

# Painswick Patient Participation Group – Full Meeting

5.00 – 7.00pm Tuesday 12th May 2026 at the Surgery

## Attendance

*PPG members present: David Perry (DP) – Chair, Brian Painting (BP), John Finney (JF), David Gration (DG), Peter Morse (PM), Jo Richardson (JR), Neena Buntwal (NB), Veronika Duffield-Valeckova (VDV), Liz Taylor (LT) – new member*

*Apologies: Ron Sparrow (RS), Bill Summerskill (BS)*

*Practice staff: Jenny Vallely (JV) – Practice Manager*

*Visiting speakers: Adis Kikic – Painswick Pharmacy; Alex Oprea – PCN Clinical Pharmacist*

## Welcome

DP welcomed new member Liz Taylor to the group. One vacancy remains on the PPG.

### 1. Outcomes of Patient-Only Meeting, 10th March (DP)

DP noted that a report on the patient-only meeting had been circulated in advance. The meeting was run informally to allow members unfamiliar with NHS structures and terminology to raise questions and clarify areas of uncertainty.

### 2. Report from Senior Partner, Dr Rhys Evans (RE)

Dr Evans was unable to attend due to clinical commitments. This item is carried forward to the next meeting.

### 3. Responses to the Digital Presentation – Last Meeting

#### **3a. Should we provide support for using the Practice website? Is there a need?**

JV explained that the Practice website is kept deliberately simple. Most web-based forms have been switched off to avoid creating multiple parallel portals for reception staff to monitor. eConsult remains the single online consultation route. The two forms retained are: Join the PPG, and Friends and Family.

JV confirmed that the PPG minutes are accessible on the website. DP noted that the 'About the Practice' section matters for the public-facing identity of the surgery.

BP asked whether there were any website functions currently disabled that might be useful. JV agreed to review the available options and report back.

**ACTION – JV:** Review the Practice website's available forms/functions and report back on anything potentially useful to patients.

#### **3b. Current situation with eConsult and S1-Connect**

JV clarified that the Practice uses SystemOne (S1) as its clinical database – all patient records, blood results, referrals, and secondary care documents are held there.

On S1-Connect: JV was not aware of the specific product referenced in the previous meeting and would seek to find out what had been meant. She noted that there are numerous commercial add-ons to SystemOne, and BP observed this was likely a feed between eConsult and SystemOne or similar.

**ACTION – JV:** Establish what 'S1-Connect' referred to in the previous digital presentation and report back.

BP shared data from publicly available NHS eConsult statistics (compiled by GP digital analyst Anne-Marie Cunningham, recently elected Digital Lead of the RCGP). Key findings for this practice in February 2026:

- 333 online consultations generated – 71.8 per 1,000 patients vs. national average of 68
- Approximately one third of all incoming consultations arrive via eConsult
- Only 3% of consultations arrived via the NHS App – the remainder came through eConsult directly
- Patient satisfaction with online consultation is notably above the national average, despite above-average usage – an outlier in the dataset

BP noted the data can be sliced by age group, deprivation index, and individual practice, making it a useful planning tool. The group discussed whether there is visibility on how many patients start but do not complete an eConsult. JV confirmed the phone system tracks call abandonment reliably; eConsult data is available from the supplier but was not to hand.

**ACTION –**

**JV:** Obtain eConsult drop-off/abandonment data from the supplier for the group's information.

**BP:** Share dataset and Anne-Marie's blog

### **3c. Current situation with repeat prescriptions**

JV confirmed that repeat prescriptions via the NHS App are working well and represent a significant proportion of requests. The system now prompts patients when a medication requires clinical review before issue, and indicates when a medication cannot be ordered until a given date – both improvements on previous versions noted by VDV.

One member noted a GP had telephoned expecting a reply to a text message that had not yet arrived – a reminder that message delivery times are not guaranteed and cannot be tracked from the Practice end.

JV noted that the transition to digital ordering had displaced one patient's habitual walk to the surgery and pharmacy as a form of exercise – a small but human example of unintended consequences.

### **3d. How useful is JUYI (Join Up Your Information)?**

Brief discussion confirmed JUYI is valued locally and likely to continue until a single patient record is in place nationally. It does not currently include hospital discharge summaries. JV confirmed it is functioning as intended for Gloucestershire.

### **3e. Use of dialogue rather than one-way transmission by the Practice**

DP noted this is a topic widely covered in the health IT press: moving from the Practice sending information to patients, towards genuine two-way digital dialogue. The group discussed how AccuRx text messages now allow patients to reply, and that exchanges are visible in the NHS App. BP confirmed this from personal experience – a test result prompt with a booking link had produced a seamless, efficient pathway.

The group acknowledged constraints: clinical staff need time to monitor incoming replies, not all exchanges are time-critical, and the GP appointment system itself can be a downstream bottleneck. BP cautioned against uncritical enthusiasm for dialogue tools, noting the risk of adding to already pressured workloads. VDV raised particular considerations for older patients, whose responses may be less structured or clinically focused.

DP suggested the group keep this theme in view when reading coverage of NHS digital strategy.

### **3f. Ambient scribing – is this the right time?**

DP introduced the topic. Ambient scribing refers to AI-assisted real-time recording of GP consultations that generates an automatic summary note, allowing the GP to maintain eye contact with the patient rather than typing. JV confirmed practices are increasingly adopting it.

BP distinguished two variants:

- Transcription and summarisation: records and summarises the consultation – directly analogous to a meeting transcription tool. Requires standard data governance checks.
- Diagnostic prompting: listens to the consultation and prompts the GP ('you might want to consider X'). This requires a medical device licence and a more substantial governance process, including Data Privacy Impact Assessments. Patients can opt out of either.

The group noted significant benefits: GPs are freed to look at patients, consultation stress is reduced, and the record is more accurate. JV noted from GP forum experience that the technology has advanced markedly and that clinicians are enthusiastic. The group agreed it would be a positive development for this practice and that the timing question is primarily one of readiness and resourcing.

### **3g. Some other insights into the national picture (BP)**

BP shared the analysis of eConsult data described under 3b above. He also contextualised the broader NHS data architecture discussion prompted by questions in the room:

- The NHS Spine acts as an index of patient registrations – records are held at practice level, not on the Spine itself.
- Secondary care systems are separate from GP systems. The NHS 10-Year Plan proposes a federated data platform that would create a single longitudinal record for each patient across all care settings.
- Palantir holds the current contract to operate this federated data platform (the FDP). Members noted that GP records being added to the FDP increases the data held under that contract – a point BP noted is directly relevant to Vitanium's positioning on data sovereignty.
- Interoperability between secondary care trusts, and between primary and secondary care, remains largely unresolved despite decades of NHS digital strategy.
- The summary care record is the nearest current approximation to a unified record, but is limited in scope and access.

DP noted he had monitored NHS IT strategy as far back as the late 1980s, and that the aspiration for a unified record predates that.

## **4. NHS App and Other Digital Support Developments (NB & DP)**

### **4a. April library session**

NB reported that the April library session for NHS App support attracted a small number of attendees – approximately two per member present. Four PPG members were active helpers (RS and PM among them). Practical learning was taking place: NB had brought a soft-tipped stylus pen which proved valuable for a patient whose hand tremor made screen-pressing difficult.

NB confirmed that liaison is ongoing with two commissioned digital support organisations – one funded by the National Lottery Community Fund and Gloucestershire County Council and one through a combination of GCC and NHS funding. The two organisations are mutually exclusive for funding purposes.

NB and DP noted that following Painswick's success in the Village of the Year assessment (digital support identified as the one area for improvement), the Parish Council is expected to take a lead on commissioning broader digital literacy support for the village. A report recommending which of the two digital support bodies to pursue has been submitted and is on the agenda for the Parish Council meeting later this month.

**ACTION – NB/DP:** Report back to the group following the Parish Council decision on digital support commissioning.

#### **4b. Richmond developments (DG)**

DG reported progress in engaging residents at Richmond with the NHS App. An opportunity has arisen to speak collectively to a larger group of residents before a planned PPG/digital support visit, enabling DG to build interest and buy-in in advance. Early indications suggest this approach will be well-received and is expected to increase uptake significantly when the session takes place.

**ACTION – DG:** Keep the group updated on progress at Richmond, including the outcome of the pre-session engagement and subsequent NHS App take-up.

### **5. Practice Manager's Report (JV)**

#### **5a. Covid vaccinations**

JV confirmed that the spring Covid vaccination programme is now complete – the vaccines have reached their expiry date. All patients wishing to be vaccinated have been seen. JV noted she did not have the final uptake figures to hand but would circulate them. DP observed that take-up appears to have declined compared to previous rounds, consistent with a national trend of increasing complacency. The logistics of the sessions were praised as slick – patients typically processed very quickly.

**ACTION – JV:** Circulate final Covid vaccination uptake figures to the group.

#### **5b. Impacts of ICB reorganisation into the regional cluster**

JV reported no significant operational impact on the Practice to date from the integration of NHS Gloucestershire ICB into the regional cluster. BP noted that the last meeting of the ICB patient engagement steering group (which he attends) is on the following Monday – a casualty of the engagement team cuts accompanying the reorganisation.

**Action:**

**BP** to report on Steering Group at next session

#### **5c. Other matters**

**Nursing team:** One nurse is currently on leave. The remaining nurses and Alice (healthcare assistant/phlebotomy) are covering, with temporary cover proving difficult to source for practice nursing. The Practice is prioritising urgent clinical needs – urgent bloods, dressings, and ECGs – and hopes to resolve the gap by early June.

**Reception/admin:** A recently recruited receptionist found the pace of the role unsuitable and has left. A replacement has been recruited from within general practice and is due to start within two weeks. DP and others noted the reception team remains cheerful and helpful. JV

confirmed there have been no serious abuse incidents since the last meeting, though two members of staff received unpleasant responses from patients during routine calls.

Edward Jenner Unit: VDV raised a case where her son (who is autistic) was initially refused a GP-requested blood test at the Edward Jenner Unit and was only accepted once his autism was disclosed. JV noted the Practice would not routinely send patients there and acknowledged the unit's acceptance criteria for GP requests have been variable. The issue is not currently impacting the Practice significantly.

Blood test processing: BP noted that blood test turnaround from the Practice remains impressive, with results often returning the same day. JV confirmed the laboratory van collects at lunchtime and late afternoon.

## 6. Pharmacy Developments

### **6a. Painswick Pharmacy – Adis Kikic**

Adis Kikic (AK) provided an update on developments at Painswick Pharmacy. He noted that the traditional role of pharmacists has evolved significantly beyond dispensing: computer-assisted checking has freed time for patient-facing services, though staffing and funding have not kept pace with the expanded scope.

Pharmacy First: AK outlined the seven conditions currently treatable at pharmacy under Pharmacy First:

- Infected insect bites (all ages)
- Acute otitis media (ear infection) – children 1–17
- Impetigo (skin infection)
- Shingles – adults
- Sinusitis – adults
- Sore throat – adults
- Uncomplicated urinary tract infection (UTI) – women aged 16–64 only

AK noted that awareness of the eligibility criteria among patients remains patchy. Advertising has been primarily online and largely left to individual pharmacies. He highlighted the UTI age restriction (16–64) as a particular source of confusion and frustration for patients. VDV recounted witnessing a confrontation at another pharmacy where neither the pharmacist nor the patient could adequately explain why a 22 year old woman with an ear infection could not be seen (in that case the limit was 18 for otitis media).

BP suggested the Painswick Beacon and the PPG's email bulletin might carry a clear, accessible guide to Pharmacy First eligibility – what you can and cannot go to the pharmacy for, in plain language. DP agreed to include this in the next Beacon contribution, noting space constraints may require it to be covered across more than one issue.

**ACTION – DP/BP:** Draft a clear guide to Pharmacy First eligibility conditions and restrictions for inclusion in The Beacon and the PPG email bulletin.

Prescription supply shortages: AK noted that sourcing certain medicines is an ongoing and worsening issue, adding approximately two hours per day to pharmacy workload. Rationing of stock is sometimes necessary. He works to resolve shortages without referring back to the GP wherever possible, but some drug substitutions require GP involvement.

Deliveries: The pharmacy delivers approximately 15% of prescriptions, currently free of charge. AK noted this is not sustainable long-term for rural pharmacies; a comparable pharmacy he is associated with in Devon has introduced a delivery charge.

Staffing: AK is currently the sole pharmacist at Painswick. A second pharmacist left some years ago and has not been replaced. Each Pharmacy First service requires specific training, which he has completed. The group noted the same systemic pressures facing GP practices apply equally to community pharmacy.

## **6b. PCN Clinical Pharmacist – Alex Oprea**

Alex Oprea (AO) introduced himself as the Clinical Pharmacist based across the Primary Care Network (PCN) of five practices, employed through the PCN Additional Roles Reimbursement Scheme (ARRS). His clinical specialisms are respiratory (particularly asthma management) and cardiovascular prevention.

Core activities:

- Asthma reviews and inhaler management
- Medicine supply shortages – finding alternatives when a prescribed product is unavailable
- Protocol review and CQC compliance work with JV
- Care home medicines optimisation – a recently completed six-month project with Resthaven care home and their associated pharmacy, improving communication across three sites and reducing medicines waste
- Discharge summary review – clinical letters and hospital discharge summaries are allocated to the pharmacy team; AO noted a gap of days or weeks can occur between patient discharge and receipt of the summary at the practice

The group discussed polypharmacy – the accumulation of multiple medications prescribed at different times for different conditions. AO confirmed this is actively managed, with frail or high-risk patients prioritised for structured medication reviews. The ICB provides guidance on which patient groups should be prioritised.

BP raised the issue of antimicrobial resistance and whether patients failing to complete antibiotic courses is being addressed. AO noted the ICB antimicrobial stewardship team provides prescribing guidelines. JV acknowledged the difficulty GPs face in convincing patients that antibiotics are not needed for viral infections. VDV suggested point-of-care CRP testing (a finger-prick test used routinely in some European countries to distinguish bacterial from viral infection) as a potentially useful tool. JV confirmed this has been piloted in the UK but is not widely funded.

BP proposed that the PPG has a role in public health education on antibiotic use, and that this might be a topic for The Beacon or the email bulletin. The group agreed this should be developed with clinical input to ensure accuracy.

Face-to-face appointments: JV explained that AO has largely moved away from face-to-face clinics to maximise the number of patient contacts he can support, given the clinical model difference between pharmacist and GP consultations (pharmacists typically take longer per patient). He has covered some face-to-face sessions while a nurse is absent.

Social prescribing: JV noted that social prescribers have been reduced from three to one across the five-practice PCN, and referrals have been paused pending recruitment. AO does not currently have a significant social prescribing role. The group discussed whether the PPG might usefully publish information about social prescribing to improve patient awareness.

DP thanked both Adis Kikic and Alex Oprea for giving their time outside their working hours.

## **Close**

DP closed the meeting. A brief report will be prepared rapidly for inclusion in the May Beacon.

*Date of next meeting: to be agreed and circulated*