# NEWBRIDGE SURGERY
# PATIENT PARTICIPATION GROUP MEETING
# MINUTES OF THE MEETING HELD ON
# Tuesday 3 March 2026 at 4:15 pm

## PRESENT

Patient Representatives: J Hancox, (JH) J Evans (JE),) C Dymond (CD), J Horton (JH) D Hayes (DH) J Horton (JH), C Patel (CP), P Boswell (PB)

Practice Representatives: V Roddie (VR), Dr G Pickavance (GP), J Griffiths (JG)

| | | ACTION |
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| 1. | **Welcome & Introductions**<br>All participants at the meeting introduced themselves | |
| 2. | **Apologies for Absence** –<br>R Ashwell (RA), S Corbett (SC), K Ong (KO), CG Luck (GL); D Luck (DL) | |
| 3. | **Minutes of the last meeting –**<br>Agreed as a true record except P Boswell attended the last meeting on 4.11.25 but omitted from the minutes. | |
| 4. | **Matters Arising –**<br>A summary of 10 year plan was provided and Dr Pickavance discussed this in more detail. See addendum(s) page 5 – 7<br><br>Role of Community Pharmacist v Practice Pharmacist was discussed and copy attached with the minutes. Practice pharmacist can attend in future if patients would like this. See addendum page 8 | CFI<br><br>CFI |
| 5. | **Items from the Chair**<br>Unfortunately, no feedback to share.<br><br>There is a meeting to discuss the NHS 10 year plan, consultants and doctors will be there to answer any questions you would like to raise. This is at Birmingham Council Chambers Committee Room 2 on Monday 23 March 2026 at 7:30 pm if anyone would like to attend with a Q&A. JH will attend. | |
| 6. | **Items from the Practice**<br><br>**Disclaimer document for PPG members**<br>Following a recent training session held for CQC it was suggested that patient members need to complete a disclaimer as currently their names are included on the minutes of the previous meetings and these are displayed on the Practice website or alternatively to remove names. Full names are not included on the document but patients could still be identified and suggest that this could be redacted. There was a short discussion about this, and a vote taken by the group that they all agreed that they did not have any issues with their names being displayed and they will complete a disclaimer. Disclaimer to be circulated by patient group and to forward a copy for our records. JH was happy for her name to be included on minutes and also could include her telephone number and welcomes this opportunity to reach out to patients.<br><br>**Telephone System**<br>Following recent contractual changes by NHS England, our current phone system does not have a “call back” facility for patients. It has previously been reported that there have been snagging issues from our current provider and our PCN | |

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phone system is with a different provider. Therefore, there will be changes to the phone system in the next quarter. Patients should not notice any difference other than a call back facility being introduced and in operation; this is so patients can keep their position in a queue. NHS England requirement for all practices to have this option regardless of size or staffing. Lift phone to be sorted separately as this will be out of scope.

In future there will be monitoring of all call back stats by NHS England/Department of Health and Social Care for all practices as all data is being uploaded onto a primary dashboard which includes GP National Survey, CQC information. If the data is green then this is ok but if it enters into red then there will be necessary interventions.

JH asked the group if they had any problems getting through on our current phone system and the feedback was positive with no concerns.

**ICB Contract Monitoring Visit – 21 January 2026**

Contract monitoring update reported on last update. 2 members of ICB attended, one clinical and one operational. Feedback was positive, a few action points to be updated by the Practice by mid-March 2026. Need to update complaints leaflet, and practice leaflet. Their visit is a triangulation approach to check policies against processes and also to speak with staff.

**Staffing Update**

Recruitment - Receptionist vacancies – currently have a long-term sickness and one person previously recruited but can no longer fulfil afternoon shifts due to childcare so re-advertising this role.

**GP Assistant – return from family leave**

GP Assistant has returned from family leave and returned in February 26. This role is both admin and with clinical sessions.

**First Saturday of the Month – GP Doctor**

From 1 January 2026 there is now a GP Doctor available on the first Saturday of the month, including GP Assistant appointments. Whitmore Reans also offer GP doctor appointments.

**Reception Front Window**

Awaiting quote from a local builder for solution such as double-glazed sliding patio style window. Previous builders turned up but did not produce their quotes for the works. Probably too small job for them. Currently ongoing.

**GP New Contract – See Addendum Page 10 for main changes**

Reception teams will no longer be able to ask patients to call back next day if there are no appointments and patients will need to be signposted to a future appointment or advice.

**Integrated Care Hubs**

Previously these were to be assigned to family hubs but this is not possible. across Wolverhampton due to the location split. East Park and Fordhouses will be included in North Network with appointed Clinical Director Dr Rafiq.

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| | Newbridge Surgery is situated in the West hub and Clinical Director is Dr Kam Ahmed. | |
| 7. | **Primary Care Network (PCN) Updates**<br><br>**Smear project in association with Public Health**<br>Additional smear clinics have been set up across the PCN to target a cohort of women who are overdue smears or have not had smears. Transport support is provided for patients if they have difficulty in attending the appointment, especially if is not held at their local practice. Previous information has been provided on a newsletter regarding this.<br><br>ARRS staff – Newbridge Surgery currently have a Pharmacist Technician since December 2025 and looking for this arrangement to be continued.<br><br>Prostate Cancer targets to focus on Black over age of 45 patients and offering them self-book appointments. Previously Newbridge Surgery targeted male groups previously with some positive interventions.<br><br>Fit test – these are given out to patients to complete and return back, but are not always returned so we are looking at a digital alert system to get these returned in.<br><br>Lung Cancer Screening – Sandwell and Walsall looking at those patients who have ever smoked and having a low intensity CT scan and for this to be rolled out across Wolverhampton. | |
| 8. | **Friends and Family Test**<br><br>January 2026 – 97.6% based on 376 responses<br>February 2026 – 95.3% based on 385 responses<br><br>VR went through with the group the main findings and any negative / constructive feedback received. Main findings are currently displayed in front foyer, but PB suggested that we had a ***"you said we did"*** display board | |
| 8. | **Any Other Business** | |
| | CD feedback to say that the Digital Information meeting he was due to attend has been cancelled twice (Sept and Jan) due to lack of support.<br><br>JH asked about fit notes for work and with the recent changes to request these via Accurx and how was this being disseminated to patients who do not have online facilities. It was confirmed if patients were to have difficulty, then this can be requested verbally and this to be included for the next Newsletter. | |
| 9. | **Date and Time of Next Meetings** | |
| | Thursday 7 May 2026 at 4:15 pm<br>Tuesday 7 July 2026 at 4:15 pm<br><br>Meeting closed at 5:40 pm | |

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**Abbreviations used above:**
PPG – Patient Participation Group
PCN – Primary Care Network
ICB – Integrated Care Board
FYI – For your information
ALL – All to action
AGM – Annual General Meeting
EMIS – name of the GP Clinical System

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**ADDENDUM 1a- Summary of 10 year plan for NHS**

The NHS 10-Year Health Plan sets out a long-term overhaul of how health and care will work in England, responding to deep pressures such as long waits, workforce strain, and poor outcomes in key disease areas. At its core, the plan aims to shift the system toward **community-based care**, **digital transformation**, and **prevention**, while restoring access and improving outcomes.

**What the plan is trying to fix**

The plan is built on the findings of Lord Darzi's investigation, which concluded the NHS was in *"critical condition"* due to:

- Difficulty accessing GP and dental appointments.
- Ballooning waiting lists for hospital and community care.
- Demoralised and overstretched staff.
- Outcomes for major killers like cancer lagging behind comparable countries.
- Rising demand from an ageing population.

The plan frames this as an existential moment: without major change, access and outcomes will worsen and more people will turn to private care.

**The three major shifts**

NHS England describes the plan as delivering three system-wide shifts:

- **From hospital to community** — more care delivered at home or locally, reducing pressure on hospitals.
- **From analogue to digital** — technology to reduce admin, improve access, and allow people to manage care online.
- **From sickness to prevention** — earlier intervention, healthier environments, and making "the healthy choice the easy choice."

These shifts are intended to reduce demand on hospitals, shorten waiting times, and improve value for taxpayers.

**Key themes and commitments**

**Community-centred care**

- Expansion of community services to reduce reliance on hospitals.
- More home-based care options, including virtual wards and remote monitoring.

**Digital transformation**

- Modernising NHS IT systems.
- Enabling patients to book, track, and manage care digitally.
- Reducing administrative burden on staff.

**Prevention and population health**

- Tackling risk factors such as smoking, obesity, and inactivity.
- Earlier diagnosis of major diseases, especially cancer and cardiovascular conditions.

**Workforce and culture**

- Addressing staff morale and retention.
- Improving working conditions and reducing bureaucracy.

**Financial sustainability**

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- Delivering high-quality care without consuming an ever-growing share of national wealth.
- Using technology and prevention to reduce long-term costs.

**Wider context and implications**
The plan is seen as a landmark moment for the NHS and the wider health and care system. Analysts note that while the ambitions are welcome, success depends on:

- Adequate long-term funding.
- Major workforce investment.
- Realistic timelines for digital transformation.

Integration with social care, which faces its own severe pressure

Printed off 3.3.26

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**ADDENDUM 1b**

**Overview of 10 Year Plan – Verbal feedback from Dr Pickavance**

Access – looking at other methods such as on-line triage – multiple ways for patients to access appointments, some patients prefer email, accuRx or telephone calls, or face to face. Also providing variety of methods to be used; telephone consultations or video consultations

Contact 111 if difficulty in accessing dentist appointments.

NHS Staff Survey – currently our practice has signed up for this and the deadline for completing it was November 2025 and we are currently awaiting feedback.

Allied Roles Reimbursement Scheme (ARRS) – Currently in 5th or 6th year of this facility whereby Networks are provided money to spend on ARRS staff. First Contact Practitioners, Health Coaches, Social Prescribers, Healthy Ageing Co-ordinator, Cancer Care Co-ordinator, Advanced Nurse Practitioner, Clinical Pharmacists Technicians and Pharmacists who hold cholesterol clinics, currently receptionist staff triage well here and also direct to Pharmacy First schemes for UTI's, ear ache, minor ailment schemes. Community Pharmacists can help with pill checks, and also offer appointments.

Community teams and looking now at the introduction of Integrated Care Hubs; we are situated in the West Hub. Big issues locally are childhood obesity, and diabetes. Obesity and problems with high rate of diabetes and also strokes. Also issues with pregnant ladies who are overweight and then this then turns into childhood obesity. Alcohol interventions available but patients are reluctant to accept some of the interventions. Looking at scans for the liver to see if this has gone stretchy as this is an early indication as opposed to waiting for blood test results.

Integrated Care Hubs currently 4 in Wolverhampton, and we are situated in West Hub. Still scoping out how this will look and they have consulted with certain patient groups, and identified alcohol and isolation and childhood obesity as areas for improvements. Looking at wrap around support from local schools and public health and also housing.

Quality Outcomes Framework (QOF) to look at obesity as population 60% overweight. This will be a step wise approach with high risk groups targeted first.

Digital interventions; utilising systems such as GP Automate for disseminating blood test results, e.g. providing guidance if pre-diabetic and offering such interventions. NHS app availability for patients to see their own results and for patient to follow what is normal for them.

Joy app – introduced to be used as a central referral system for obesity and smoking. Patients can also self refer.

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**ADDENDUM 2**
**Difference in roles for Pharmacist Community v GP Pharmacist as at 3.3.26**

Community pharmacists and general practice pharmacists are both fully qualified pharmacists, but they work in **different settings**, with **different day-to-day responsibilities**, levels of **clinical involvement**, and **types of patient contact**. The distinction is about **scope and environment**, not qualification.

### 🏪 Community pharmacist (high-street / retail pharmacy)

Community pharmacists are the most publicly visible pharmacists. They work in pharmacies such as Boots, Lloyds, Well, or independent chemists.

**What they focus on**

- **Dispensing medicines** safely and accurately.
- **Providing immediate health advice** as the first point of contact for minor illnesses.
- **Running NHS services** such as vaccinations, emergency contraception, smoking cessation, and blood pressure checks.
- **Supporting self-care** and advising on over-the-counter treatments.
- **Identifying medication issues** (interactions, side effects) and referring to GPs when needed.

**Why their role matters**

Community pharmacy is one of the four pillars of primary care and plays a major role in access, prevention, and relieving pressure on GP surgeries.

### 🏥 General practice pharmacist (GP or PCN pharmacist)

General practice pharmacists work **inside GP surgeries or Primary Care Networks (PCNs)** as part of the multidisciplinary clinical team.

**What they focus on**

- **Structured medication reviews** for people with long-term conditions (e.g., diabetes, asthma, heart disease).
- **Optimising complex medicines** and reducing risks such as polypharmacy.
- **Managing long-term conditions** alongside GPs and nurses.
- **Handling medication queries** from patients and clinicians.
- **Supporting prescribing** (many are independent prescribers or training to be).
- **Improving safety and quality** of prescribing across the practice.

**Why their role matters**

They bring specialist medicines expertise directly into general practice, improving safety and freeing GP time. They are regulated and supported to work within their clinical competence.

### 🔍 Key differences at a glance

| Area | Community Pharmacist | General Practice Pharmacist |
|---|---|---|
| **Setting** | High-street pharmacy | GP surgery / PCN |
| **Main focus** | Dispensing, minor illness, public health | Medication reviews, long-term conditions, prescribing support |
| **Patient contact** | Walk-in, immediate advice | Booked clinical appointments |
| **Prescribing** | Usually not a prescriber | Many are independent prescribers or training |

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| Area | Community Pharmacist | General Practice Pharmacist |
|---|---|---|
| **Workload** | Mix of clinical + retail | Primarily clinical and administrative |
| **Role in NHS** | Access, prevention, self-care | Clinical optimisation, safety, reducing GP workload |

🧠 **A useful way to think about it**

- **Community pharmacists** = *front-door access* to healthcare, immediate advice, medicines supply, and prevention.
- **General practice pharmacists** = *clinical medicines specialists* embedded in GP teams, focusing on long-term conditions and safe prescribing.

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## ADDENDUM 3 – Changes to GP Contract from April 2026

The 2025–26 GP Contract brings **one of the largest uplifts in recent years** and gives practices **more staffing flexibility, more funding stability, and a clearer service framework**. This breakdown focuses specifically on **what it means for practices**, drawing on NHS England's contract letter and BMA guidance. 2

### 💷 What the Funding Uplift Means for Practices

The contract delivers a **£969m investment uplift**, including **£889m to core contract funding** and **£80m for e-RS advice and guidance**. For practices, this translates into:

- **More predictable baseline income** after several years of real-terms erosion.
- **Better ability to cover inflationary pressures** (energy, estates, indemnity, staffing).
- **Restoration/uplift of SFE reimbursements**, including sickness and parental leave, which reduces financial risk when staff are absent.

This uplift is widely viewed as a **stabilisation year**, giving practices breathing space before the more prescriptive 2026/27 contract.

### 🧑‍⚕️ Workforce: Major ARRS Changes That Directly Affect Practices

The most practice-impacting reform is the **expansion of ARRS**:

- **GPs and practice nurses added to ARRS**.
- **No caps** on the number of GPs or nurses that can be recruited.
- **Minimum GP salary reimbursement increased** in line with BMA salaried GP pay ranges.

**Why this matters for practices:**

- You can now **recruit core clinical staff directly** using ARRS funding rather than relying solely on PCN-level roles.
- Practices gain **more autonomy** over workforce planning.
- It may help **reduce locum spend** and stabilise continuity of care.
- PCNs may need to rethink workforce distribution, but practices gain more control.

This is arguably the **biggest structural shift** in the contract.

### 🩺 Service Requirements: What Practices Must Deliver

**Pre-referral Advice & Guidance (A&G)**

A new enhanced service pays **£20 per A&G request**. For practices, this means:

- A new income stream tied to clinical activity.
- Potential reduction in unnecessary referrals.
- Need to embed A&G into workflow (templates, coding, clinician training).

**Access & Patient Experience**

While the strict same-day access mandate arrives in 2026/27, NHS England frames 2025/26 as part of a wider access improvement programme. Practices should expect:

- Continued scrutiny of **call handling**, **appointment availability**, and **patient experience**.
- Increasing emphasis on **digital telephony**, **online requests**, and **triage models**.
- Early preparation for 2026/27 requirements (e.g., same-day urgent response).

### 📋 Operational Implications for Practices

**1. Financial Planning**

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- The uplift allows practices to **stabilise budgets** and plan for medium-term staffing.
- Practices may want to **model ARRS-funded GP/nurse roles** to reduce locum reliance.

**2. Workforce Strategy**
- Opportunity to **reshape teams** with more GPs and nurses funded through ARRS.
- Practices may need to coordinate with PCNs to avoid duplication or gaps.

**3. Workflow Redesign**
- Embedding A&G processes.
- Strengthening triage and navigation systems.
- Preparing for future access reporting and same-day response requirements.

**4. PCN Relationships**
- ARRS changes shift power back toward practices.
- PCNs may need to renegotiate workforce plans and governance.

### 📊 How This Contract Positions Practices for 2026/27
The 2026/27 contract introduces:
- **Same-day urgent response requirements**
- **Practice-level access data collection**
- **Repurposing of PCN Capacity & Access Payment to practices**

The 2025/26 contract effectively **lays the groundwork** by:
- Strengthening finances.
- Expanding workforce autonomy.
- Starting the shift toward more consistent access expectations.

### 🧭 Bottom Line for Practices
The 2025–26 GP Contract is a **stabilisation and preparation year**. For practices, the biggest wins are:
- **A major funding uplift** that shores up core income.
- **ARRS reform** that finally allows practices to recruit GPs and nurses directly.
- **A new A&G enhanced service** that rewards clinical work.
- **Restored reimbursements** that reduce financial risk.

It gives practices more control, more flexibility, and more stability—while signalling that **2026/27 will bring more prescriptive access requirements**.

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