

Reading Patient Voice Group Draft Minutes

Thames Valley Integrated
Care System
Reading locality

Co-chairs: Catherine Mustill, David Cooper
Treasurer: Jill Lake Information Officer: Tom Lake
Membership Officer: Tom Lake Data Officer: Francis Brown

1 Welcome and Apologies

Date	30th September 2026
Location line Present	Committee Room 1, Civic Offices, Reading & online Paul Williams, University Health Centre Jill Lake, Pembroke Surgery Cathy Cousins, Pembroke Surgery David Penson, Emmer Green Geoffrey Million, Balmore Park David Cooper, University Health Centre Tom Lake, Pembroke Surgery Tomiko Morley, University Health Centre Francis Brown, Balmore Park Jane Lamphill Deirdre Drukker, Longbarn Lane Mark Drukker, Longbarn Lane John Norris University Health Centre Hazel McCullough, Teresa Broad, Western Elms and Circuit Lane Dr Gerard D’Cruz Pembroke Surgery Andrew Pickrsgill, Wokingham
Apologies	Sunila Lobo, University Health Centre Valerie Gardiner, University Medical Centre

2 Activities

2.1 Action Log

No.	Action	Date	Who	Status
3	Follow up problem with audibility of calling of names in A&E waiting room	24oc16	Sunila Lobo	Formal question posed
7	Explain the GP Improvements Programme	25sp24	Alice Kunnjappy-Clifton	pending
8	Is Johns Hopkins same as Frailty index?	25oc15	Catherine Mustill	pending
9	Carry out analyses of patient experience measures at corporate GP practices, trust-run GP practices and IHO-run GP practices	25oc15	Francis Brown	pending
10	Contact Reading Public Health about patient experience measures at GP practices	25oc15	Tom Lake and Francis Brown	pending
11	Update on RBH Patient Portal	26mr18	Catherine Mustill	pending

2.2 Suggested Meeting Topics

1	How does a GP practice work?	24oc16	In survey
2	Resuscitation, DNACPR, choices and forms	24oc16	In survey
3	Hydrotherapy - how did we get to this?	24oc16	In survey
4	Weight management - drugs and lifestyle	24oc16	In survey
5	NHS 10-year plan	24oc16	In survey
7	Meet Matt Rodda MP	24oc16	In survey
8	Diabetes including social aspects	25fe19	In survey
9	Virtual Wards	25fe21	In survey
10	Johns Hopkins model for classifying patients	25fe21	Pending
11	Process Improvement at RBH	25fe21	Pending

3 Behind the Scenes at a GP Surgery - Samuel Kingsley

Please see these slides

3.1 The Surgery

There have been big changes to consultation - now all practices must have an online consultation tool. We also have an online tool called GPTriage which gets symptoms and details through online forms - then, if appropriate, an appointment is given.

Our systems record long term conditions of patients and the recall flag will be raised, usually in the

birthday month. e.g. for diabetes - preliminary tests are booked - then the patient will be seen with the results available.

We have three levels of urgency for an appointment: red (same day) amber (24-48 hours) green (longer) and we schedule so many of each per day.

With online tools, clinical risk increases so the practice has to give considerable assurance re use of tools, eg abdominal pain, fever, sickness - what does it say?

We have given the triage system that we suggested a Local test of its handling of symptoms.

Is it robust to small variations of inputs?

If the tool doesn't know what to do does it pass the info to the patient/clinician securely?

We run a clinical risk register - responsive to patient needs.

Recently, with appts available (released 8am and 12noon) - two patients were given the same appointment - software can have errors or fail to meet the need.

We hold a monthly review of problems - tools must consistently meet the need.

We try our best to have a familiar clinician for the patient. Not always possible especially if on the day. For a routine appt one can choose the clinician. Within 2 weeks one can usually choose. On the day - it may not happen.

We regularly audit the number of appts on each day with the skill mix they offer. E.g. Back pain → first contact Physio.

Our practice Team includes Health coaches, pharmacy technicians, etc.

Practice Manager's responsibilities - Staffing, money best possible use, premises clinically safe, infection safe.

3.2 What about our participation in a Primary Care Network?

A Primary Care Network (PCN) has a minimum population requirement for its group of practices. 30,000 patients. It is meant to share staff - Additional roles - paramedics, health coaches with goals the prevention of long term conditions.

The Government has a 10-year health plan. Lot about neighborhoods. Collection of primary care providers - over 100K - delivering services closer to home.

The services might involve: home nurse visits, phlebotomy, a pain clinic.

Old fashioned family practices less valued - need is now for larger units.

3.3 Thames Valley Integrated Care Board

It sets budgets.

ICB Change Priorities: Health inequalities, support for people at risk, early years, mental health.

ICB is pushing for use of online consultation tools. At Pembroke a patient can request a home visit.

3.4 Reviewing our work

We bought in our triage system. It takes a lot of background work. to arrive at the triage outcome.

We use a tool called connected care. All patients are coded with LTC etc. Puts patients in red, amber, green categories.

Red - high risk - certain targets every month. Medicines review - admission prevention - social prescribing. Patient associated with flag means requiring action. Spends on correct data. Clinicians, receptionists, admin. Police incident, domestic violence - coded in the record.

At Pembroke - most requests for appt arrive via online triage.

We audit red slot use every week - more needed in winter. If no red slot - look for amber slot or cancellation.

So far we are on our escond truage/appointment system and, since Jan 2026, no major incident except the overlapped appts.

3.5 Cancer

Cancer diagnosis - we are seeking faster diagnosis. There are established protocols - 2 week wait pathway in the hospital.

FIT test - bowel cancer - push for quicker diagnosis.

3.6 Other Referrals

Non-cancer referrals waits: 84

Orthopaedic urgent: we can have contact with consultant or treatment.

Advice and guidance - urgent or semi-urgent - note to A&G service for the specialism - dermatology is widely used - dermatoscope - opinion within week or two - some longer.

Reasonably well handled so far.

3.7 NHS Health Check

NHS Health check is offered at 40 - 74 more frequently if risk factor. e.g. borderline hypertension.

Admin has to pick out appropriate patients on month - not previously seen. Quite a lot of work. Works will come to a clinician - ambiguity - prediabetic - manage - case finding searches all the time.

Proportion coming for health check is low.

3.8 Responsibility for reviewing results

Patients undergoing treatment - chemo or radio - surgery will see blood test results - it is a surgery responsibility to check results.

Sometimes - major procedure - eg liver resection - results are sent to primary care - to read. Ensure that specialist has seen the results.

3.9 Prescriptions

Repeat prescription - we must perform safety checks - some need blood tests. or kidney function deteriorates - patient needs change of meds.

Our list size is 6300 - we get 150/200 repeats per day. Some straightforward. But not all so we see the patients complaint. Many need extra checks.

Hospital changes meds - we must take note.

3.10 Administration and Governance

150-200 admin requests a week come in.

Pembroke has CQC good in all 5 domains.

Safeguarding - we have a duty of care - listen privately to patients stories. We hold safeguarding meetings.

There can be children or adults at risk - very time consuming - domestic conflict. This is a huge responsibility in primary care.

Risks are being dumped on primary care.

We recruit train, ensure safety for staff.

Lots of requests for medical records - could be 100 pages.

May have to redact if no permission to give all.

Medicine seems to be following the US - fault based - no one taking clinical risk.

Requests have quadrupled - 60 a quarter.

We are responsible for ACP records re end of life care choices.

Catherine Mustill: Thank you Dr Kingsley for a really excellent talk. You offered to take questions.

3.11 Question and Answer

Libby Stroud: The Urgent Care Centre at RBH - now plan to equalise access. I understand the women's clinic was closed by the health authority.

Samuel Kingsley: Pembroke was part of a pilot to determine demand - 5 Reading Central PCN surgeries - about 100 appts - divert from A&E - allocation for so many appts per day. If no appt at Pembroke look for an appt at UCC. Used for over 1 year now - we are constantly reviewing - it is run by an alliance of practices - takes overflow - smooths the flow - open to 8pm

Jill Lake: When changes to online triage came in - what kind of training do receptionists have to triage?

SM: Most practices - receptionists have NHS certified care navigation training - question prompt - we say to them, if complex take the basic info and put it on the duty list for the clinician as urgent to ring patient.

Receptionists can go through triage with the patient.

IS the triage tool designed in the practice? Designed elsewhere - certified by NHS England - we set algorithms for assignment of patient - it is a commercial product.

David Cooper: Can you get a health check after 74?

Samuel Kingsley: you can have a check - it is a matter of judgement - there would be no financial incentive to the practice

Jill Lake: What are the exclusion criteria at UCC?

Samuel Kingsley: I can't give them all off the top of my head but e.g. leg ulcer or sudden high blood pressure. Can't issue a sick note. Deals with acute etc.

Jill Lake: If you go to A&E you can be routed to the UCC without being registered for A&E.

Francis Brown: Our practice has an Online consultation tool - we are still reviewing its usability especially by the older adult population whose competence is limited. Do you take into account these constraints?

Samuel Kingsley: Absolutely right. - Receptionists are told that if anyone has difficulty then receptionist fills the triage with the patient. Tried having a PC by reception but no more. Takes 6-7 minutes but this happens rarely.

Catherine Mustill: At some practices the internal practice staff does the triage not the algorithm.

Samuel Kingsley: The Accurx tool takes free text and throws it to an inbox for the duty clinician.

If patient correctly answers it is very accurate.

Over the phone misunderstandings can occur -

Tom Lake: Do you have much interaction with public health

Samuel Kingsley: For communicable diseases. Also now with neighbourhood health planning and over prevention through changing lifestyle,

Catherine Mustill: Thank you very much for your excellent talk and for answering our questions - it is much appreciated.

3.12 Post-Meeting Additional Notes from Dr Samuel Kingsley

3.12.1 Innovation

It was an absolute pleasure to speak to the group and to have the opportunity to share some of the work we are undertaking at both practice and PCN level.

One area I did not have the opportunity to touch on was the broader programme of innovation we have developed across Central Reading PCN. Much of this has only been made possible through Gerard's pioneering leadership over many years, together with his consistent support for developing community-based diagnostics and creating the conditions in which primary care can work differently.

A good example is our ultrasound service at Pembroke, which we have progressively extended to support patients from other practices across the PCN. We provide this without any direct financial incentive to ourselves. The underlying principle has simply been to make better use of the skills, capability, and infrastructure already available within primary care, improving access for patients, supporting more timely clinical decision-making, reducing unnecessary onward referral where appropriate, and bringing care closer to home.

More broadly, this reflects what we are continually trying to achieve across primary care: moving beyond traditional organisational boundaries, developing services around the needs of patients, and demonstrating what can be delivered safely and effectively within neighbourhood and community settings when there is the right clinical leadership, governance and system support.

There is already a considerable amount that primary care delivers in this way, often quietly and without additional incentive. I hope that, collectively, we can continue to build on this work and help shape a more integrated and sustainable model of care for the future — one that makes best use of the respective strengths of primary, community and secondary care while remaining firmly centred on the needs of patients and local populations.

As the NHS continues to evolve, the challenge will be to ensure that innovation at neighbourhood and primary care level is recognised, supported and incorporated into wider system planning. Equally, there is a real opportunity to use existing clinical capability differently, reduce avoidable pressure elsewhere in the system and develop pathways that are both more responsive to patients and more sustainable for the future.

As promised, please see below the criteria for the Urgent Care Centre.

3.12.2 Inclusion Criteria at RBH Urgent Care Centre

Main principle is if the patient would be safely seen in general practice, then they can be referred to the Urgent Care Centre clinic.

- Minor ailments:
 - high temperature
 - Skin infections not requiring incision and drainage
 - headaches
 - headaches and dizziness
 - coughs, colds, and flu-like symptoms
 - hay fever/allergies
 - ear, nose, and throat infections
 - minor eye conditions/infections – conjunctivitis, eye inflammation, styes
 - abdominal pain, indigestion, constipation, vomiting and diarrhoea
 - dermatological and skin complaints, for example, rashes, minor allergic reactions, scabies, head lice, sunburn
 - Genito-urinary problems, for example, urinary infections, thrush, and menstrual problems
 - falls in patients of any age without history of dizziness or blackout
 - breathing problems, for example, asthma
 - chest infections.
- Exclusion criteria Minor injury presentations including the following (refer to MIU):
 - Head injuries
 - Superficial cuts including wound closure (suturing, stapling, gluing, steri-strips)
 - ear injury
 - Minor eye injuries – removal of superficial foreign bodies
 - Injury of severity not amenable to simple domestic first aid
 - Trauma (minor) to hands, limbs, or feet
 - Minor burns and scalds
 - Insect, animal, or human bites
 - Potential fractures and foreign bodies (X-ray required)
 - Muscle and joint injury
 - Sprains and strains
 - Joint dislocations

NB: Other presentations which are assessed as safe by the ED team could be seen in the service following discussion with the clinician
- Major trauma (remain in ED):
 - Pedestrian or cyclist hit by a vehicle (any speed)

- Motorcyclist travelling at > 20mph
- Driver or passenger travelling at combined speed of > 50mph
- Ejection/fall from moving object or vehicle
- Extrication from vehicle
- Death of another occupant in vehicle
- Stabbing
- Gunshot
- Penetrating or blast injuries
- Burns > 3% of body surface or any burn involving face, neck, or head
- Inhalation injury
- Electrocutions
- Strangulation/hanging incident
- Suffocation
- Near drowning
- Other exclusions including (remain in ED):
 - Any case with high news score 5-6 (urgent)
 - PAWS < 3
 - Paediatrics minor injuries are to go to paediatrics minor injuries first
 - Apnoea in paediatrics
 - Post op surgical complications (paediatrics)
 - Non-blanching rash
 - Seizure
 - Overdose/alcohol/substance withdrawal
 - Chest pain or shortness of breath (unable to complete full sentences)
 - Dental pain
 - Diabetic emergency
 - Stroke/TIA/FAST positive
 - Severe uncontrolled pain
 - Unstable patients (they must be able to transfer from ED to SDA unit without risk of deterioration in their condition)
 - Patients that have already had an assessment by a qualified GP or Practitioner who have been advised or referred to ED
 - Psychotic patients requiring restraining
 - Any patient not capable of sitting in chair/wheelchair to await appointment.
 - Any patient requiring emergency treatment (anaphylaxis, suspected meningitis, grossly abnormal basic observations)
 - Suspected testicular torsion – patients should be taken directly into the ED and handed over
 - Overtly psychotic patients/high suicide risk patients escorted to ED
 - Children where there are safeguarding concerns

4 RBH Update

Paul Williams: I have begun circulating reports from the comms team. Please circulate them more widely.

Still large numbers turning up at A&E - who could have gone to their GP. They may be diverted to the minor incident team.

The Urgent Care Centre is not walk-in. When I attended I was asked: Had I been referred? Had I used 111? (Poor experience in the past.) Dealt with sprained ankle. Walk-in not offered but they were not busy. Issued crutches, referred to X-ray.

Francis Brown: Notice on door explains opening hours. Often not always busy. It is now in a little area quite close to main reception desk.

Paul Williams: Some trusts would like to get rid of governors - includes RBH. No future elections are planned. They are assuming governors will go quietly. We will soon be inquorate at meetings. Many are in employment and cannot attend daytime meetings. Our last Gov meeting was inquorate. There is no volunteer for lead governor.

David Cooper: Have they thought through the question of holding the non-execs to account.

Paul Williams: : No - the trust will do itself.

Tom Lake: This is the first time I have heard about definite intention. It is a big topic. Maybe we should meet separately.

Paul Williams: Trusts are meant to collaborate. Where is the evidence?

Mark Drukker: I went to A&E in the morning - got an appt at UCC pm - not too good - they gave me a specimen tube to return to the GP. Back to A&E - scan - procedure.

Tom Lake: The Royal Berks AGM recently was quite positive but they do have quite a financial squeeze. They have been used to getting ££40M "deficit support" each year. This year is it only £9M, and next year £0. How will they make these huge savings? They claim that use of the virtual ward and "patient-initiated follow up" (i.e. follow up on request rather than automatically) will save a lot. We shall see.

Paul Williams: We are getting info on sites for the new hospital. In Wokingham? What will a hospital be in 2039?

Catherine Mustill: There is a rumour that RBH is buying the land.

Paul Williams: They are making some savings by using generic drugs. Change of supplier of pharmacy. There is ongoing pressure on staff numbers. The new chief exec is finding his feet. Can be very secretive.

Trust felt disappointed that AGM had low numbers of attendees..

Jill Lake: Who would buy the land?

Paul Williams: NHS nationally. Need to have the land in 10-20 years time. Looking at land where Oracle was previously based. Traffic access looks very difficult.

David Cooper: If the hospital was on the M4 we could still have A&E in central Reading.

5 PPGs

David Cooper: I had a useful conversation with Elizabeth Johnston. Asked how improvement takes place. She agreed that she would talk about it at next PPG (November). Other practices might like to explore this in PPGs.

Francis Brown: After our analysis of patient experience influences at University Medical Group I did a

Similar analysis for Balmore Park. I was pleased to see that the partner present at the PPG took spare copies for the partners meeting.

Teresa Broad: What checks are there on PPGs. What is their purpose?

Francis Brown: Until recently there was a National Association of Patient Participation (NAPP).. I have many of their documents. Which will help. There are 2 models. Driven by the Practice Manager to discuss issues. Alternately driven by an independent group of patients - critical friends of the practice.

Jill Lake: In the last year or so Sam et al have set up a meeting at Pembroke for any of the people who wanted to go along - every 4 or 6 months.

Francis Brown: The GP contact requires practices to have a PPG. ICB will call on each practice to make an annual report.

Andrew Pickersgill: Here is a picture of the new Bracknell health centre with a couple of GP practices and other services. I see that you are all admiring it.