HARVEY GROUP PRACTICE: PATIENT PARTICIPATION GROUP.

DRAFT NOTES OF THE 5TH MEETING HELD ON WEDNESDAY 28TH OCTOBER 2015, 1800:1930

VENUE: **JERSEY FARM SURGERY**

ATTENDEES: **12**

CHAIR: **MR. SPART HAMDARD, PRACTICE MANAGER (PM)**

NOTES: **MR.PETER FARDELL**

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1. INTRODUCTIONS

1. The PM thanked everyone for attending. He had sent out 85 emails to the PPG membership with details of the meeting and posted notices in the waiting rooms at both sites.

1.2 He had been in the post since Mid June 2015 (approx. 4 months) but explained that he had previously had much experience at working in the health sector, having started his career in the NHS. He had previously been a Practice Manager at London-based (Harrow) and Bedfordshire-based Practices.

1.3 His impression of the Harvey group Practice before joining was not too favourable as he had read negative comments on the "NHS Choices" website. However it rapidly became clear to him on joining the Practice that it is outstanding both in terms of clinical care and organisation/administration.

1.4 There was some discussion about comments left on the NHS Choice website and it was agreed that the vast majority of patients who are totally satisfied with the Practice would rarely think about writing a comment, so a small minority who are dissatisfied are giving an overall impression of the Practice which is not representative of the general experience.

1.5 He stated that his core aim was to ensure that all patients were satisfied with their experience of using the Practice. He therefore welcomed this opportunity of meeting patient's representatives, hearing their views, and taking action where appropriate to improve the patient/Practice experience. The face-to-face meeting arrangements at this Practice were especially welcome as in his previous experience; patient views and Practice actions were often communicated impersonally by phone, SMS, or email. A meeting offered better two-way communication and support and encouraged lively debate. The PM's aim would be to have one or two meetings per year with email communication in between. Attendees were encouraged to recruit more members to the PPG through their personal contacts.

1.6 The PM then invited the attendees to introduce themselves with a brief outline of their background with respect to using the Practice. Some had been with the Practice for over 60 years with all attendees expressing a high degree of satisfaction.

2. TOPICS AND DISCUSSION

2.1 Communications: General issues.

There was a general discussion on the numbers of patients who used computers/internet. Although this was significant and apparently growing, it was accepted that there was (and always will be) a significant proportion who do not use computers, smart phones and the internet. A broad range of communication methods would have to be maintained indefinitely.

2.2 Communications: Patient Access

The patient access (EMIS) links were generally agreed to be excellent and patient access to medical history, the on-line prescription and the messaging features were especially valuable. One member reported continually experiencing an "error message" when signing in (with the correct ID's and using the Firefox browser) which nevertheless gave normal access when clicking on the error message.

ACTION POINT. PM to briefly check if the "error" message was a widespread problem –possibly limited to the browser type (Firefox).

2.3 Communications: SMS mobile phone messaging.

2.3.1 The use of SMS texting on mobile phones to remind patients of an upcoming appointment appeared to be working but little data on the improvement to "Did Not Attend's" (DNA's) was known. It was suggested that the PM might attempt a brief survey of "Before and After" data if feasible, to determine what level of improvement had occurred.

ACTION POINT: If feasible, PM to look at DNA's before and after the mobile phone texting service.

2.3.2 There was a suggestion that communication by SMS texting should be "two-way" – e.g. to confirm that an appointment reminder had been noted or that an appointment could not be kept. The PM agreed that this would be very useful and he stated that this was coming our way very soon and that the practice would definitely sign up to the scheme.

ACTION POINT. PM to keep the PPG appraised of efforts to provide two-way texting to/from the surgery.

2.3.3 It was suggested by a member, that Dr. Mike Walton, who drove the application of IT within the Practice, might be invited to the next PPG meeting to outline the existing IT links to patients and any plans for expansion in the future. In particular an update of the use of

internet access and messaging, including mobile phones using I.o.s., Android and Windows phone operating systems and apps, would be useful.

ACTION POINT: PM to discuss if it would be appropriate/possible for Dr. Mike Walton to attend the next meeting to outline the current and future planned Practice IT structure.

2.4 Communications: Telephone Advice Line. (TAL)

2.4.1 It was agreed that this was a most valuable service which worked well and is much appreciated by patients.

2.4.2 The PM cited the TAL as an example of the excellence of the Practice, which unusually (in his experience) was staffed by a dedicated doctor. The service had proved so popular that the TAL doctor had on some occasions worked well over the allocated time to clear all phone-ins.

2.5 Communications: Hospitals and Consultants.

2.5.1 Several members cited problems with the hospital/consultant appointment system which on occasions seemed incapable of being flexible enough to accommodate changing appointments due to changing circumstance, for whatever reason.

2.5.2 One member stated that historically following a letter from the surgery to hospital a consultant appointment could be expected within 6 weeks, but that is now the exception rather than the norm.

2.5.3 There were also problems on occasions with test results, reports etc, finding their way back in a timely fashion to the Practice from the hospitals/consultants. The PM pointed out that after referral to a consultant, the clinical staff at the Practice had little control over the following dates and times reserved for patients and timing for tests etc. or for speeding up the process.

2.5.4 Test results are sent to the consultant or GP who requested them in the first place. Therefore they are not always sent to the GP if the tests were requested by the Hospital Consultant. It was agreed that there was room for improvement in this aspect of communications.

2.5.5 The PM agreed that a lot of time could be wasted chasing test results and other documents relating to patients seeing consultants. It appeared that in some cases all clinicians involved in a patients case were not “copied in” on these. He hoped that this would improve over the next year.

2.6 “Did Not Attend” (DNA’s)

2.6.1 It was recognised that although the level of DNA’s was still unacceptably high, there had to be a distinction drawn between “consistent offenders” and those who through a number of unavoidable “legitimate” reasons either forget to attend or were unable to attend at short

notice, on an isolated occasion. Included in the latter should be those who cancel at the "last minute".

2.6.2 There was no agreement on what constituted an acceptable level of DNA's but a "persistent offender" was loosely defined as someone who showed three consecutive DNA's in a month.

2.6.3 A member pointed out that if every single appointment was actually attended, there could be a "log jam" in servicing appointments and also there would be less scope for fitting in patients who presented on the day without prior appointment- or at least there would be extended waiting times for these patients. It was also suggested that if there was a "plus" side to DNA's it is that the occasional gap due to a DNA (or last minute cancellation) gives more time for clinical staff to take phone calls or other queries, deal with paperwork etc.

ACTION POINT. PM to devise a system of defining, targeting and challenging persistent DNA "offenders".

2.7 Practice appointments system.

2.7.1 There was some frustration expressed over the inability to book an appointment several months ahead when the clinician had asked for this.

2.7.2 The PM agreed it would be beneficial to some patients to be able to book an appointment beyond the 6 week maximum currently operating, but warned that in his experience the level of DNA's increased with increasing periods between appointments. He did however agree in principle that It was up to the Practice to provide such appointments if the clinician had asked for it, if the software supports this.

ACTION POINT: PM to determine the scope for appointments to be made beyond the current 6 week maximum period.

2.8 Duration of repeat prescription items.

2.8.1 There was a discussion over the possibility of extending the period between repeat prescription items for some patients, from its current period of 2 months.

2.8.2 As a possible reason for this, another member cited a study which had showed rather alarmingly that statistically, only (approximately) one third of prescribed drugs were taken at the correct intervals with the other two thirds either taken over longer periods or not at all. This resulted in "stockpiling" of drugs with the patient and subsequent loss of therapeutic value and not least, wastage as drugs passed their use-by date.

2.9 Practice services.

2.9.1 **Practice brochure.** One member thought that the printed form of the Practice services brochure was out of date and should be updated. Details of the PPG could also now be included.

2.9.2 **Nursing services.** It was pointed out that cases had arisen where normal nurse appointments had been substantially delayed or interrupted/extended due to various

causes, including the need in some cases to obtain a doctor's view. The question was asked as to whether the Practice was short of one nurse.

The PM pointed out that the nature of the nurses' work is rather unpredictable, as they have occasional referrals from doctors to deal with as well as their own appointments – e.g. a patient may need an ECG. In these situations nurses had the option of working overtime to clear the day's appointments.

There was some confusion over whether the Practice had nurses who could prescribe.

ACTION POINT. PM to check if the Practice nurses can prescribe in some cases without the need for a doctor's signature and to determine the scope for recruiting another nurse.

2.9.3 **Carer support.** The PM reported that the Practice had signed up to the Carer Support initiative and this will have a "Carer Champion" to run it. There is a Carers' notice board now in each surgery's waiting room.

2.9.4 **Vaccinations.** There was some concern over the lack of communication between the Practice and pharmacies offering (and giving) free flu vaccination with varying degrees of checking on the eligibility/suitability of patients. This was especially worrying as a pharmacy will invariably not have the full medical history of patients. The PM stated that this was of concern but some 150 patients considered the most vulnerable had been emailed where possible to invite them for vaccination but that within the Practice about 4,500 qualified for a free vaccination.

2.10 Phlebotomy services.

2.10.1. There were several voices raised in protest at the current situation at St. Albans City Hospital (SACH) phlebotomy services. The main problem was the often long waiting time and expense of parking.

2.10.2 It was agreed that if the Practice could offer Phlebotomy most patients would be willing to wait a little longer in the surgery if blood tests had been ordered by the GP to have their blood sample taken in-house on the same day. It was further pointed out that some GP surgeries (e.g.in Hemel Hempstead) already operated a phlebotomy service.

2.10.3 One member recalled (see meeting notes for PPG meeting no. 4, section 9.4) that a care assistant at our Practice had begun training for phlebotomy only to leave the Practice before the training was complete. This did not seem to have been followed up.

2.10.4 Another member suggested having a "loan nurse" from the phlebotomy service at SACH to work for limited periods at the Practice.

ACTION POINT: The PM to look into the possibility of providing phlebotomy services in the Practice- but clearly nothing could be promised at this stage as it is a locally commissioned service.

2.11 NHS commissioning.

The PM outlined the current situation and projected changes to the way health services are and will be commissioned in the future. Amongst other changes:

- There are many cases of GP surgeries linking together and discussions are in progress on the merits of a "federation" of GP Practices.
- PPG's are no longer to be funded by the NHS – surgeries will have to find their own funds to operate them. As the PPG is deemed a "support group" the CQC might be able to assist.

2.12 Future meetings.

2.12.1 Guidelines/ground rules for the structure and conduct of PPG meetings were discussed as set out by the National Association for Patient Participation (NAPP). There is a fee of £60 to join. Amongst other suggestions was that the PPG be chaired by a patient with calls for attendance by the PM/clinical staff as the situation dictated. A number of other "common sense" rules were also set out.

2.12.2 It was agreed that due to the unique nature of any particular Practice in terms of its structure, demographics, patient mix, clinical and care requirements, treatment mix, local community links etc. it would be better for our PPG to adopt our own format already successfully established e.g.

- face-to-face meetings with an informal format to encourage lively debate.
- good representation across the patient mix,
- chaired by the PM,
- calls for attendance by clinical staff only when appropriate,
- full notes and an action list prepared after each meeting.
- No need to join NAPP at this time but keep under review.

2.12.3 The PM stated that he would like to have possibly two face-to-face PPG meetings every year along the lines summarised in 2.12.2.

2.12.4 It was suggested that the PPG be given its own direct link from the Practice website home page. At present it was somewhat "buried" under "Useful Links" and then "Our Services"

ACTION POINT: PM to provide a direct link to the PPG reports from the EMIS website home page.

2.13 Close

The PM thanked members for attending and commented that he had found the meeting very valuable. Members in turn thanked the PM for organising the meeting which dispersed at 19:30.

3. ACTION LIST SUMMARY FOR THE PM

3.1 Check if the “error” message on for accessing the emis website was a widespread problem or possibly limited to the browser type (Firefox).

3.2 Keep the PPG appraised of efforts to provide two-way texting to/from the surgery.

3.3 Discuss if it would be appropriate/possible for Dr. Mike Walton to attend the next meeting to outline the current and future planned Practice IT structure.

3.4 Devise a system of defining, targeting and challenging persistent DNA “offenders”.

3.5 Determine the scope for appointments to be made beyond the current 6 week maximum period.

3.6 Check if the Practice nurses can prescribe in some cases without the need for a doctor’s signature and to determine the scope for recruiting another nurse.

3.7 Look into the possibility of providing phlebotomy services in the Practice-(but clearly nothing could be promised at this stage as it is a locally commissioned service).

3.8 Provide a direct link to the PPG reports from the EMIS website home page.

P.J. Fardell

02/11/2015.