Parish Council Meeting 4.9.2024

1. Has the practice considered the merits of holding group sessions for patients to attend common ailments, conditions, and issues such as menopause, which would avoid them having all to contact the surgery individually and therefore save medical practitioners time dealing with them. Jeremy

2. Is the surgery fully staffed in terms of pharmacy, nurses, doctors etc or are there plans to increase the number of healthcare professionals to meet the demand of the growing numbers in patients.

The evidence is not that the list size is growing. This has remained stable over the last 5-10 years and is always around 24-25K patients. The problem is to do with general demand per patient and complexity of work rather than increasing number of patients. The practice has adapted to this in line with its involvement in the PCN, recruiting large numbers of allied staff. These staff take on work that would have traditionally been done only by GPs. This allows GPs to focus on the more complex care needs of the average patient. Examples of this include practice pharmacists who do almost all the medication reviews now, first contact MSK who see the majority of joint problems and a mental health nurse who has started seeing patients with lower grade mental health conditions. There are also multiple other visiting staff who help with chronic disease reviews such as COPD and asthma but these staff all need supervision.

All of these roles require overview by the GPs and support. This in turn makes the GP role much more varied than in the past with supervision built into their daily workload.

In terms of staffing, we are fully staffed now with GPs compared to when the last CQC inspection was done in 2022. We are currently looking to recruit 1 nurse. We do not have plans to increase our workforce as this would be to the detriment of the business which has finite resources to spend on staff. If there was to be an uplift in funding above and beyond inflation that was recurring then we would look to expand our workforce.

Having said that, the Primary Cre Network (PCN) releases funding streams intermittently for allied staff, with a possibility in this financial year that GP roles may be funded via them. We await further details on this. There is often winter pressure funding which occurs from October. In 2022 we were able to access this and had several locum GPs with us for around 6 months which improved patient access over the winter. In 2023, the funding released by the PCN was only around 1/6th of that in 2022, not allowing us to make any meaningful staff investments.

In 2023 we were one of several practices that housed a community respiratory hub 2 days a week for our/other practices patients to access to ease pressures on A and E in the winter months. This occurred from around October to April. We have not been told of any plans to repeat this this year as

The practice offers evening and weekend appointments for patients that can't access the surgery in normal working hours. The workforce for this is an expansion on our core workforce and is a continuing feature.

3. As an elected representative of local residents, we would like to have a member of the town council on the PPG and at regular meetings, is there any good reason why this can't happen?

The Patient Participation Group (PPG) is open to all patients of the practice, and being a council member does not prevent you from joining. There are specific rules within the PPG, and if you only share information that has been officially recorded in the minutes, it is acceptable to do so. If you are wanting to join as a member, the PPG would be best placed to have this conversation with you.

4. How do vulnerable people who have no support, are immobile and or not able to use a computer or cannot use a phone whilst during their working hours cope with your systems?

We have alerts in place for those vulnerable patients, for example if a patient is deaf or blind, these alerts would show on the patient home page of their medical record, and were extra provisions are needed for these patients we put this in place.
Our doors and telephone lines are open 8am-6:30pm Monday — Friday, we feel these hours offer some flexibility to all patients.

5. There have been many newspapers reports about patients waiting in lengthy telephone queues early in the morning to speak to a GP reception for an appt/advice. How do Deepings deal with this. Tracy/CIare

It is a common challenge of managing high volumes of calls, especially during peak times like 8 am. We have 8 receptionists and team leads on each shift ready to answer calls but as you've noted, it can still lead to overwhelming queues. We regularly review data and we have an appointment group meeting attended by practice managers, 2 partners and reception / rota team staff. In this group we review all call data inc times of calls, call back info, wait times, talk times, and peak times during the weeks. The average wait time to answer a call is 8.5 mins and the total inc talk time is 11.25 minutes.

We are considering a new way of working that some local practices have implemented which has made the gam rush disappear due to all contact being online. patients can book appointments, ask questions, or request repeat prescriptions online. This system not only helps in managing the morning rush but also allows staff to allocate their time more effectively, focusing on more complex issues that require personal interaction.

6. The CQC inspection in March 2022 rated and improvement needed in the category responsive. Have the actions taken in this response to the concerns raised remained robust and effective. How are they assessed by the practice on an ongoing basis to ensure continually understand and deliver the needs of your local population. Dan

In 2022, the practice had a system of only allowing people to call on the day for an appointment, once all of these were gone, the patients were being told to call again the following day. Many practices still use this system. We decided not to continue this but now operate a waiting list based system. This means that patients only make one call for routine problems and the practice then contacts them when an appointment becomes available. Anyone with an urgent care need is either added to the same day emergency list or told to attend urgent care by reception who act as care navigators.

Reception follow strict protocols for this designed by GPs and will ask GPs who are on call if they are not sure about what to advise a patient. This system is much more responsive to the individual patient than just telling everyone to call back the following day.

Wait times for routine appointments can be several weeks but at least patients are not making multiple calls for the same issue and clogging the phone lines. Primary care in general in England cannot meet patient demand Even in spite of these measures the phone lines become full. Once a patient is into the

phone system, the average time to call completion is only 8-9 minutes. We use a callback system so patients can use this rather than waiting in the queue itself. Reception is fully staffed with no option to expand due to no increase in baseline funding by NHSE for many years in a

row.

GPs provide a lot of background support alongside usual booked appointments. This occurs in the form of 'tasks' sent by reception or dispensary to the GP where patients are asking for advice or prescriptions outside of booked appointments. This gives patients often huge access to their GPs outside of any booked formal appointment, Examples would include requests for further supplies of acute medications, reviews of skin lesions via photo with advice returned by the GP within a few days and fit note requests.

The average number of tasks which save appointments per week per GP is 70. If I chose to not engage with the above and replied to every message saying to just book an appointment, 70 more patients would be added to the waiting list. As we have 7 partners who largely behave in the same way, this would be nearly 500 extra patients waiting per week.

We plan to reintroduce online appointments soon. This will be an increase in baseline appointments as GPs will offer more slots per session than a phone session or face to face session. This system requires reception support in the background and takes receptionists off the phones or off their other duties to do this work. With a finite resource we always have to choose what our focus will be on. When one item increases or is a new item, another item will be affected detrimentally. We hope that the net increase in appointments will ease the phone burden and improve the patient experience.

7. Please can the practice instigate where possible a repeat prescription generated annually for relevant long-term conditions e.g. epilepsy narcolepsy.

We must work safely and cannot issue medications for a long period of time without any review, doing this would be dangerous and cost the NHS an extortionate about of money due to medication wastage.

8. It is almost impossible to get an appointment on the app at 8am. The usual availability is a blood appt if ordered by a GP (how when you can't get an appt to see/talk to a doctor) F2F physio phone physio. Before covid you could call in and get an appt in advance. A full explanation of the appt system and changes to it since would be most helpful.

As above, demand compared to pre covid is incomparable. Total practice appointments have gone up from around 135k a year pre covid to 190k a year now. Every part of the NHS is busier. As above, we are reintroducing online triage. Appointments are released on a rolling 2 week basis. These are now always taken by the waiting list patients. It would be inherently unfair if we were allowing patients to book GP appointments online ahead of the people that have been waiting for a slot and would discriminate against those patients that can't use online booking.

Physio is not employed via the practice. These services are provided by other NHS providers who use rooms in the practice. We cannot tell them how to run their service and patients should feedback to the providers of this if they are not happy with the service they receive. We can pass on any feedback to them but cannot reply to these complaints for them or force them to change their system.

9. Are statistics available that analyse the number of lives that could have been saved through speedier intervention, accurate diagnosis, and subsequent treatment, contingent upon this, if the patients services this avoidable delay, would their quality of life have been so much better. Dan

Not specifically. This is a wide sweeping question that would involve complex data analysis. The ICB does not do this. We have been asking for a long time for our figures for our patient attendance at Spalding UTC. We recently got these and discovered that we were one of the lower volume users per patient population for our PCN. Our patients used the UTC 10% less than predicted for the size of our population. With the change in system, I would argue that patients are being directed to appropriate urgent services now in much more timely way. In the past all patients would be told to call back the following day or attend urgent care. Almost all patients in the past would be very reluctant to go anywhere else other than the surgery so would delay the help they needed by waiting for the next working day. This would have a direct effect on their mortality as they were leaving things too long. There has been a slow but positive culture shift on our patients who now are more willing to travel the short distance to the UTC, A and E or Stamford minor injuries to receive timely help for their urgent problem.

10. It appears that the GP's are not supplying the services as pre covid and patients are referred to 111 or the walk-in centres/A&E. Therefore, my question is do the GP's feel partially responsible for the horrendous waiting times at the hospitals because they are not doing their fair share of seeing patients.

No. We have recently received our data for usage of the UTC and Spalding and the results show we underuse the service.

Primary care workload has increased, and we receive extra workload from hospitals that contractually should not be passed onto us. The funding for primary care is shrinking.

11. One of the main concerns has been the length of time it takes to get a f2f appt with the GP. If the practice were able to find and recruit more doctors would the present Deepings practice financial position be able to fund this. Also, more nurse practitioners recruited and employed would help this situation.

No, there is no funding available to increase GP workforce. What people don't realise is that face to face is not a panacea of great care. Much can be done on the phone in a much more flexible way for most patients. GPs do more consultations in a phone clinic than a face to face clinic. Converting back to all face to face would lead to a drop in appointment numbers and would increase our waiting lists, Patients that struggle to leave work would have reduced access to health advice since they would have to take time out to attend the appointment.

We operate a telephone first system for efficiency. If a patient only wants to be seen face to face they can speak to the GP during their call and request this. GPs can then offer a lot of flexibility as to when they can be brought in to be seen. The same funding problems exist for ANPs. There is no funding for this at the current time. Also increasing ANPs only generally props up urgent care available in other parts of the NHS since they generally see acute cases. This does not help the patients waiting to have routine or follow up care.

12. Thinking from a parishioner viewpoint. I would ask when we will be able to book a doctors appt at Glinton practice. Many of the Glinton residents are old and have mobility issues. At the moment it seems the surgery is just used for physio and some nurses which is good but adding doctor appts would help patients.

We have doctors clinics at Glinton 5 days per week, some of these are telephone clinics and some face to face clinics.

13. I would like to know how the practice feels about any potential enlargement of client numbers i.e. if more houses are built. With the Deepings and surrounding areas growing at quite a speed and the number of patients growing what steps and plans are in place to accommodate the increasing numbers.

See previous answer re our patient numbers not changing much. If the locality were to dramatically increase in size we would need to review this then. We have no plans to close our Glinton branch (As asked on during the meeting).

14. Can there be a better process for providing timely appts for results?

We offer appointments as soon as we can based on the demand of our service and the priority of the appointment. As discussed previously we are looking at different appointment systems to see if they would improve the wait times, whilst ensuring we are all working to a safe limit.

15. We know that you were turned down for a walk-in centre, why and can we apply again with the backing of all the other councils. Tracy/Claire

This is something that we have had conversations about with the PPG, as a practice we do not feel we can bring this up again with the ICB as we have nothing new to give. This would be down to local councils putting pressure onto their member of parliament to start new conversations which we would be more than happy to join at the table if this moves forward.