YORK MEDICAL PRACTICE PATIENT GROUP MEETING

Tuesday 28th November 2017

Chair: Maggie Ennis

Minute taker: Joyce Jacobs

Present: Richard Bedwell (RB), Nurse Sheila Breen (SB), Eleanor Brunton (EB), Peter Henderson (PH), Paul Leonard (PL), Alan Macmillan (AM), Dr Quentin Parsons (QP),

1 **Apologies**: Penny Alexander (PA), Stephen Alexander, Lauren Hoadley (LH), Glyndwr Whitworth
Sonia Jacks and Katie Anthony have resigned from the Committee

2 **Minutes** of the last meeting: 26th September 2017 - agreed

3 **Matters arising** not included in the Agenda: none

4 **Stress, Anxiety Event**: PA, in her absence was thanked for organising the event which QP would like repeated next year. There were 23 attendees and nine staff and GPs from the Practice.

5 **Carers Event**: After Katie Anthony's departure PL volunteered to take over this event and it will be held at 6pm on Wednesday 28th February. He will contact the Carers Centre in Briar Road to ask for a speaker. PH asked if there was a target group eg young or elderly carers and RB pointed out that carers were well catered for and that an evening event held may be difficult for some carers. EB said the event would be a way of meeting others in a familiar location and it may identify people who are carers but do not know about all the help which is available. Lauren Hoadley will put the event on the website and will email people on the mailing list.
Action: LH to put on the website and email. PL to report in January.

6 **Accessibility working group** report. ME said she wanted to know how the Practice dealt with people who had varying disabilities. PA had circulated the report which is below with LH's response in red. EB pointed out that codes are common throughout the NHS system but when a new patient enrols onto the YMP books they are asked to complete a form with their details and requirements. This is usually all the Practice has to go on as it can take up to a year for the patient records to arrive from their previous Practice.
AM wanted to know about patient mobility and if there is a code showing the patient may not be able to get to the surgery. QP said that housebound people are coded as

such on their record. If the Patient is intermittently housebound the NHS leaves it up to the Practice to decide how to deal with such patients. QP confirmed to RB that the Practice differentiates between housebound and bed-bound patients and that clinicians see the patient's codes before any other record. New patients' notes are standardised to the Practice notes and audited by Dr Watts.
Action: ME, PA and JJ to follow up LH's comments

7 **Complaints** – There have been eight in total from April to 28th November. Of these five were medical complaints, one was about the telephone system but was not followed up and two were feedback about the text messaging system*. EB said that complaints will be made verbally or in writing and the Practice will ask patients who make a serious complaint verbally to put it in writing. QP mentioned that a complaint against an individual in the Practice had gone as far as the Ombudsman but was rejected in every aspect. Nevertheless it was a very stressful couple of years for the Practice individual concerned. RB pointed out that the number of complaints was tiny in relation to the number of patient appointments and patients on the Practice books.

* EB had emailed ME while ME was on holiday about a small survey about the text-messaging reminder system. It was to seek the views of the PG and the Interest Group.
Action: ME said she would forward the email to the PG.

8 **YMP patients' survey:** This was initiated by the CCG and ME as a representative on the PCCC, had seen the results for all Richmond GP Practices. YMP were at top of some categories and low in others yet this was with a score of the 94% (national average 97%). 288 questionnaires had been sent out and only 97 had responded. It was felt that the sample was too small and the number of possible answers – 3 – to each question did not allow for a more subtle response than if the number of possible answers had been higher, eg10
The results of this survey can be seen at:
HTTPS:/GP-patient. co.uk/surveysandreports

9 **AOB:** PL raised the question of the NHS opt-out which will allow patients chose if their data is for their individual care and treatment or shared for research and planning purposes. Patients will be able to state their opt-out preferences by March 2018. ME suggested this item should go onto the January agenda.
Action: JJ to add to January agenda with clarification from YMP staff
PH raised the problem of too many and confusing notices in the waiting room, particularly by the check-in machine. EB said she would deal with them.

QP asked if the members of the PG thought the YMP staff and GPs should wear name badges. The comments were in agreement as follows -

- more personal so a patient will know who they are dealing with
- the patient will know who to complain about if anything goes wrong
- they help to put a face to a name
- no badge implies the member of staff wants to be anonymous if anything goes wrong.

Patient Group Matters.

1. Sonia Jacks had left the PG and the Practice so there was no-one now to look after volunteers for the Core group and the Interest Group. The Interest Group had not been contacted for many months and there was a debate about whether we need an Interest Group. But EB had suggested that the Interest Group could be invited to comment on the text- messaging survey. (See item 7 above)
2. ME said she would contact the patient who had volunteered to serve on the Core Group as Sonia Jacks had resigned.
3. ME was disappointed that there had been no contact from St Mary's University and would go there and try to make an appointment to speak to the new President of the Students' Union (Conal)
4. ME said she now wanted to relinquish the chair of the PG and PH volunteered in her place. He will take the chair in January
5. The group memory had failed about the problem with the Terms of Reference

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See item 6 above

Taken from: - ***Accessibility Information Standard 6.2, 5 Steps (page 15 NHS Guidance on Accessibility 2015)***

1. ASK:- Identify/find out if an individual has any communication needs relating to a disability and if so what they are. Find out how to meet those needs. *Upon registration patients are asked to provide us with any relevant medical history or anything we should be aware of. This information is then recorded in the patients' notes and where applicable coded as priority 1 in the patients' notes.*

2. RECORD :- record these needs in a clear, unambiguous and standardised way in electronic and / or paper based record / administrative systems / documents.*These are recorded electronically into the Clinical System. These are unambiguous as the system provides standardised read codes. Anything with a high priority is marked as Priority 1 and appears in a patient's filtered screen.*

3. ALERT / flag / highlight. Ensure recorded needs are "highly visible" whenever the individual's record is accessed and prompt for action. *As above*

4. SHARE :- include information about individual's information/communication needs as part of existing data sharing processes (and in line with existing information governance frameworks) *Relevant information is shared amongst practice and other healthcare individuals such as district nurses as part of weekly MDT Meetings.*

5. ACT :- take steps to ensure that individuals receive information which they can access, understand and receive communication support if they need it. *We have a many ways in which we manage this as a practice. Larger font leaflets, a learning disability register, access to language line for those that cannot speak English, ground floor access with doorways wide enough for wheelchair access, a housebound register for those patients unable to get into the practice. As well as the above mentioned points 1-4.*

See Pages 14, 15, 17and 18 of the document: - Identifying Needs

Suggestions from the PPG sub group:-

1. The Practice needs to ensure that all staff identify and highlight **any** difficulty a patient has, including problems with mobility – suggestions as to how we highlight this other than via the electronic record? We do not use paper notes so other than electronically I'm not sure how we would do this?

2. The website should describe a pathway for patients with physical, communication or mental health needs and how they inform the practice of these needs. – I will write something and email to the PPG for Feedback before I add to the website. I've looked on other practices websites and cannot find anything similar, have the PPG seen this elsewhere so that I can take an example?

3. Should there be a named person in the practice to lead on, take responsibility for and monitor accessibility targets? What targets are being referred to? Can this be expanded on?

4. IT Computer software should allow entry of patient needs regarding accessibility that all staff can access - Vision already does this.