Minutes of the Patient Participation Group Minutes 28th June 2012

Present: David Burnage; Sydney Cantello; Steve Dale;Jean Greenhalgh; Florence Grimwood; Shirley Hickey; Dr Dan Jefferies; Jackie Kaldenberg; Yvonne Rowat; Jean Shergold; Molly Tavani; Dennis Teesdale; Liz Wigzell, Susan Wilson

Apologies: Jan Baker; Margaret Corke; Caroline Custard; Mike Ford; Pam Hazeltine; Nicky May, Kate Oakley;

Minutes: Erica Ballard

Dr Jefferies welcomed the group and explained that the meeting had come about as a result of the survey published in April. Patients felt they would like to see an improvement in the Triage system and a reduced wait for routine appointments.

Dr Jefferies explained that he had offered to speak to the group to explain why the triage system was put in place and the advantages and disadvantages to both patients and the practice.
(full presentation sheets attached)

Essentially, triage had been introduced to counter the difficulties of the previous system (particularly on Monday mornings) where 0830 saw a sea of people at the door, and ironically the 'fittest of those,
(ie. those able to reach the desk first) were able to secure an appointment. All appointments were usually taken by 0835, leaving countless patients disappointed (plus those trying to get through on the phone)

Under the triage system, all patients receive a call back and are appropriately treated. eg. if a dressing is required, an appointment with a nurse, rather than the doctor. Prior to triage, a patient may have booked in automatically with the doctor, resulting in a wasted appointment for both patient and clinician.

Triage calls are taken right up until midday, thus avoiding the need for an 0830 'rush', and reducing waiting times on the phone. Perception of 'urgent' not always the same as realityof clinically urgent and triage is very good for this - ensuring those who need priority do get it.

90% of calls are handled by the triage nurse, with the remaining 10% picked up by the duty doctor.

Members of the group voiced some very strong feelings.

Phoning in at 0830 to be called back perhaps not until 1030, for an appontment at 1130, was not considered helpful if a patient to go off to work. Long list of patients on triage inevitably takes time to work through. Could two nurses not be employed? Dr Jefferies explained that staff and cost would be an issue.

Had actively abandoning triage altogether had been considered? Though not set in stone, Dr Jefferies explained that there were no plans to do so. There was a tendency for triage to be blamed for the lack of prebookable appointments - in fact this is not the case. Much worse prior to triage. For example, on a Monday we now have 50/50 triage and prebookable slots. Pre-triage, all of those slots would be solely 'book on the day'.
Currently, 18 appointments per doctor in the morning (a mixture of prebookable and triage) and 12 in the afternoon.

Possibility of continuing triage into the afternoon had been considered (some surgeries do this) Again, staffing would be an issue. Employing a nurse to do triage leaves them less time to do other work. Duty doctor would have the same problem.

Concern was expressed that elderly patients, particularly those on the Park, neither understand nor like triage. Particularly unhappy at relaying their problem to a receptionist, then again to the nurse, and potentially, once more to the doctor. They want to see their own doctor. Dr Jefferies explained that in terms of manning the calls, the receptionist is the starting point. All staff are bound by the same strict rules of confidentiality. One option from the group was for the receptionist to take sufficient detail to enable nurse to book an appointment without having to speak to the patient and ask all over again. Problem is receptionists are not clinical. It was felt that an explanatory advice slip in very simple terms might be of help. Posters/slips explaining how triage works are already available in reception but perhaps something more 'tailored' to elderly patients might bring a more positive response. Two members of the group were willing to produce and/or deliver something suitable. Other members of the group felt vulnerable elderly patients may be better to ask friends/carers to phone instead on their behalf.

Could triage not be replaced with another doctor?
Dr Jefferies explained that a salaried GP would cost £10-12,000 p.a. per session, for 3 hours of appts and paperwork. Need 200 extra patients to pay for that. However, we have started to book our locum GP for an extra 2 sessons a week to help with prebookable appointments.

Surgery funding discussed - per capita cost and global sum - no. of patients. Commissioning about to come in. Future in NHS is very uncertain.
Major income based on what GPs do and have to do. For example, bp checks. Need to demonstrate interval between blood pressure checks and what % or patients fall under certain level.
Payment is on justification. However, lowering bp of a 95 year old for example, could lead to fainting and potential broken hip; yet no payment if target not reached!

Perception of 'family GP' no longer the same. No longer adequate time for historical 'pop-ins' and increased number of patients per GP list. Dr Jefferies

was asked what a modern GP's workload actually involved and outlined a typical day - 0815 arrival Monday to Friday; appts; visits; prescriptions; calls; referrals and any other paperwork, plus a Wednesday morning branch surgery in Turners Hill; monthly Saturday surgery and specialist clinic at The Vale every Friday morning. Aside from a Wednesday afternoon, rarely leaves the surgery before 7pm. Workload increasing all the time. Hugely increased admin load in addition to regular 'doctoring'.
eg a letter from the hospital requesting a change of medication can take 15 minutes per patient. More emphasis on prevention and monitoring, in addition to treating new problems.

4 partners currently at Crawley Down, 3 male and one female. As well as appointments at the surgery, weekly branch surgeries are held for outlying areas (Turners Hill on a Wednesday morning; West Hoathly Tuesday and Thursday mornings) and extended hours clinics for commuters (Monday evening and monthly Saturdays) Home visits also available if clinical need, though inevitably, these take more time. To see 3 patients at the surgery would normally take 30 minutes, 3 visits would be 1.5 hours.

New houses popping up all the time. Patient list size has grown substantially- now approx. 7900.

Average no. of telephone calls guessed at 80-100 per day, probably half of those triage, though test log (about 18 months ago) showed over 1000 calls in the course of a week. Practice growing all the time.

Group feedback was too many patients - not enough doctors! 4-6 weeks for a routine appointment too long to wait. At Moatfield, can see own GP within two days. Patients are moving practice because of this. Dr Jefferies explained very difficult to match up appointments with ever-growing demand. More appointment time also needed for preventative care. Once a week, he and Erica go through the appointments to maximise available slots. Also dscussed every Friday at the Health Centre Practice Meeting (Practice Manager and the GPs)

Moatfield have more GPs and more nursing staff. Also tend to rely more on registrars (less experienced doctors)

Issue was also raised of patients who fail to keep appointments - over 19 hours a month of wasted clinical time. What sanctions are in place to deal with this? Charging patients not really an option in the NHS (private practices do impose 'fines'). Consideration to be given as to whether a letter should be sent, particularly for repeat offenders. Sending text reminders for appointments (done manually or by automated system) was also discussed though could be heavy cost implications. Could an 'opt-in' be looked at for patients,for those willing to pay to get a text?

Action and Outcomes

Concern was raised that the group had just been a 'talking shop'. What was actually going to be done?

Erica explained that the Group was designed to be patient led. She and Dr Jefferies were guests.

Group Action Plan

Nominate a Chair to steer future meetings.

Report back to the Health Centre with issues they would like addressing or helpful ideas to progress.

Potential for a smaller sub-group to be set up, guided by the practice to take on the issues raised. eg. in conjunction with the surgery, to publish and distribute information e.g a leaflet about the triage system for elderly patients on the Park

Surgery Action

Maximise available appointments. Consider sending out formal letter to patients who fail to turn up

Better use of telephone system to cut down on waiting time (eg shorter answerphone message)

Effective use of information to keep patients updated on change (surgery handouts/local magazine updates)

Consider more leeway/ 'phasing in' for existing patients less used to change (eg the elderly)

Consider possibility of volunteers to improve service but keep down staffing costs.