**Draft (20/11/16)**

**Dartmouth Medical Practice**

**Patients Participation Group**

**Draft DMP-PPG Joint Action Plan 2017**

1. *Establish 5 working days as the cap on waiting time for a new appointment. To achieve this objective, recruit at least one more doctor to the Practice. Try to recruit a doctor who is willing to devote at least 4 days (8 sessions) a week to the Practice. This would make getting a non-urgent appointment easier and help clear the backlog.*

**DMP is happy to accept a target of 5 working days for booked routine appointment.**

**The issue of recruitment we feel is an operational matter for the practice. As previous data has shown, the practice offers more sessions of GP time than a town with a population the size of Dartmouth should require. Demand is the primary issue. Increased capacity, whilst offering temporary solution, therefore is not an answer one could propose as a sustainable solution. We have successfully recruited Dr Cotton and Dr Price recently. It is beyond the remit of both the practice and the PPG to specify that a GP is recruited that works 8 sessions.**

**DMP can commit to making improvements to the way it manages capacity and demand through better matching the 2 in a sustainable manner that doesn’t threaten the viability of the business.**

1. *Allow consultation appointments with a practice nurse without having to be referred by a doctor, with clear guidelines for the conditions/symptoms/tasks that they would treat to avoid a double the workload if they find that they have frequently to refer patients to the doctors.*

**We were not really clear about what this referred to. Patients are already free to book and attend nursing appointments without being referred by a GP. What is really important is for patients to be able to be assisted by reception to guide them to the most appropriate appointment for their concern. I acknowledge that often patient end up in the wrong place and therefore have to be referred onwards. Guidelines and protocols help and we continuously try to improve these. We have been missing a senior nursing team leader and with Gavin starting things should improve here. It may be helpful for the PPG to help us on Facebook to promote the value in reception asking some questions**.

1. *Make the on-line booking system easier to operate.*

**This has been a transitional phase and will improve. The service is being rolled out through the alphabet and the functionality improved**

1. *Provide dedicated appointments for carers. Give priority to carers.* *To this end, define the situations that merit priority booking for carers and how it should be managed. Giving priority in an already completely booked system will require leaving some appointment slots blank to be filled by carers if required and freed up near the time for others.*

**The problem with ring-fencing appointments is that it reduces appointment availability for everyone else. We find that releasing appointments a day or so before (if not taken) tends to result in the slots being taken by those with minor complaints who would otherwise be managed by our triage system.**

**We know that carers provide a fundamental role in supporting our population and that they are prone to under-playing their own needs. We have a register of carers but this is I am sure an underestimate. PHE decided to scale down the medical support available to carers as they have had to make difficult choices with such stringent local authority cuts.**

**I think at the moment between triage (immediately available) contacts and booked appointments we cover the requests. It would be helpful to further promote carers self declarations.**

1. *Make it easier to get through to the Practice on the phone and put in place a numbered phone queuing system.*

**We are unable to expand the telephone system due to its age. When we move this will markedly improve. We have the maximum number of operators on the maximum number of phones we can-again some responsibility needs to be taken by those seeking help at a arate that exceeds expectation.**

1. *Open the Surgery on Saturday morning and institute longer opening hours on a trial basis.*

**None of the Drs currently want to work Saturdays. When we did open Saturdays uptake was poor, DNAs very high and the stated aim of improving access for working people failed-attendees were mainly retirees.**

**We are currently considering extending our opening hours in the week and will consult with the PPG before making any changes.**

1. *Make far more use of email. Quick questions should be answered by email. Develop a complete list of emails that can be used for circulating the bi-monthly Newsletter and other health information*

**We now ask for email details at each patient contact (or should be doing) as we agree it is a better way to communicate info. Some patients are unwilling to share. We already do answer lots of patient emails-probably 1-2 per GP per day. Unfortunately we have yet to allocate any time to such queries and opening up this service will need us to reduce the number of appointments available for face to face services. I think this will be a slowly-slowly approach, making small changes and seeing how they bed in.**

1. *Provide access to one’s medical records and test results online. This will need to be managed with care to ensure patient confidentiality and security of data. We understand that the CCG is working on this proposal.*

**This is a nationally driven programme with national timescales beyond our local control**

1. *Use email, a phone call or a SMS to confirm whether a test needs a follow-up or not. This could result in a quicker follow-up on blood tests and the like.*

**Agree. We have started SMS normal results. Drs need to be better at telling people what will happen with results-the default should be “I will contact you should your tests show I need to..” We still receive a lot of calls from people looking for normal results despite such advice-again demand/expectation remains a challenge**

1. *Explore whether regular health screening for over 65's (scans, bloods, prostate checks, heart monitoring etc.) and automatic patient health checks for specific conditions is justified, taking account of national screening programmes. The Practice/NHS policy on health checks needs to be better explained and communicated.*

**Due to the cut in local authority funding Health Checks have largely stopped being funded. We take advice from NHSE about which checks to offer and which add value. 5 yearly BPs are a recommendation. I don’t think there are any other preventative programmes outside of national programmes that have evidence basis**

1. *Put in a telephone answer-phone facility so that patients can leave their repeat prescription requirements when the surgery is closed and thus alleviating the problems encountered by having to use the extremely limited two hour window which is often busy.*

**As part of improving the script access service we will probably be turning off telephone requests for medication during 2017. This is to follow best practice and we are one of only a handful of practices to retain this facility. The counter side will be an increase from 1 months supply to 2 months supply for most patients.**

1. *Improved care for contraception and women’s health.*

**I think Dr Hendy’s addition has helped here. Between her, Dr Chopin, Dr Cotton and now Dr Price we have a wealth of expertise in these areas, it may be more about awareness of this knowledge**

1. *Set a performance target for blood tests etc. to reduce the wait to get a test done. Currently the delay may exceed a week. The practice should consider training and employing a phlebotomist to take bloods every day and relieve the nurses to do more appropriate work.*

**We currently offer phlebotomy services 5d a week. We are in negotiation with transport to try to get samples collected later in the day to increase capacity further. Where blood tests are urgent they are done promptly. Most of our tests are generated by monitoring of medications and health conditions eg diabetes and as such are routine planned procedures. Target may help for immediate ones but these tend to be done on the day or certainly within 48h.**

1. *Revamp the provision of public health information in the Surgery to focus on a limited number of key messages. A complete list of available leaflets and brochures can be kept in a folder in the waiting area, regularly updated and keep the leaflets etc. in a filing cabinet.*

**Our intention is to wholly revamp our information offering when we move to Riverview**

1. *Improve the video messages in the Surgery waiting areas by: (i) siting the video screens where they can be more easily seen; (ii) use larger type face so the messages can be more easily read; and (iii) give the reader more time to read each slide.*

**Our ‘anatomy’ largely determines siting of screens. The messages are provided by CCG**

1. *Manage patient expectations better by providing patients with clearer and more complete information about what to services and procedures to expect.*

**It may be helpful to have some expansion on what this refers to so I can look into further**

1. *If a patient is to be given bad news (such as having cancer), give the news in person and not over the phone when one is on one’s own. All the doctors need to go on a “transmitting bad news” course if they have not already done so and should be very clear of the importance of this point.*

**We always try to give bad news in a sensitive and timely manner. Inevitably sometimes this has to be over the phone. All our GPs are well experienced in giving bad news and its not really something you can learn on a course.**

1. *Post a list of the various doctors' 'specialities' in a prominent place in the surgery as not everyone is online. Knowing that a particular doctor has a greater knowledge on the subject might be very useful.*

**Completely agree tho the ideal place is the website, which urgently needs updating. I think we will do this in time for the move to Riverview.**

1. *Provide disinfecting gel available in the waiting room.*

**I don’t think there is any evidence that this would be of help to anyone**

1. *Review communications procedures between the Practice and hospital relating to patients’ admission to ensure all needed information is passed on to the admitting hospital and institute necessary improvements.* *This may involve an audit to include a questionnaire for the hospital to fill in as it is a two way process-- something for the CCG and the ICO to consider together with the Practice.*

**All referrals to hospital (outpatients, A+E and admissions) are sent with a full GP summary including all relevant past history, medications and allergies. All discharges from the ICO (acute and community) are discharged with a typed discharge summary on the day of discharge**

1. *Together with hospitals and Dartmouth Caring, review follow-up procedures for DMP patients discharged from hospital to establish ways to reassure patients that all required follow up actions are being taken. Ensure all patients are made aware of these follow-up procedures.* *It is* *important is that the Practice acknowledges to the patient that they know the patient has been discharged and that they have checked that a care plan is in place. If there is not one, then to create one with all the caring organisations.*

**The Bridge Worker role provides this reassurance. It has been previously suggested that a GP would visit all patients on discharge. I don’t think this is a workable solution although I agree that some form a formalised acknowledgement should be in place and I don’t think the various bits join up together very well. We will endeavour to improve how this works**