**YORK MEDICAL PRACTICE PATIENT GROUP MEETING**

**Tuesday 29th March 2022**

**1pm via Teams**

Chair: Peter Henderson

Minute-taker: Joyce Jacobs

**PRESENT:** Penny Alexander (PA), Stephen Alexander (SA), Richard Bedwell (RB), Maggie Ennis (ME), Gillian Gibbs (GG), Margaret Hewitt (MH), Dr Chris Watts (CW)

1 **Apologies:** Paul Leonard.

2 **Minutes** **of the last meeting 25th January 2022**: Agreed

3 **Matters arising:** *GG to report YMP copies of anti-viral jab letters for vulnerable patients:* GG and CW said that the Practice had no information yet about how the fourth jabs were to be delivered. The campaign is run by NHS England who only provide Practices with information if their input is required. As far as patients were concerned they could either take the initiative themselves and book online or by phone. Alternatively, they could wait to be contacted, but not yet, if at all, by the Surgeries.

*PH circulation of form of Terms of Reference for GG to put on the website:* PH thanked GG for putting the agreed TofR on the website.

*GG GP’s response to recruiting to the PG:* GG reported that she had asked the Doctors to mention to patients who they thought might be interested and this is ongoing. PH said we, PG was unaware of any applications to join the PG. ME suggested that the medical staff could have a slip of paper that could be given to patients who may be interested. CW said he thought the Practice website was probably the first port of call for younger, more motivated people. PH suggested that the PG should concentrate more on the nurses who deal with groups like eg the INR or baby clinics. SA suggested the PG should design the slip and CW agreed that the Clinical Staff would distribute it.

**Action**: SA to put together a form of words for the slip.

**4 NAPP and recruitment to PG***: This was dealt with in PG items at the end of the meeting – see below.*

**5 Prescription re-ordering by batch or repeat:** SA said he found the current system of batch and repeat prescriptions incomprehensible. He had tried to find out how the system is supposed to work but had found that the NHS website unhelpful. EMIS who run the system claimed they could do nothing about it. He said he would continue trying to find out more about how the system is supposed to work. But his view now was that the burden of running the system was now with pharmacists who, from his own experience, are overwhelmed by it.

**Action:** SA to report to next meeting.

6 **Complaints and compliments:** GG reported that since the last meeting there have been three new complaints which were reviewed by the Partners who found that two were valid but they showed no trends. As far as compliments there have been a couple of good Google reviews bringing the score up to 4.1. There was also a complimentary email about one of the Registrars. PH asked about the waiting times at the moment. GG said the Practice was still providing face-to-face appointments. CW said the waiting time for a routine appointment was about ten days which was substantially better than the national average. He said he thought the Practice was 20-30% busier now that it was two years ago before the pandemic. He also said the Practice provides a large number of on-the-day appointments and that if you have a sick child you could very likely be seen within an hour. The knock-on effect is that the Practice cannot offer the same access to more routine appointments. 15.16 PH said that the PG should congratulate and thank the YMP for what they are achieving. MH said that some correspondence in *The Times* newspaper had highlighted how in some areas the access to GPs was very difficult. PH asked if Dr Elgey was to be replaced and CW said that Dr Lambert was to become a partner from 1st April. This means there will be four Partners and one of the other doctors is working an extra day. The list of patients is still increasing as people realise that patients have good access to GPs, which can create its own problems. The matter will be reviewed in the summer when the trainee doctors finish their training and are replaced by others.

**7 AOB**: CW said that SA’s comments about the problems with prescription ordering was one the Practice was aware of. There will be a Practice meeting at the end of April to review the problem, with the Pharmacists and try to streamline the process. One confusing aspect was the definition of ‘repeat dispensing’ and repeat JJ asked if SA could sit in on the review to participate from the Patients’ point of view. CW’s view was it would be better to have the meeting and then summarise the outcome to be discussed at the next PG meeting. PH asked about synchronising prescription updates with Patients’ annual check-up (blood pressure, blood test etc) which is linked to the Patient’s birth month. CW said this had been the intention before the pandemic and had to be put on hold but from 1st April it will start up again. PH suggested this might be a subject for the March Newsletter but JJ said there was now no room. CW said one of the things worth thinking about was the definition of repeat prescriptions and repeat dispensing. They are subtly different and cause a lot of confusion. With a repeat prescription the GP expects the patient to take the medication for a defined period of time, usually three or six months, sometimes 12 depending when the GP wants to see the Patient again. The prescription cannot then be re-issued until it has been reviewed by a GP. Batch prescriptions are usually issued for a year when it is clear the dose is not going to change.

Repeat dispensing is for items which generally do not change, eg eye drops. For conditions that do not require frequent monitoring. The difference between repeat prescriptions and repeat dispensing depends on how often the GP wishes to check the patient and the GPs need to make it clear which medication goes on which system. PH said the problem for patients is understanding which of their medication is on which system and who are likely to have medications which fall into both categories and when the patient needs to take action. SA asked CW if a representative from EMIS or Patient Access was going to be at the meeting? He said there was not enough information for patients on the NHS app or the EMIS website about which category their drugs fall into. *(The communication with CW and GG froze several times and kept on freezing and at this stage froze for many minutes.)*

CW said it would be useful the next time we meet if we could log in to one of our EMIS pages. SA said he was happy to give his log-in details to GG so the GPs at their meeting could see what the patient sees. CW said, that the next PG meeting, one of us should log in so we can see exactly what the information says in real time.

**Action:** SA to provide his Patient Access log-in details to GG

During the break in transmission RB wondered when the PG meetings would be held in person again PH said that we could meet in person again of there was a room of sufficient size with ventilation but the meeting room at the Practice was probably not big enough. The waiting room, though large, was not suitable during working hours and using it after hours was not on.

The consensus was that we should try to get back to normal and the usual meeting room would be suitable with the windows open. PA suggested asking GG a couple of weeks before the next meeting if the Practice was happy to allow us back into the meeting room.

**Action:** JJ to ask GG about venue/Teams for May’s PG Meeting

ME said she wanted to draw people’s attention to GG’s recent email which asked us to have a look at the updated New Patient’s Registration pack and the updated section on Health Awareness/Screening. Comments by email to GG would be appreciated.

GG said that ME had asked for the number of Covid vaccines as a percentage of eligible patients. Up to now 97% of eligible patients have had two vaccines, and 85% have had their booster jab.

PA said she had had an email from Caroline O’Neill (CO) at the CCG to ask what her and ME’s views were about the value of the CCGPPG and its future. PA said she would circulate her and ME’s comments if anyone wanted to add anything.

**Action:** PA and ME to circulate to the PG their views before responding to CO by 5th April

PH asked GG how communication within the PCN was going and we, the PG, had not had any communication with the other Practices’ PGs because of Covid. GG said that things were getting going again and there were a few plans now moving forward with the other Practices in the PCN. PH asked if there needed to be some publicity so patients could know what was going on? CW said the discussions were more to do with Management and employment issues. A proposal was to have Social Prescribers, Pharmacists and mental health workers and these have now been recruited and are being employed across the PCN. There are plans to provide weekend access at a PCN level which could be in place from October but it is not yet clear how it is going to happen.

JJ asked about the number of hits per month on YMP website. GG said she would find the number.

**Action:** GG to provide the number at the May PG meeting.

ME said that at the previous meeting she would look at the notice board in the entrance hall. She was waiting for the March newsletter and would require two A3-size pages. She would re-organise the notice board after Easter. MH sad that when she last looked at it was looking very sad and faded. She was not sure what could be done to liven it up. ME invited MH to help change/improve the notice board when it is done. ME said she would send a couple of dates to MH when she (ME) might be going.

SA reported that RB who had to leave the meeting wanted to emphasise, on behalf of the housebound, how difficult the batch/repeat prescription system is to understand.

MH said there had been a lot of correspondence in the newspaper about patients being allocated GPs and this meant that diagnosis would be easier and more accurate with continuity. But Practices have been told that are not allowed to do this anymore. But generally, she sees the GP she wants to see. SA said that if a patient is over 75 they can have an allocated GP but the patient can’t expect to see the GP anytime they have an appointment. PH said that it is always possible to see the same doctor but it would probably be necessary to wait two or three weeks to do so. Groups of appointments are not set aside for GPs to see their allocated patients. On the other hand certain GPs have specialised interests and skills. ME pointed out that many GPs are now working part-time making it even more difficult to see an allocated GP. If a patient is at a Practice with a sole practitioner then they would get continuity. JJ said that having asthma she sees the Nurse Whitworth from time to time and if she had a problem she would talk to CW, the GP whose speciality is respiratory disease. PA said the problems arose when patients have complex problems, need to see a GP, but not urgently and they may have to wait longer for an appointment.

**PG Items:** ME reported that in an NAPP bulletin (171 January) it stated that it was the Practices’ responsibility and had to be involved in finding new patients for Patient Groups. However, the PG felt there was some reluctance on the Practice’s part to get involved. ME felt the reluctance was to do with time and that is why a slip was a good idea. MH suggested the best place to distribute the slips were the specialist clinics.

**Date of next meeting:** Tuesday 24th May