Twickenham Park Surgery

Local Patient Participation Group Report March 2015

Profile of the Practice Population and PPG

Twickenham Park Surgery has approximately 7100 patients and formed its Patient Participation Group in December 2012. As of March 2015 we currently have 9 members who we stay in contact with face to face at our regular meetings and by e-mail and letters.

a. a description of the profile of the members of the PRG

The profile of the members of the group includes 7 women and 2 men, aged between 39-75 years with ethnic background of British and Indian.

b. Steps taken to ensure that the PRG is representative of our registered patients.

An invitation to join was displayed in the waiting area and application forms were available at the reception desk. We have a PPG section on our website which also gives information about how to join.

c. Details of the steps taken to determine and reach agreement on the issues.

Throughout 2015 the group has worked on understanding referral pathways, ensuring the system is robust and easily understandable to the surgery and its patients. This was decided on by our PPG group following on from personal experiences of the referral pathways.

d. The manner in which the surgery plans to obtain the views of its registered patients

The PPG created feed-back forms and spent time in the practice taking to patients to understand if there is a gap in communication between the surgery and hospital and surgery and patients. We examined the following questions:

1. Do patients understand why they have been referred?
2. Did patients feel fully included in the decision to refer?
3. Do patients understand the process?
4. How long should the wait be before contact from hospital?
5. What to do if patients have not heard about the referral?

e. Details of steps taken by the practice to provide an opportunity for the patient reference group to discuss the contents of the action plan. patients

The PPG were active in attending local CCG meetings to learn and discuss this area in more detail. Comments were collected from patients in the waiting room. Patient information sheets were created to set out some pathways – (urgent referrals) The PPG created a flowchart setting out the process which was put on our PPG notice board. Minutes of the discussions were shared at the Doctors clinical meetings to help Doctors identify where they could provide more information.

f. Details of the action plan setting out how the finding or proposals arising out of the local practice survey can be implemented and, if appropriate, reasons why any such finds or proposals should not be implemented.

Following on from this meeting where results are discussed an action plan will be created and embedded into practice policy. Our intention is to implement as many majority opinions as we can once the merits and/or disadvantages have been discussed.

Twickenham Park Surgery 8th March 2015

REFERRALS – working document

Objective : Patient Group to measure whether patient has understood the referrals process and felt involved in the decision making process.

What can surgery do to improve how they handle referrals?

Personal opinion / conclusion :

Not a good survey – too few patients contacted.

Remarkable level of satisfaction for a very unstable process but expectations very low. Patients surprised when things go well and in a timely fashion.

There are innumerable holes where referrals can be lost, delayed & ignored by all parties including patients.

There is not much that can be done by surgeries until there are joined up systems that track the progress of referrals & patients within the process.

Suggestions for discussion at next Surgery Patient Group:

Short term action ……

- Find a way to encourage patients to keep records up to date (address & telephone numbers essential for contact within referral process).
- GP to notify patient of referral priority assigned.
- Find a way to get message across that at the moment, patient is responsible for referral progress i.e. GP is not tracking and after what time period patient should chase-up.
- Lobby CCG to get priority for GP referrals to local & all A&Es.
- Evaluate how many DNAs (did not attend) for referred treatment and how this can be / is logged against patient.
- Investigate further the confusion of multiple referrals on patients.
- Find a way to get INTERIM & FINAL results to GP much faster along with copy to patients – lobby CCG.
- How does /can GP close referral with patient e.g. appointment to discuss results.

Longer term action….

- Get CCG to look at all types of referrals not just thru RCAS with view to creating a joined up "end to end" tracking process that can hold all parties including patients to account and provide a more timely & cost effective service.
    - RCAS Referral Assessment Service
    - Direct referral
    - Immediate to A&E or hospital ward as In-patient
    - Private
    - Social e.g. bereavement, weight, housing conditions

Patients that have been referred & agreed to be contacted.

1. **Mrs BG**
Referred to Gynaecology at West Middlesex on the 20th January 2015 via RCAS.

2/2 16:00 left message

2/2 19:30 made contact. Her home telephone number changed last week – she will come & change. She has been away for last week and hasn't opened mail yet. She said she has been ill and didn't understand she had been referred.

She agreed that it was ok to call her back in a couple of days when she had got sorted.

9/2 19:15 left message

*****P – Confusion regarding being referred**. This may become clearer on call back.

2. **Mrs SF**
Referred to Urology at West Mid on the 29th December 2014 – Direct referral.

2/2 16:00 Spoke to Leon (young child) – mummy in bed : said I would call back later.

2/2 19:45 Spoke to lady – she prefers to be called on her mobile.

She did not know about urology referral but was aware of pregnancy referral to Kingston hospital, not West Mid as she had had a bad experience there. Passed this problem to Serena at surgery and she is addressing it.

9/2 19:15 left message

*****P– confusion when there are multiple referrals in progress – they get mixed up, merged, forgotten etc**

3. **MrsJS**
Referred to Neurology via RCAS on the 5th January 2015. Through RCAS.
2/2 16:00 left message
2/2 19:30 left message
9/2 19:15 left message

4. **Mr CR**
Referred to Chest Physician at West Middlesex Hospital on the 31st December 2014. Direct referral.

2/2 16:00 left message
2/2 19:30 GP discussion very good and Dr Johal also referenced for his opinion and joint decision that x-ray a good idea so was referred. Had x-ray over a week ago but no results yet – would like surgery to call & discuss results. Passed request to Selina who has sorted it but it highlighted a problem.
*****P – When a test results in further investigations the patient is not aware of interim results, what is going on and why – quite scary for patient.**

5. **Mr SH**
Referred to Cardiology at West Middlesex on the 31st December 2014. Direct referral.
2/2 16:00 at work so short conversation. He got appointment notice within a week for a consult 2 to3 weeks later. Was happy with process.

6. **Mr HA**
Referred for Chest X-ray to West Mid on the 5th December 2014. Direct Referral.

2/2 16:00 left message

2/2 19:45 left message

9/2 19:15 instant request to leave message, left message

7. **Mr LC**

Referred to Urology at Kingston Hospital 3rd December 2014. Through RCAS.
2/2 16:00 left message
2/2 19:45 left message
9/2 19:30 left message

8. **Mrs RP**
Private Referral to Sports medicine / Podiatrist Parkside on 29th January 2015.
2/2 Too soon to call – 0 working days ago
9/2 left message & asked her to call me on my home number

9. **Mr JB**
Referred to Urologist at Teddington Hospital April 2014. Direct referral.
Subsequently referred to West Middlesex.
2/2 16:00 Could not remember Teddington referral discussion with GP or timeline so must have been ok. They also did a follow-up appointment. The result letter came a long time afterward – seemed to come from Bristol!
Patient was told to get back in touch if not heard anything (?time frame) and they would chase.
Then referred to West Mid who then referred him to another dept. This was all done very quickly.
Suggested and would be happy to have results & appointments emailed to save time & money.
*****P – Delay in getting results**

Summary of findings :

*****1 – priority/importance and wait times are hardly ever discussed -***

may be deliberate as GP does not want to scare patients.

*****2– general perception that process slow, unreliable and stressful –**

in particular, results (including interim results) must get to GP & patient without delay. Currently much too slow.

*****3– Some good experiences and levels of satisfaction**

*****4 - Incorrect telephone numbers / addresses on surgery records**
It is the responsibility of patients to keep their details up to date but if incorrect it has a knock on effect as it wastes the time of everyone in the referral process. What can be done about this?

*****5 - There is no driver for referrals.** If process stops for any reason, nobody picks up and sets it in motion again. The Patient has to be clairvoyant and know there is a problem and chase it if they have the capacity.
***6 – **Lack of understanding of referrals by patients**. Many patients do not appear to understand that they have responsibilities and for making it happen – ensuring they have an appointment that suits, remembering, attending. The GP sets it off but they are not their Mother.

REFERRALS - RELATED ISSUES

Based on previous experience and talking to neighbours ……

Special needs for consultation / tests. Are these stated on referral to ensure a suitable facility is found. This covers many existing conditions eg blind, wheelchair bound, MS, transport needs, carer co-ordination, medication needs.

Some conditions require **scoring** (e.g. sight, hip, knees, sleep, pain) to enable assessment. This is difficult for some conditions and delays referral (ie returned) due to insufficient information on first submission. GPs are not the experts that is why they are referring.

Referral assessment service refusals – how do they notify patients that the procedure / investigations they are requesting are **not supported under the NHS or local clinical commissioning group**. This can lead to conflict and scenes – Who and How is this handled??
The NHS and/or CCG justifications and contact details should be given with refusal – not left to GP to take flack and destroy relationships with patients.

Who can refer:
Can Opticians refer to an opthamologist without going thru GP. Do these referrals need scoring?
How does GP know a referral has been made?
Can Dentists and other medical professions refer direct? Who can do this?

GP referral to A&E:
A GP referral to an A&E department carries no priority. GP writes a letter to be carried by hand with patient to A&E department of their choosing. This is when a surgery does not have the required facilities eg imaging, blood tests, ecg. A patient has to wait the same as all other A&E attendees. *Does this "double wait" encourage patients to go their GP first!!??*

NHS eligibility:
It is the responsibility of secondary care to determine whether a patient is eligible for free NHS care. Just because it is a GP referral does not give this clearance as their records may be out of date

How does a GP determine that a patient is or no longer eligible for free NHS treatment. Many second homes in this area which confuses. Is an Inland Revenue check possible – single and on mass for refresher check of everyone on books?

A&E referral to Secondary Care:
When a referral is made by A&E, is a NHS treatment eligibility test made and is a reference made back to the patients GP for history? Should this go back to GP for referral and / or registration at a GP if not registered.

GP referral for Mental Health care:
Are the same processes used? Are the processes understood and do they work well?

Referrals resulting in "do not attends":
What is the level of DNAs?
Do GPs analyse their referrals to evaluate speed, outcome, black hole, patients cancelling or not attending.

Cancelled Appointments:
There does no appear to be any way of registering for cancelled appointments if you are normally available (eg retired) and can respond in a very short time.

Patient Rights:
Richmond CCG right to ….. "start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and
be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected"

this is unclear …….

Is start time from patient with GP or when RCAS approves?
Is start time for treatment after a diagnosis been made? Or does 18 weeks start when you first see a specialist? Or when you have initial discussion with GP?

GP direct referral for consultant/ tests:
Some tests cannot be made without going through a consultant and test is amended to reflect this. For example, a GP request for a colonoscopy is downgraded to a sigmoidoscopy without a gastroenterologist consult.
If patient gets home and decides they want to go somewhere else, difficult to change route – has to bother GP again (guilt!)
What is the benefit of a direct referral ? eg specific consultant, location, needs, patient choice.

Urgent Care centre referral to A&E :
This works very well. Contact & arrangements are made in advance so they are expected and treatment starts immediately.

Patient Group - Maureen Chatterley

g. Where the practice has entered into arrangements under the extended hours access scheme, the times at which healthcare professionals are accessible to registered patients.

The following information can be found on our Website and practice leaflet and the OOH telephone number is on our answer phone message.

If you need a doctor out of hours, you can call **03000 240 000**.

Calls are answered by East Berkshire Primary Care Out of Hours to prioritise for Harmoni. If you phone us out of hours, a recorded message will give you the above number and the time we are next open. Please use the out of hours service only if you feel the problem cannot wait until our next surgery.

FOR LIFE THREATENING SITUATIONS DIAL 999

WALK IN CENTRE 020 8408 8224

Walk In Centre, Teddington Memorial Hospital, Hampton Road, Teddington TW11 0JL

Monday to Friday 8 am to 10 pm (GP available 18.30-22.00)

Saturdays, Sundays and Bank Holidays 8 am to 9 pm (GP available 08.00-21.00)

NHS DIRECT 08 45 46 47

NHS Direct is a 24 hour confidential helpline staffed by expert nurses. The helpline has access to interpreters who can speak other languages.

NHS DIRECT ONLINE www.nhsdirect.nhs.uk

This is an internet site which provides information about health services, conditions and treatment choices.

Validation:

1. Our Patient Participation Group has been set up and comprises of registered patients. We recruited for the group by way of waiting room posters, application forms at reception, word of mouth and added application forms and information to our website. We felt this was a good way of making the group available to everyone. From the applications we received we worked on a first come first served basis of selection to ensure our Practice Population was represented. Our Practice population is 51% Female and 49% Male and this is reflected in our PPG. Working hours and family commitments were also taken into account. We have a high population of stay at home parents and full time workers, so it was felt that running our PPG meetings in the evening would allow easier access to the group. Our long term plan as agreed with the PPG is to make the group a "virtual" one with less face-to-face meetings and more regular on-line groups. We hope that by offering an On-line option for the group that it will become accessible to patients that would not find it easy to attend ie. Housebound patients or carers.
2. The PPG group discussed the surgery's strong and weak points to identify improvements that could be made. We reviewed comments from the NHS choices website and "comments and suggestions" received within the surgery comments box in reception. The group identified weak points within the practice from these sources and focussed our patient survey questions toward improving these issues.
3. Our survey is due to be distributed to a minimum of 50 patients on Wednesday 12th March 2014. The results from this will be collated and reported back to the PPG group at our next meeting in April 2014.
4. The group will be asked to discuss the results of the survey at this meeting and formulate an action plan, prioritising issues that need

immediate review. Our aim is to discuss implementing change if there is a majority view on a particular issue. Implementing some changes have wider implications and these will be taken into account during these discussion and where possible shared openly with the PPG group. We understand that if the surgery and the PPG group have conflicting views regarding a change to a service, the CCG can assist.

5. Once an action plan with priorities has been formulated with the PPG group, they will be kept fully informed and involved in how these changes will be implemented. We understand that the CCG can assist on this point if necessary.