North Staffordshire LOCAL MEDICAL COMMITTEE

NORTH STAFFORDSHIRE LOCAL MEDICAL COMMITTEE

RELEASING CAPACITY IN GENERAL PRACTICE EVENT - 21ST APRIL 2016

GROUP WORK SESSION - ALL FEEDBACK FROM FLIPCHARTS/FACILITATORS

PERSONAL PRODUCTIVITY

Clinical responsibility - hospital

- GP

Boost morale

Stress management

Admin time

Docman - CQC

Setting boundaries

Time management

Speed reading

Enjoy rather than complain

Targets - practice workload

Positive mindset

Prioritise work and action to take like visits and path reports

PARTNERSHIP WORKING

Age Concern lunch in community pub

PPG organised diabetes event

Guitar group would clear the waiting room

Practices working together

Pharmacist, churches, mosque, youth groups, Age UK, befriending telephone service, Saltbox, Carers Association

CAB - previously funded

CPN's, Community Cancer, CPO's (and bring pts to surgeries), COSI, Mental health voluntary sectors ? HUB for this

Up to date Directory of Services

Minor surgery for other Practices

Vasectomies

Need openness between Practices

7 day opening (also perceived as a threat)

8 - 8 working

Support needed to facilitate mergers and co-working

ACTIVE SIGNPOSTING

Care navigation Patent access to results

HUB telephone consultations for same day acute problems

Currently we :
- Pharmacy First barriers
  - Patient wants
  - Receptionist training
  - ?Electronic signposting

Wish list signpost to(but needs timely waiting times)

- Physiotherapy
- Podiatry
- Wellbeing

Solution: HUB with freephone number for receptionist to give out / Practice website

Group ? GP overflow appts

Getting info out to patients using facebook, twitter, websites etc

Carers folder - Directory of Services

Self referrals e.g to physio bypassing GP

Following patients up after A&E attendances using clinical staff - phone calls may reduce face to face appts

PRODUCTIVE WORKFLOWS

EPS Text messaging (MJog, EMIS web)

Clinical pharmacist MED 3 continuation

Floor walking - roaming GP 8.00a.m. to 10.30a.m.

Repeat prescribing intervals on repeat meds Increased telephone consultations

Kiosks in reception for BP's etc E-mail requests for appts

Software algorhythms for reception team - signposting

Triaged post Repeat EPS (Rpt dispensing)

Texting results Fit note lists

Med reviews - 12 months if appropriate

Ear gizmo/technology (photographic orascope)

HUB - taking referrals/waits on the phone (needs to be better)

SELF CARE AND MANAGEMENT

Patent focus groups - self help education

Expert patients

Signposting using volunteers or CAB

Tackle loneliness

Telehealth - FLO - reminder texts

Support needed from Federation and locality for IT, texting and spreading good Practice

Leaflet distribution e.g. childhood infection/illness

Facebook/website links

Social media and apps

Standardised waiting room messages

Education - PPG

Leaflets, posters, website

Provide written plans and information

Emphasise consequences of *poor health*

Opportunistic education during consultation e.g. lifestyle, smoking, alcohol

Encouraging pts to take ownership of their hea

Use of FLO telehealth for self management

Facebook

Use PPG, CCG, local media and voluntary sector

REDUCING DNA's

Use EMIS Ideas and Support for DNAs solutions (can contact Angela Bath angela.bath@emishealth.com)

Use text reminders - free EMIS web (? consent to text and ? does it cost)

Phone pt after a DNA

Record DNA on pt med record

Decrease time in advance to book appt

Patient to write down the appt and receptionist to read back

Publish DNA rates and costs on website, facebook, in waiting room

Easy cancellation - phone appt - pt access

DNA policy -

- Issue pt with letter
- Remove pre-book rights
- Alert on pt record 'No pre books'

Identify who's DNAing

Policy across patch on DNA's

Dedicated phone line to cancel appts - easy cancellation can leave a message

Encourage Pt Access - book online and cancel online

Send appt reminders

Recording appts -

- Write appt and get pt to read back
- Pt write their own appt and read back to receptionist
- Use labels and give printed appts

Reduce forward booking of appts to one week

Use SMS to remind pts re appts

ICE system reminders? - not using

Report DNA's in Practice with a poster

Avoid 'just in case' bookings

DNA management on appt book (EMIS) - DNA alert

SOCIAL PRESCRIBING

'Social prescribing' work being done in Practices currently include:

- Age UK
- Dementia champions - working with PPG
- Beth Johnson signposting support - wanting to start different conditions groups
- Healthy minds referrals of pads
- Carers group - link with North Staffs Carers Association
- Walking group
- Befriending

To develop social prescribing in Practices need:

- To map local communities to find out what is available
- Local volunteers (asking people personally is far more effective than putting up posters etc)
- Practice champions
- PPG mapping
- Build up local knowledge
- To change time of meetings

More information re local voluntary organisations can be found:

- Keele university year 5 medical students voluntary sector Hub work
- Healthwatch - patient engagement
- VAST can provide information on community leads, advocacy, access to voluntary sector database (which they keep up to date)

Support/help needed:

- Federated model - locality level
- How to get started with working with community groups?
- Who sets it going?
- Involving own Practice population - how to get started - linking with receptionist
- Voluntary sector hub information
- Difficult to get leaflets (however, word mouth is much more effective)
- Needs pump priming support

NEW CONSULTATION TYPES

Telephone:

- Cannot always be limited to 5 mins
- Sometimes after phone call pt needs to come in for face to face consultation
- Triage eg of home visits useful
- Good when pt had previous DNAs eg annual reviews
- Good to give pt choice for this mode of consultation
- Needs to be set up so patient makes their phone accessible eg for one hour so GP/nurse not tied to exact time
- Seems more useful to have home phone number rather than mobile – to some present; but that means only happens when pt is at home
- Can use for phone reviews for patients: triaging follow ups, care plan reviews; for follow up re incentive schemes
- Need protocol describing low/intermediate/high risk selection criteria for pts – then use these to apply for providing acute care and follow up of LTCs
- Useful for multidisciplinary interaction
- Potentially more time efficient if right selection criteria

E-mail:

- Most clinicians no experience of email consultation
- Fear of generating more workload- with low threshold for patients asking questions/ engaging in several back/fro interchanges
- Concerns if pt expects quick email reply (acute symptoms) when pt ill; and no-one looks at email for ages (eg GP on holiday/weekend) ie pts have inappropriate expectations
- Could be useful for pts who DNA
- Useful maybe for transactional interchanges between clinician/pt
- Some pts have no computer/don't use emails-so does that mean could be extending discrimination
- Clinical fear of lack of confidentiality

Skype: (only one person round the tables had started using skype)

- Limited access for some pts
- If high staff turnover in practice team, have to keep upskilling individuals to use skype
- Internet access/lack of WiFi may make skype connectivity impossible
- Some unsure if skype effective mode of communication: - is there any evidence of its effectiveness?; are there privacy/confidentiality issues?;
- Clinicians lack competence & confidence to start using skype with patients
- May enhance access to care for patient- at workplace, in evening etc
- Might do via EMIS using video consultations- new product exists a practice manager advised the group
- Seems to give more security than telephone consultation- seeing patient can be more sure who they are
- Should be able to get help from CSU/IT to set up skype in surgery consultation rooms; but reservations about how quickly IT aids practices- poor experience of help given in past
- A trusted practice protocol including guidelines for usage should help practice start using skype – with consideration to enhancing privacy and safety (with patient selection criteria)
- Clinicians unsure if image is good enough for certain conditions eg rash- the selection criteria need to clarify this
- Need to be clear who initiates the skype consultation (clinician) and flexibility of pt being available to receive it

Group consultations:

- Not rated highly by clinicians unless for information giving, building peer support; clinicians wary that most patients would not want to share personal information; so a group consultation might end up taking extra time as would not be instead of one to one consultation for a LTC
- Might be effective/more productive for group with same adverse lifestyle habits eg smoking, overweight, alcohol misuse- with peer support helping; and clinical advice being more generic, patient details of experience in beating poor lifestyle habits being less personal
- Lack of confidentiality for individual patients
- Clinicians think would have lack of control over a group as opposed to individual patients

Facebook (none of the participants in the round table groups had Facebook in their practices)

- Need safe focus – eg beating adverse lifestyle habits (eg weight management, smoking cessation) so less likely to breach individual patient confidentiality, and less likelihood that a patient participant feeds in ‘dangerous’ or ‘abusive’ messages

- Clinicians/practice managers worried Facebook might generate negative comments and complaints
- Need correct cohort of patients/ so enhance likelihood of appropriate communication

Overview of who might help?

- As above- practical help for skype from CSU/IT – but wary as their track record for help re computer systems is slow response
- Some interest in Federation creating local knowledgeable champions/action learning style approach – for phone/email/skype consultations
- Interest in learning more from CCGs' team of telehealth facilitators for Flo telehealth
- Interest for help with Facebook from Marc Schmid –commissioned by CCGs – some practices already using his help

DEVELOPING THE TEAM (Summary of Feedback)

- There are already a good number of different roles working in primary care in our area. These include clinical co-ordinator, dementia care facilitator, elderly care facilitator, paramedics and pharmacists. Key is the success of in-house training or course training as few have had any primary care exposure.
- There was much interest in developing the role of the Health Care Support Worker and some understanding of how they work in different practices.
- Prescribing courses would be essential for the development of the new roles of paramedics,pharmacists and physicians associates.
- There was interest in having mental health and musculoskeletal (physio) services embedded in primary care with health navigators to assist directing patients to consult them first.
- More foundation doctors could train in primary care and some exposure to primary care in F1 as well as F2.
- It was felt that administrative staff and practice managers could enhance their roles with access to more training.

Work for the Federation and CCG

- Improve access to bespoke courses particularly for pharmacists and paramedics and physicians associates.
- Spread the learning from those practices who have successfully recruited staff who are not doctors or nurses.
- Improve understanding of HCSW role and how that role can be extended safely.

DEVELOP QUALITY IMPROVEMENT EXPERTISE

The one common theme was (unsurprisingly) that people do want to engage, but there is no capacity for double-running or picking up the pieces should innovation not effect the desired change.

An “App” was suggested along the lines of the waiting times one for UHNM/Haywood which is currently available – a means that patients can access to see what the waiting times are for OPDs – perhaps even there maybe scope to have some sort of parcel-tracking type set up – you put in your booking reference number and you get a visual representation of where you are.

There was a suggestion that the Federation should employ someone with the appropriate expertise to support Practices to use appropriate tools to make quality improvements and to develop their own QI expertise.