Glossop and Hadfield

Patient Participation Group

Patient Participation Group Meeting

Tuesday 13th October 2020 1p.m

Virtual, Via Microsoft Teams

Present: WA (Chair), JA, GA, IE, CE, JO, VM, LA, PP, LB, Dr LD, SS

Apologies: HB, ZH

Welcome: WA welcomed all to the first virtual formal meeting.

1. Minutes: None: due to Covid, last formal meeting held in Jan 2020. Current agenda supersedes issues from that.

2. Matters Arising: See above.

3. Update from Surgery (LD and paper from Dr ZH)

i) LD outlined the transformation of service required because of the Covid pandemic; the changes have been significant and will need to remain in place for the foreseeable future. Initially, the surgery building became very quiet although the levels of activity, carried out remotely in large part, were high and have continued at a level that is perhaps the busiest it has been. There have been quite high sickness levels among staff, not all Covid related but with an impact upon the service. At first, only the most unwell patients were seen but currently, almost all services are running with the exceptions of aerosol generated procedures (those requiring the expelling of air by patients)foot checks for diabetic patients (other routine diabetic checks are in place) and routine blood tests that can safely be postponed.

ii) LD described the problems of Covid symptoms in which SATS (Oxygen saturation) levels can drop dramatically without a sense of intense illness by the patient; a portable SATS testing machine in the car park enabled a number of ill patients to be thus screened and appropriately treated.

iii) Currently, the flu vaccination programme is almost complete and further stocks of the vaccine are due. There was agreement that the programme had worked well, although there had been concerns that parking at the Glossop surgery was not possible and this could leave disabled patients in difficulty. LD said that provisions were made to vaccinate disabled patients in their cars and housebound patients at home.

iv) There remain the difficulties associated with the extra time required for F2F (face to face) appointments: i.e. standard blood tests previously took 3 minutes; they now take 20, as cleaning has to be thorough between each contact.

v) LD reported the use of Facebook by the surgery for cascading information; several PPG members commented that this was not universally used and thus had its limitations as a conduit for information. WA has been collating relevant Facebook posts and forwarding to VM for distribution to the PPG as it is considered that they do need to be aware of information posted..

vi) VM asked about the potential use of the large waiting room during winter months and ZH's reference to a traffic lights system in his paper; LD discussed the five-stage protocol that currently governs how services are delivered: stages are adopted in response to the levels of the risk. In March, it was level 5; it is now 2A and a move to stage 1 is unlikely until an effective vaccine is available. Discussions about the stages are continuous. Currently, there is discussion about outside waiting during the coming winter months and what might be safely put into place; the concerns around providing safety within the large waiting room (the level and frequency of cleaning required) make it an unlikely prospect. LD commented that some of the changes adopted because of Covid may well remain if/when the situation improves, e.g: asking patients with flu/colds to wait in their cars until their appointments, rather than in the waiting rooms with other, non-affected patients.

vii) WA asked if the protocol is national or locally decided: LD said that Public Health England provide national guidance but surgeries are not legally bound to follow this. They are required to provide care, but it is up to them to decide how they will do so. An example has been PPE (Personal Protection Equipment) where the surgery considered PHE's guidance insufficient. There was considerable support by patients and the public with donations of masks, visors, protective suits and the current position is adequate. The only exception is the PPE needed for aerosol-generated procedures which carry risks for the clinician.

viii) IE asked about the amount of time wasted for clinicians when patients are unavailable for booked telephone consults; is there anything that the PPG can do to support staff? LD explained the process, of 3 attempts to reach a patient and offering 1-2 hour slot rather than a broader morning or afternoon time only. JA wondered if patients could be asked to nominate another contact in case of non-response as a way of reducing concerns over missed consults. LD agreed to consider this as the demand has increased markedly and it is, theoretically, relatively easy to take a call via a mobile, not having to rely on being at a fixed point. There was some discussion that a greater use of telephone consults would be a permanent result of Covid.

ix) IE also asked how patients are triaged for F2F appointments; LD said that this is only done by the GPs, reception staff do not do this. F2F is used within strict parameters with an understanding that the GP who books the appointment in is the same one to see the patient. There is some use of virtual appointments, but not all patients have either the IT or are willing to use it.

x) JA asked about medical records and the disappearance from patients' online records of hospital letters and some consultations. Both LD and LB explained that this is not a Manor House issue but a wider one following from a discovery that documents were being dropped into patients' notes for them to access before the surgery had seen the contents. This had led to some patients discovering upsetting information/serious diagnoses without a consultation. The issue is one between EMIS and Docman (IT systems) which Manor House does not control. There was discussion on the need for this to be resolved, with some urgency. In the interim, patients can contact reception to ask for copies of letters to be sent; LD asked if these requests could be emailed, to limit the demands on the telephone

system. It was noted that reception staff had responded positively when asked to provide documentation that was currently missing from the online records.

xi) IE asked if the surgery knew what patients' views were on the new telephone system, particularly if they are informed there are numerous calls waiting ahead of them. PPG members have experienced being up to number 30 in the queue. LD thought the waiting times were not so severe and that a major advantage was that patients did not get the engaged tone but took their place in the queue. It was agreed that the time spent in a queue could not be predicted, whatever the number given. LD said that time of day could affect call volume, with 12 p.m and between 5-6 p.m. generally being less busy. The average number of calls per day is up to 1,000, with September having 17,957 calls and an average waiting time of 4m 18 seconds. The average length of a call is approximately 2 minutes.

xii) LD reported some issues with a small minority of patients refusing to wear masks this presents difficulties in terms of the duty of care required; there are continuing discussions on how best to manage the risks that this poses. It is considered that there are very few valid reasons for refusing to wear a mask.

xiii) LD reported that the shielding process had worked very badly: surgeries were not consulted by government in terms of appropriate patients, criteria for shielding was not published, some were told to shield who did not need to and others who should have done so were not informed.

xiv) LD said that there are significant concerns about the coming winter: the normal increase in coughs, colds and winter bugs has begun with the ensuing difficulties of distinguishing these from Covid. The workload is therefore likely to increase considerably. Staff are committed to attending PPG meetings as usual, but it may be necessary to implement alternative measures if there are high sickness rates.

Action: It was agreed that, if issues arise in informal PPG meetings, VM will send such to LD/LB prior to any formal meeting.

4. Dates for 2021 Meetings:

All meetings will continue as Virtual Meetings for the foreseeable future.

Informal Meetings 2 p.m on Tuesdays	Formal Meetings 1p.m on Mondays:
12th January	9th February
9th March	13th April
11th May	8th June
13th July	
12th October	14th September
14th December	9th November

As usual, there is no meeting planned for August.

Next Meeting:

Informal: Tuesday 27th October, 2 p.m via Microsoft Teams.

Formal: Tuesday 3rd November 2020, 1p.m via Microsoft Teams.