step being taken was to recruit two young people to the committee Jesse Anthony and Radhika Biswas both of whom had mentioned the use of social media and mobile devices as being the more likely ways to engage young people successfully. Clearly this needed to be a priority particularly given the change in IT systems about to take place in the practice.

Finally RB mentioned the networking attempts that had been made over the last six months with admittedly little success so far and the meetings with Dr Davis and Liz Webb roughly every six weeks to review progress and plan the next steps including this meeting.

JM outlined the activities that had been undertaken on behalf of the PPG. She explained how CS keeps the PPG pages of the Manor View Practice web site up to date and uploads details of

meetings, talks, the newsletter and a lot of other information. This includes the PPG's own email address: mvppg1@google.com which is not to be used for anything of a clinical nature. The PPG is a separate body from the surgery, so this is not a back door into the clinicians or staff.

The new Manor View Practice Newsletter which at present is being produced quarterly has proved popular. The newsletter is available on the Website (under PPG) and is posted out those members of the PPG who do not have a web address. It is also available at reception in the surgery. At the end of the newsletter are listing useful addresses and phone numbers for locally available services. She asked those present to let her know if they had any to add. Ditto any subjects people would like us to look into and we will do our best.

As promised a series of talks/conversations has started for the benefit of patients. These are very informal and the presenter is always more than happy to take question. The first on afternoon of 24th March attended by some 20 people was from a member of the EMDAS (Early Memory Diagnostic & Support) team and addressed the subject of whether memory loss was a consequence of general **ageing or due to dementia.** The second was in the evening of 9th June, when Dr Kirsty Moore asked the question **Who Cares for the Carers** – and explained just what the problems might be for carers and how Manor View addresses those problems and described some of the many services available to carers provided they record themselves as such at the practice. A third talk is provisionally scheduled for 9th September at 7pm looking at **How do we know If We Have Diabetes?** And what can be done to prevent it? from a Diabetic Specialist Nurse at West Herts. It is hoped attendance is higher this time. There are other topics in the pipeline some clinical and some social. Printed accounts of the talks are posted on the Website.

The PPG has 'taken possession' of the white notice board in the waiting room (thank you MVP). We will try to keep you up to date on a weekly/monthly basis of anything we feel you should know, any changes that are happening, meetings or urgent information. So keep your eye on it!

Dr Davis (DD) agreed with RB's definition of a Patient Led PPG with more importance given to what the patients want rather than what the Drs want. He was confident that there would be a productive relationship with regular meetings which would lead to an improvement in patient education and availability of information. DD spoke about the changes from the practices point of view and in particular their priorities for the future including the changeover of the IT system, reducing the DNA rate (did not attend/missed appointments) which the new IT system should assist and the introduction of a patient advocate system using the PPG in the case of complaints. The staff changes set out in the June news letter were formally announced and those leaving thanked and those joining welcomed. Liz Webb (LW) added some details to this including an update on the practice list numbers (approx 13,000 and growing faster than other surgeries in our CCG (Clinical Commissioning Group) area). Although we were not part of the group of Watford practices which joined together to offer/share weekend appointments (Attenborough Surgery is part of this group) we still do offer Saturday and Sunday morning appointments once a month. Things may change in the future. We are awaiting our CQC (Care Quality Commission) inspection. It is hoped that members of the PPG will be available to speak to the inspectors

Dr Gos (DG) – who has joined us from a practice in North Watford – gave a presentation on the proposed new Health Centre. The site and building is owned by some doctors from Attenborough Surgery plus other financial backers. Manor View Practice will lease its premises from them.

Hopefully work will start in the next few months on this 3 story building with a completion date around early 2017. We will have 75% more space – including much bigger consulting rooms and facilities for extra services. All surgeries and waiting areas will be on the ground floor with offices above and a private treatment suite on the top floor. The Health Centre will be very much a 'Community Hub' offering services to about 30,000 patients which is 16% of the total Watford locality. This potentially gives patients a fair amount of influence in their services.

Answering questions from the floor, DG saidit appears that despite being near the neighbouring flats, no objections have been raised regarding the proximity of the access road. There should be better and more parking spaces (78) on one site. We have no information regarding 'on road' parking nor if there will be any restriction on turning right on exiting the site. We have no information as yet on heating/air conditioning. We have no information as yet on what new surgery facilities/medical procedures such as Red Cross equipment and diagnostic equipment would be available. However it was certain that there will be a Pharmacy and a consultant's suit.

RB introduced the draft constitution and asked if there were any amendments anyone wanted to suggest other than the one he had proposed at 7.8 relating to publishing the committee meeting timetable and minutes on the notice board and web site. There being no others he put the draft constitution to the meeting. It was agreed unanimously as appended to these minutes.

RB introduced the draft terms of reference and asked if there were any amendments anyone wanted to suggest other than the one he had proposed at 3.2 relating to organising meetings and in 4.1 adding "(or their successor bodies)" after Car Quality Commission to avoid the need to change the terms of reference each time the name of the NHS quality assurance body changing its name. There being no others he put the terms of reference to the meeting. They were agreed unanimously as appended to these minutes.

A brief outline of the experience of 4 of those putting themselves forward for the committee (Richard Beeden, Joan Manning, Colin Stodel and Jesse Anthony) had been circulated at the meeting and a fifth from Radhika Biswas was read out. A sixth nomination from Brian Robinson had been received by email and Mr John Perry put his name forward. As there were fewer nominations (7) than openings on the new committee (8) all seven were elected unopposed. The brief outlines will be posted to the web site

JM outlined some suggestions she had for future meetings.

- Mother & Baby : How do I know if I'm doing it right?
- All: My pills & me (Pharmacist/pharmacologist).
- All: Is it something I've Eaten? Nutritionist from a food clinic.
- All: Laughter is the best medicine, isn't it?
- All: How to make a complaint in the NHS. (Healthwatch)
- Youth: What do I need to know before going off to Uni?

She circulated a paper asked for ideas from the floor and topics for the newsletter.

In relation to future priorities there were suggestions about improving communications and the introduction of using social media to communicate with younger patients in particular.

Arrangements for future meetings were agreed as follows

1. Possible general meeting December 2015;
2. Next AGM July or August or September 2016;
3. Events: four or so a year?;
4. Committee 4 times per year;
5. Chair and Vice Chair to meet with the lead partner and practice manager about every 6 weeks;

There being no other business the meeting closed at 8:40

Manor View Practice Patient Participation Group (MVPPG)

Constitution

1. TITLE

1.1 The name shall be ‘Manor View Practice Patient Participation Group (MVPPG) hereinafter called ‘the Group’.

2. ASSOCIATION

2.1 The Group is affiliated to the National Association for Patient Participation (N.A.P.P.).

3. MISSION STATEMENT

3.1 To strengthen the input of patients on the Manor View Practice's (hereinafter called ‘the Practice’) list to the development, organisation and delivery of high quality general practice services.

4. OBJECTIVES

COMMUNICATION:

4.1 To improve two way communication and partnership between the Practice and its patients.

COMMUNITY NEEDS

4.2 To assist the Practice in improving services to patients ensuring it remains accountable and responsive to all its patients' needs.

HEALTH EDUCATION

4.3 To promote health education and awareness on topics of interest and value to the patients and to co-operate with medical activities, where appropriate.

PRIMARY CARE ORGANISATION

4.4 To be informed about and comment on behalf of patients on the general practice policies relating to the Herts Valleys Clinical Commissioning Group (HVCCG) (or any subsequent organisation that replaces it) to which the Practice belongs. The Practice will give appropriate weight to these opinions within their HVCCG.

OTHER:

4.4.1 To promote, after discussion with the Practice, any other matter that is deemed to be in the interest of the patients and the Practice.

5. MEMB ERSHIP

5.1 Membership of the Group shall be open to all persons over the age of 16 who are registered patients of the Practice.

5.2 Membership does not confer any prior claims on the Practice or any right to preferential treatment.

5.3 Membership of the Group shall be terminated in the event of a member ceasing to be a patient of the Practice.

6. POWERS

6.1 For the purpose of carrying out the above Objective, but not otherwise, the Group shall have the power to do all such things set out in the Group's terms of reference.

6.2 The decisions of the MVPPG are not binding on the Practice but will be taken into account and given appropriate weight in the Practice's decision making and planning processes.

7. MANAGEMENT

7.1 The management of the Group shall be undertaken by a Committee consisting of a minimum of four and a maximum of eight members, including its officers, normally: Chair, Vice-Chair, Secretary and Treasurer.

7.2 The Committee may co-opt other members for specific tasks as the need arises. The co-optees will not have voting rights on the Committee.

7.3 The Committee will be elected for one year at the Annual General Meeting (AGM). The maximum term of continuous service on the Committee is five years.

7.4 There should be at least one and preferably two representative of the Practice at each meeting of the Committee and the Group. The Practice will nominate its own representative(s), who will attend ex officio in an advisory capacity. A partner and senior administrator would be ideal.

7.5 The day-to-day management of the Group shall be conducted by the elected officers. Any action(s) taken by any officer on this basis shall be reported to the next meeting of the Committee.

7.6 An independent auditor will be appointed at each AGM.

7.7 This constitution and the Group's terms of reference shall be published on the Practice web site.

7.8 Meeting timetables will be published in advance followed by meeting minutes on appropriate notice boards, surgery waiting rooms and the MVPPG web site.

8. MEETINGS

8.1 Annual General Meeting (AGM):

8.1.1 An Annual General Meeting of the Group shall be held each calendar year within three months of the end of its financial year at a time and place determined by the Committee and advertised on the Practice notice board, Group newsletter and the Practice web site.

8.1.2 Any item for the agenda shall normally be sent to the Secretary at least four weeks prior to the AGM date.

8.1.3 A minimum of twenty-one days' notice of the AGM shall be given.

8.1.4 All patients currently registered as members of the Group shall be entitled to attend, stand to be a member of the Committee and have one vote.

8.1.5 In the event of there being more than one nominee for any seat on the committee an election must be held determined by a show of hands at the meeting. In the event of a tie the chair will have a casting vote.

8.1.6 All matters at the AGM shall be determined by a majority of those present. In the event of a tied vote the Chair shall have a second or casting vote.

8.1.7 The AGM shall receive a report on the year's activity of the Group and a statement on the audited accounts for the Group's previous financial year.

8.2 Special General Meeting:

Adopted at the AGM held on 25/06/2015 and last revised by resolution 25/06/2015

8.2.1 A Special General Meeting of the Group shall be called on application to the Secretary, signed by not less than fifteen members. The meeting shall be called to discuss only that item for which it was called.

8.2.2 Rules on notice, voting and advertising such a meeting shall be as for the AGM in paragraphs 8.1.3, 8.1.4 and 8.1.6 above.

8.3 Committee Meetings:

8.3.1 The Committee shall meet at least four times between consecutive AGMs.

8.3.2 The Committee may fill casual vacancies between AGMs Time served in this capacity will not count towards the maximum of five years of continuous service on the Committee.

8.3.3 The Chair may call special meetings of the Committee as the need arises.

8.3.4 Committee members shall normally have at least seven days' notice of any meetings together with its agenda.

8.3.5 The Committee may appoint subcommittees and delegate relevant powers to them.

8.3.6 The quorum of the Committee shall be half its members.

8.3.7 If both the Chair and Vice-Chair are absent from any meeting, those members present shall nominate another member to act as Chair for that meeting.

8.3.8 Unless otherwise provided herein, all matters shall be determined by a majority of those present. In the event of a tied vote the Chair shall have a second or casting vote.

8.3.9 Minutes shall be kept of the proceedings of all meetings.

9. FINANCE

9.1 In the event of the Group raising funds all such funds will be handed to the treasurer who shall pay the same into an account in the name of the Group at such bank or building society at the Committee may from time to time decide.

9.2 Two officers of the committee must authorise all withdrawals/cheques

9.3 Out of pocket expenses on behalf of the Group shall be claimed at any Committee meeting.

9.4 Annual associate membership shall be paid to NAPP.

9.5 The financial year shall coincide with that of the Practice currently from 01 July to 30 June.

9.6 Proper accounting records shall be kept and all monies accounted for.

9.7 The annual accounts shall be presented at the AGM and will be subject to an independent audit.

10. ALTERATION OF THE CONSTITUTION

10.1 This Constitution may be altered by a resolution passed at an AGM or a Special General Meeting, by a majority of at least two thirds of the members present, three weeks' notice having been given of the proposed alteration.

11. DISSOLUTION

11.1 The Group may be dissolved by a two thirds majority of members present at an AGM or Special General meeting. A motion for dissolution must be advertised with the notice of the meeting at which it will be proposed.

11.2 Upon dissolution of the Group, any surplus assets remaining after the satisfaction of all debts and liabilities shall be transferred to a body that would use said assets for the benefit of National Health Service patients.

Adopted at the AGM held on 25/06/2015 and last revised by resolution 25/06/2015

MANOR VIEW PATIENT PARTICIPATION GROUP (MVPPG)
TERMS OF REFERENCE

1. COMMUNICATION:

1.1 To provide feedback to the Practice on behalf of patients on their views, needs, concerns and interests and any other relevant matters so that the Practice's policies and decisions can be influenced by such views;

1.2 To facilitate communication between the Practice and the community to help patients understand changes in health care initiated locally, regionally or nationally and use facilities and services to the best advantage;

1.3 To act as a signpost towards the Practice's system of suggestions and complaints;

1.4 To help patients understand their responsibilities and the Practice's point of view;

1.5 To give patients a voice in the organisation of their care;

1.6 To liaise with other PPGs in the area;

1.7 To develop effective ways of communicating with patients such as Email, Text, Newsletter, social media and any other means available.

2. COMMUNITY NEEDS:

2.1 To collect patient opinions and experiences and, from time to time, conduct Patient Surveys (normally in conjunction with the Practice) that assess community 'needs' and in the light of that assessment, help the practice evaluate its services;

2.2 To provide the Practice with advice about the implications of patient opinions, experiences and surveys.;

2.3 To contribute to the Practice's development process for services and comment upon any resulting action plans;

2.4 To challenge the practice, constructively, whenever necessary.

3. HEALTH EDUCATION

3.1 To advise the Practice on the educational needs of the patient community about preventative medicine, healthy lifestyle choices, appropriate use of healthcare services and any other areas that may improve the health of the patient community and the efficient use of medical resources;

3.2 In collaboration with the Practice organise appropriate community health education meetings.

4. PRIMARY CARE ORGANISATION

4.1 To provide input to and publish feedback from the relevant Clinical Commissioning Group (CCG); to co-operate with the Care Quality Commission (CQC) (or their successor bodies) and to influence the provision of primary and secondary healthcare and social care;

4.2 To liaise with the relevant commissioning group of practices to share and develop best practice and/or resources;

4.3 To assist the practice and its patients by arranging or assisting voluntary groups and support within the community;

4.4 To influence the provision of secondary healthcare and social care locally and give feedback on relevant consultations;

4.5 To monitor services, e.g. hospital discharge and support when back in the community.

5. OTHER

5.1 To review and update the Constitution, mission and objectives of MVPPG as and when required;

5.2 To undertake such other things as the Group or Committee may deem necessary or desirable from time to time for the attainment of the Group's objectives.

Adopted at the AGM held on 25/06/2015 and last revised by resolution 25/06/2015