

Minutes of the KEY Patient Participation Group Meeting

Thursday 8th January 2026 at 7.00pm at Yarnton

Attendees

MC – Chair/patient (K)

JH – Vice chair/patient (Y)

CR – Treasurer/patient (K)

AC – Secretary/patient (K)

MJ – Patient (K)

AK – Patient (Y)

TS – Patient (K)

AnP – Patient (K)

SL – Patient (Y)

RR – Patient (Y)

Kathryn Muddle (KM) – Practice Manager

George Thomas - PML (K) – Kidlington Surgery (Y) – Yarnton Surgery

1. Welcome and Apologies

MC welcomed everyone to the meeting

No apologies received.

2. Minutes from previous meeting

a) Accuracy of minutes

Minutes from previous PPG meeting were agreed.

The minutes from the Extraordinary Meeting from 19th November were modified to include the PML description subsequently provided by NT. AC did not make clear that the GP Federation comments were additional information to the meeting, taken from the website. AC also used the '50' practices figure as listed on the PML website rather than 62 mentioned in the meeting. It transpires that the PML website requires updating to reflect increased Practice members.

b) Matters arising

(i) Support was provided by AC/AK to the patient attending the AGM regarding accessing the NHS App. They are now able to do this and have also joined the *Virtual Group*.

The patient concerned did email to query why their name was not included in the list of attendees. AC replied to explain that it is not usual practice to publish the names of non-committee members due to confidentiality and GDPR.

JH queried that technically only the AGM part of the meeting is open to 'any patient'. However it was agreed that allowing AGM visitors to remain for a sample 'normal' meeting is a potential way to gain attract members i.e. by allowing them to see how the process works. In any case the AGM is usually over within 10 minutes and it would not be reasonable to ask guest patients to leave after a brief and relatively uneventful process.

(ii) Car park CCTV.

MC approached the Parish Council and was informed they have no responsibility for the Health Centre car park.

AK noted that with the commencement of parking charges and restrictions, cameras have been installed anyway; therefore the issue is indirectly resolved.

3. Chairperson's update

Nothing to report.

4. Secretary's update

a) Communications via public Gmail account

None received.

b) Patient questions directly received for Practice Management

i) Although not directly related to The KEY MP, comments have been received from KEY patients that the move of the former *Kidlington Health Centre* activities to Oxford Health at Jordan Hill has made access extremely difficult for those with impaired mobility. Specifically:

- It is a long walk from bus stops.
- The kerbs are too high for mobility walkers and patients with limited mobility.
- Limited parking for Blue badge holders only, and if you don't have one, there is no alternative car parking provision for relatives to drop off patients for appointments and wait to pick-up afterwards.

AK agreed regarding the long walk and also badly organised.

RR made the point that it is the responsibility of Oxford Health to make reasonable adjustments to allow patients to access their facilities and that it is worth raising the issue with Oxford Health under the *Public Sector Equality Duty* (part of the *Equality Act 2010*).

AC note: This aims to promote equality of opportunity and equality for patients and should include ensuring accessibility for those with mobility and impairment issues; see <https://www.oxfordhealth.nhs.uk/wp-content/uploads/2020/03/OH-130.20-Making-Health-Services-Personal-Fair-and-Diverse.pdf> for further details.

ii) Via email - RR "would like to understand the process with letters received from NHS consultants/services and how they are acted upon. This is because in my experience, actions are consistently being missed (such as medication not being prescribed) and incorrect information (such as incorrect diagnosis) being recorded. Each time, it takes me several requests for the surgery to complete the actions. It seems to be a systemic issue from the recurrent nature of my experiences which makes me concerned it is happening to other patients too. This could then be adding to the already high workload of staff to resolve this each time."

KM explained that a third party company undertakes a lot of the coding which is electronically assigned. This can take a few days after receipt of the electronic letters. After coding, medication requirements will be assigned the medical team – but will take place after coding. There are a few in-house coders but occasionally things go wrong.

KM suggested discussing individual cases with the admin manager and to feed back problems direct to KM.

RR expressed concerned about the impact of medication delays.

TS had also experienced a two-week wait for medication updates for a family member, which causes anxiety for the patient concerned.

KM agreed to look into improving the process.

- iii) Via email from TS regarding the Johns Hopkins score. "It's just popped up on all of my family's nhs app- luckily we are not of a nervous disposition as my husband is a 10. (Maximum seems to be 11!) I'm only a 4! I would like to know what this is, why it's come without any supporting info and what it means to the practice and patient - as if they don't have enough to do."

Subsequent to raising this, TS had received a text message better advising on this.

KM explained that it is a new tool that has stratified every patient's health and assigned a score from 1-11. Some scores relate to specific conditions e.g. pregnancy. The higher the number, the more complex the healthcare needs. The tool is supposed to help prioritise treatments; but a low score does not necessarily mean a patient is not unwell. How to use the Johns Hopkins score is still being considered; but the score contains more embedded information than the score alone and could be used to plan patient care in future.

GT commented that contracts/processes are often forced on GP Practices and they have to implement them. But it can be a barrier to care and require more admin time. It's not known how sudden implementations will be received.

TS suggested the Johns Hopkins score explanation be more prominent - currently in the *News* section at the bottom of the website - to reduce questions and concerns.

TS asked if the score affects appointment priority. KM said that all patients receive the same priority but if very unwell and a high JH score, it may imply they require more urgent care.

- iv) The committee wished to record their condolences to the family of Alan Graham, a former KEY PPG committee member, who recently passed away.

5. Treasurer's update

CR stated that other than a small interest credit due, there have been no transactions.

A third signatory is still required to replace GL. MC offered to take up the role and this was agreed by all. MC and CR to liaise to complete the relevant application forms and registration process.

6. PML (Principal Medical Ltd) Partnership Update

GT began by saying he has now met many of the team and that everyone is keen and willing to make the partnership a success.

It was already known the appointment system is not working and GT is prioritising this. There is a meeting on Tuesday followed by a whole team meeting on 20th January to discuss what the new appointment system will look like. Team training will follow.

A major problem has been that the current system has never managed patient expectations. There was no strategy for first port of call. GT cited a scenario where a patient needs to see a physio, but demands to see a GP first. The GP then refers the patient to the physio. This wastes time and ultimately delays patient treatment. But the solution must not restrict patient access to support.

Also need to look at how to manage the telephone system – maybe by asking that only patients that *really need* same day urgent care call between 8.00am and 9.00am for example.

TS noted that there is a need for patient education.

GT also explained that due to unacceptable behaviour from some patients, causing reception staff to be in tears, there will be a new patient ‘behaviour classification’ with behaviour contracts and serious offenders receiving a 14-day ‘off-contract’ ban. Support will also be available for reception staff.

SL noted he was aware of contrasting incidents where patients had received an unacceptable experience at reception; with one receptionist being rude, an occasion where a patient turned out to be seriously ill with Sepsis, and another receptionist making inappropriate background remarks about a medical condition to a colleague, causing distress to the patient waiting.

KM was aware of complaints raised and action had been taken.

GT confirmed that with feedback there is the opportunity to put things right. Generally, the ‘friends and family’ feedback is 90% positive.

TS noted that the title of Receptionist’ is not really appropriate as they know far more than the role title implies. GT agreed.

RR used an analogy that we need to counter the assumption that obtaining a GP appointment is as easy as ordering a pizza. An example is that of needing a regular treatment every ten weeks – but it is not possible to forward book the next appointment, even though it needs to be regular. Thus the patient still has to go on the waiting list for appointments.

GT noted that addressing the systemic issues with the appointments system will help. He also noted that the necessary changes are initially likely to increase complaints and reduce satisfaction ratings.

RR made the point that more information about what other healthcare roles can do, e.g. physios, and stress that patients can still go on to see a GP if the first specialist cannot help.

GT also explained that patients need to be drawn away from the expectation of same day appointments when not necessary and towards receiving an appointment within a week. This will leave same day availability for genuinely urgent cases. Currently run on basis of Duty doctor, Duty2 doctor and routine appointments.

Also the new system will try to return to the ‘named GP’ concept. This provides continuity of care and saves time; as a single GP is more familiar with a patient’s history and does not have to read lots of notes before each visit.

RR confirmed we all want the new partnership to work.

7. Practice update

a) Surgery update

A new GP, Dr Demin Li, has started, covering 3 days per week, in addition to Dr Joanna Howell who also recently joined.

AK asked why can't patients in Yarnton attend their local surgery more, rather than travelling to Kidlington?

KM explained it is simply due to a lack of staff to service both sites effectively. Whilst Yarnton is a good size building in a nice location, it is poorly laid out internally with a lack of consulting rooms.

b) Funding requests

There were no funding requests.

8. Publication Working Group update

JH advised that the PWG would like to return to the idea of regular articles in local publications once PML changes have settled.

One idea is "You don't always need to see a GP" i.e. covering occasions when other healthcare professionals will provide a faster and effective service/advice.

A regular series of "A day in the life of..." articles are also on the cards to cover all team roles.

RR raised the option of using the local Facebook groups to recruit additional PPG members; emphasising the need for under-represented groups. The PWG will look at wording and placement but also see if it's possible to make it an advert only, to avoid creating an avenue for 'opinion' follow-up reply posts.

AC has emailed KM the waiting room screen presentation file for review and upload.

9. Pharmacies update

The following was received from Kidlington Pharmacy and welcomed as a positive and beneficial move by the PPG Committee:

Dear Members of the KEY PPG,

We are writing to inform you about an important service improvement that will be introduced at Kidlington Pharmacy starting in February 2026.

To enhance patient experience, the pharmacy will be implementing a new computer system designed to streamline how prescriptions are processed and collected. The primary aim of this change is to reduce waiting times, minimise queues, and improve communication with patients.

Key benefits of the new system include:

- **Automatic text message notifications** sent to patients' NHS-registered mobile phone numbers when prescriptions are ready for collection.
- **Fewer inbound phone calls** - patients will no longer need to ring the pharmacy to check whether prescriptions are ready allowing patients easier telephone access for medicine advice and medication support.
- A move towards a **paperless process** - prescriptions that are already prepared will be located, retrieved and handed out more quickly and efficiently rather than the traditional process of flicking through the stack of paper prescriptions for every patient every time.
- **Reduced queues and waiting times** when collecting prescriptions.

These improvements will allow our pharmacy team to spend more time supporting patients directly, while also making the collection process smoother and more convenient.

We appreciate that any change will raise questions, for instance our move towards a paperless process will mean that patients will be encouraged to use electronic means (e.g. the NHS app) for ordering repeats (but we will also provide repeat slips on request to those who prefer the traditional way or have limited access to computers.

Once the system is bedded in we will welcome feedback as your insights are invaluable in helping us ensure that the system works well for our patients and supports high-quality care.

The Pharmacy Team
Kidlington Pharmacy
Kidlington Health Centre
Exeter Close
Kidlington
OX5 1AP
01865371471

10. AOB

TS noted that she and JH assisted at the flu vaccination clinic and would be happy to do so again but with more advance notice next time. AK also offered to assist.

11. Date of next meeting

Thursday 26th March 2026 at 7.00pm at Yarnton.