Patient Newsletter – Spring 2017

Staff

The Partners are sad to see Dr Laura Spencer leaving us in April (to a practice nearer her home) but really pleased to announce that we have secured a replacement to cover the same days and hours so patient care will not be compromised.
We will unfortunately be losing our registrar Dr Raniah Eisa, also in April, who has been a fantastic addition to the practice team and has now fully qualified as a GP, and hopefully will start on her new career, after she makes a further addition to her family. We wish her well on both of these new changes.

Our new advanced nurse practitioners, Rubby Legbedze and Lidia Coates joined us in October and have already made a huge impact on the appointment system, with appointments still unfilled at the end of some days.

An idea from our PPG group was to have some details around the routine day your doctor is faced with, and thought the best place for this would be on this newsletter;

A Routine Day in the Life of a GP

7:30am – The morning staff arrive to get the surgery ready for the day and open the doors and telephone lines at 8am.

8am – Log onto the computer. Try to be as productive as possible before morning surgery starts. Look at any communication from Out of Hours GP service (electronic messages and faxes) about patients who have contacted them after 6:30pm. Occasionally have to list patients directly for a home visit this morning, but most of the time they are filed for information, onto the patient records. Look at electronic blood results that have come in overnight and action as many as possible. Most can be commented upon in lay terminology for the reception team to be able to read out to patients who call for their results. Some need urgent action which may be a telephone call to the patient, or the issuing of a prescription. If appropriate, this may be delegated to a member of the nursing or admin team. Look at electronic 'patient tasks' that can be sent to us from outside providers (such as the heart failure nurse, or the district nursing team). They can be for information only or needing action.

8.30am 10-40 – 2 hour morning surgery with patients at 10 minute intervals. This time is to read the computer notes and results prior to calling the patient into the room; take history; examine and then make a management plan with the patient. The documentation of each consultation also needs to be done in this time frame to ensure it is accurate. Investigations or referrals often need to be done later due to not being able to fit it in. Understandably dealing with more than one medical problem per appointment is often impossible and due to medical complexity some consultations over-run their allotted time frame. I regularly run 30 minutes late by the end of morning surgery.

10-45-11am – Clinical team catch up and coffee break, whilst the sessions usually over run here we try and manage a quick 5 minute chance for a coffee, and to discuss any home visit requests that have come in this morning so that even if it can't be the same GP seeing each patient, we do have an input into their care.

11- 12:30pm – 1.5 hour morning surgery continues as above, with some additional telephone consultations at five minute intervals. Some things can be dealt with appropriately within this time frame but occasionally can take just as long if not longer than a face to face consultation. Some patients do not answer so a message is left and I will try again later.

1pm – Leave practice to do any additional home visits for housebound patients. We are lucky to have a group of ECP's (Emergency Care Practitioners) working for the Hinckley and Bosworth Locality as the 'Acute Visiting Service' and they will see any acute needs, but after they are full, we need to visit the remainder and the chronically sick.

1:30pm – Writing up visits and making any necessary action plans such as acute prescriptions being organised for delivery or referring onto a member of the multi-disciplinary team. Find time to eat some lunch before afternoon surgery starts. May need to call specialist in hospital for some advice on a patient. Debrief GP Registrars (Doctors in training to be a GP) on their patients.

2.00 – 3.30pm - Keep up with the hundreds of prescriptions I need to sign and check each day, as well as reading approx. 100 letters on our electronic document system, and dealing with approximately 50 blood results. This is also the only time I have to deal with any referrals or admin work that was not able to be completed in morning surgery.

3:30pm – 2 hour afternoon surgery at 10 minute intervals., with additional slots to assist with duty doctor, to allow the guarantee that if your needs are urgent you will be dealt with on the same day.

6:30pm – Last patients leave the building. (If we are running on time)

6:00pm onwards – Time to ring patients who missed telephone consultations or to discuss any urgent results. Read and action post, emails, tasks and blood results that may have arrived during the day. Answer any acute prescription queries. Dictate referrals and organise investigations such as X-rays. Often leave the building at 8pm ready to do it all again the next day!

"I found this quite difficult to write as no two days are the same! Generally we have 'routine days' and 'on call days'. These are vastly different to the above – which is classed as a routine day. On a duty day I may have as many as 80 patients in a morning or afternoon session, with 'emergency appointments'. I am constantly being interrupted for urgent telephone calls about patients (for example the A&E department calling about a patient they are admitting; consultants calling with urgent results for us to action; community nurses calling about a patient who may be in the last days of life at home; care home staff calling about a resident who is unwell). I am also seeing patients in the surgery that the nurses, Advanced Nurse Practitioner or Registrar feel need a GP opinion, which cannot wait for a routine appointment. On these days it is expected that patients may have a longer wait in the surgery to be seen as the workload for the Emergency Doctor has to be triaged in order of clinical priority (hence why you are asked to give the receptionist a brief explanation of the problem when booking an emergency appointment). We are often faced with the backlash of an A&E system that is at is knees, and patients attend that would previously have presented in hospital, thinking its quicker and better, which it often is, but means we have a doctor involved for many hours meaning other patients are faced with a difficult wait.

We know we are often seen as 'not doing enough', but with our funding based on 'number of patients' rather than 'usage 'of the practice, we simply can't afford to do any more to meet the increasing demand, and whilst something has to give, you can see from a normal day, it's not just the patient that suffers exhaustion and frustrations from this system.

Dr Mitchell.

General Practice – A Profession in Crisis…

Nationally and locally we are currently under exceptional pressure as patient demand is rising and Governmental Incentives mean our workload is increasing as we take on more clinical cases that would have been traditionally dealt with by hospital consultants. There is a severe shortage of GPs and we know there is a high level of burnout amongst the profession and practice staff. A high percentage of GPs coming towards the end of their working life are planning to retire early due to the pressures, and recruitment onto the GP training schemes is challenging.

At Station View each GP is working of average 50 hours a week (even the part time GPs). To ensure we continue providing the high level service we are known and respected for. We are trying to modernise the way we work by utilising the most appropriate clinician for each case. The nursing team are crucial in this as they are highly experienced in General Practice conditions, our Advanced Nurse Practitioners are very experienced in conditions that do not need to see a GP.

We are strengthening our admin and managerial staff due to the demands being placed upon the surgery. Please trust us that we are working exceptionally hard to continue to work as well as possible in the current circumstances. We want to continue to provide a local service run with the best interests of our patients at its core.