**Dr PAA Wood & Partners**

**Patient Participation Group Meeting**
**Minutes of meeting**
**Tuesday 9th January 2018**

**Present:** Dr Caroline Saxelby, Dr Niall McKay, Geraldine Comery, Eddie van den Bron, Vanda Vickers, Neil Croll, Marianne Croll, Irene Sobek, Dorothy Fisher, Alan Nichols, Ann Askey, Pat Eley, Tony Eley, Andy Ronaldson, T.C. Rouse

1. **Apologies:** Lyn Stevens, Margot Keats, Ann Butler, Barrie Armitage, Brenda Armitage, Val Haylett, Vicky Allison, Rosemary Smith, Judith Johnson, Tom Bradley

**Vanda Vickers agreed to be Minute Secretary for the Group**

2. **Minutes of the last meeting 11/10/17:** Agreed as a correct record.

3. **Matters arising :**

- Some group members became Patient Volunteers for Derby Royal Training Hospital following last meetings presentation. They were all very positive about the experience.

4. **Dr Caroline Saxelby End of Life Talk**

As well as being one of our GPs, Dr Saxelby is a Southern Derbyshire Macmillan GP Specialist in End of Life Care.
Dr Saxelby explained current and planned systems to facilitate patient's end of life wishes.
The key is compassionate and supportive early communication with the patient and chosen relatives or important others.
Ideally an End of Life Plan would be composed in the potential last 12 months of life but circumstances might mean it happens sooner and be subject to change.

Dr Saxelby outlined the circumstances that would trigger an End of Life Plan:

- advanced progressive and incurable conditions
- frail with co-existing conditions
- sudden death
- combination of conditions, patient wishes and circumstances

In 2013 the Liverpool Care Pathway was reviewed and was criticised for poor communication.
As a result a Leadership Alliance was set up - a meeting of professionals to consider how processes could be improved.
It was considered that there was 'One chance to get it right' – individualised care to manage the last days of life.
Derbyshire took a joined up approach. They looked at other Authority's plans and all relevant documents including the GMC publication on End of Life.
The Derbyshire Alliance for End of Life Care, comprising of physicians and facilitators such as Marie Curie, Macmillan, and NHS England considered approaches and systems to ensure the best possible outcomes.
An 'End of Life Toolkit' was produced – a web based application giving information for the public and professionals. It covers symptom management, spiritualty, and medication management.
Included is a 'Recognising Dying' form. It considers clear communication with the patient and relatives or important others.
There are no tick boxes, more an aide memoire format so that anyone who sees patient can complete the form. This gives a clearer communication of what those involved - carers for example - see and think.

Opinions and observations of family are sought to see why they may feel an End of Life Plan is appropriate.
This is part of a national initiative to improve End of Life Plans running 2015 – 2020 to produce ideals for coordinated care – not just the condition but for a person with a condition.

Dr Saxelby shared outlines on how to identify who may need an End of Life Plan
She stressed this was not purely about whether or not to carry out resuscitation should a patient suffer heart or respiratory failure.

- Conditions such as inoperable cancer, long term palliative care; the GP recognises the condition is too progressive
- long term conditions where there little more to be offered e.g. heart failure receiving maximum therapy but accompanying kidney problems, respiratory disease – a steady regression
- a crisis might present – the patient may not have seen a GP for few years and symptoms have either gone unnoticed or the patient has chosen not to act on them
- patient may not wish further treatment
- at A&E other problems may be discovered

Following discussions with family/important others, a worst case scenario is considered and decisions about resuscitation and further actions are made.
There is an increasing number of senior people with dementia and it is increasingly important to consider patients with dementia, and to gather their wishes

Once a need for End of Life Plan has been identified:

- Discussion maybe with patient and relatives/important others – what **they** want from treatment at the end e.g. treatments such as oral antibiotics at home, not hospitalisation – or maybe hospitalisation but if no improvement they want to go home to die
- Not everyone does want to die at home e.g. if they live alone
- If there is a partner at home there needs to be an agreement from the partner. This is particularly important when the patient is younger – it may be traumatic for survivors
- Resuscitation is not always clinically appropriate e.g. if chemo type wouldn't work, don't offer it

Regarding CPR:

- Following a complete collapse the chances of complete recovery are only15% [decreasing after 65yrs]
- Procedure is undignified, possible broken ribs, and the quality of life afterwards is very unlikely to be same
- Currently 1 form for CPR
- CPR may be given if your heart stops and you stop breathing

Medications are discussed – maybe regular medications are no longer relevant.
GP would prescribe anticipatory medications to make the patient more comfortable; these would be given as early as possible and would be in the form of injections from district nurse. The necessary drugs would be delivered and available at home, ahead of time ready to make the person comfortable
Information will be supplied regarding what to expect e.g. hospice care and support, dementia support – the general support plan.
Out of Hours Services will be made aware.
The form should be at home, readily available. This could possibly be left with the district nurse if they are already involved
Carer needs are considered. If they reach crisis point, night sitters from Treetops or Marie Curie are available.

Nursing Homes beds – palliative care can be offered to give carers relief. The Practice looks after patients in two such beds in Stanley House.
The plan can be re-visited. GP arranges relevant reviews and increases the frequency of visits towards the end
GP has to officially confirm the death.

A new form 'Respect' is being considered for implementation by Derbyshire trusts.
It is a summary plan for emergency care **and** CPR.
The aim is for one form for all [currently hospitals have their own]. There have been problems – hospitals unaware of a patients final wishes.

There is a growing trend for people wanting to die at home, but it takes great deal of planning. Also situations change, people may change their mind at the time. It is all about planning/discussions.

Nationally 50% people die at home. Our surgery facilitates 68% patient's plans to die at home

**Further information can be found at;**
www.derbyshire.eolcare.uk
www.dyingmatters.org
http://respectprocess.org.uk

5. **Dr Niall McKay - Changes to the appointment system**

Dr McKay acknowledged the current difficulties obtaining an appointment, despite GPs working 12 hour days to efficiently and effectively deal with patient care.
The current system 'blocks out' times. This is the safest option to allow for emergency appointment calls on the day but means not enough pre-bookable appointments are available
Online appointment bookings can only be made for two weeks in advance. Telephone appointments can only be made on the day within a small timeslot.
This causes frustration for patients and staff alike, hence new plans for the appointment system

Dr McKay gave background information:
Nationally there is a catastrophic overload of patients. There is a big increase in the number of patients and their complexity of need. More patients need to be seen more frequently and for longer. Surgeries have a significant number vulnerable patients. The allocated 10 minute appointment slot is insufficient to deal with the complexity of care.
Whilst extra funding means Primary Care and Outreach services are to be increased, there is to be no additional funding for GP practices.
The implication is the generation of more 'cases' for GPs without any additional support.

Dr McKay stated the need to make the appointment system more efficient, allowing complex needs to be met and increase the availability of 12/15 minute appointments, bookable in advance
Research has shown a telephone on the day acute demand triage system is more efficient and effective.
A telephone consultation with a GP or Advanced Nurse Practitioner (ANP) would signpost the patient to the next step, e.g. visit to the pharmacy, self-medication or book an appointment.
A GP and ANP would run the triage system, hopefully increasing the number of pre bookable appointments with the other GPs
The Practice has advertised the post of ANP and will implement the new system in due course.

Dr McKay requested feedback from the group following the implementation of the new system

6. **GC Medicines order line – carried over to April meeting**

7. **GC Survey results – carried over to April meeting**

8. **Email/Contact details being shared to Chairman**

   Do group members who supply email addresses object to them being available to the Chairman so he is more able to communicate relevant information to group members?
   All agreed with their email addresses being made available to the PPG Chairman.

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9. **Chairman's Update – carried over to April meeting**

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10. **AOB**

    The patient arrival screen software at Park Farm Medical Centre had a fault but is now back up and running.
    It includes information available in other languages. The patient data was surveyed as to which languages were most appropriate.
    The new system is very easy to use and is being encouraged.

11. **2018 Meeting dates agreed:**

Wednesday 11th April 2018
Wednesday 11th July 2018
Wednesday 17th October 2018