Patient Participation 2014/ 2015 – Priority Areas and Implementation Action Plan

3 Priorities agreed with the Patient Group (Description)	Actions (what actions were taken to address the priority)	Progress (Result of actions and impact on patients and carers, including how publicised)	Review Comments (Progress reviewed January 2015)
1. Proactive care for over 75s (800+ Patients) Organise an over 75s working group to decide on additional services we can offer to patients over 75 to support them with their health and wellbeing.	• An over 75s working group has been set up. • All patients over 75 sent a letter to invite them to the Practice for a Health Check Plus. • All patients over 75 have been sent a letter to notify them of who their named GP is. • Wellbeing Enterprises agreed to work with us to develop services and educational sessions. • Additional GP employed for 12 months from August 2014 to free up GP partners to work on further development issues.	• Working group now in place and several meetings have taken place • A number of possible ideas to trial have come from the group, including: ✓ Set up an initial prevention/support/education session for a selection of over 75s, inviting lots of outside agencies to highlight what is out there to help everyone continue to live well in their own home ✓ Set up a special survey for over 75s to get their views on what services they would like to see. ✓ Check viability of developing an annual proactive call to over 75s not seen in surgery ✓ Consider introducing dedicated telephone slots for over 75s. • Initial prevention/support session took place on the 20th September. To limit numbers attending his session was aimed at those patients over 75 who currently have no chronic illnesses. The session was extremely successful and very appreciated by all who attended but numbers were disappointingly low • A survey was distributed to those patients who attended the prevention/support session. The feedback from this survey was positive but not enough returns to confirm what new services might be needed. • Patient newsletter issued in summer 2014, asking patients aged 75 and over to let us know their views on services	• Wellbeing approached about offering proactive calls to those not heard from during year. Some IG/data protection issues still to be resolved but ok in principle • Agreed to roll out education/support sessions to other practices. • In light of Prime Minister's challenge Fund (PMCF) bid – see below – it was decided to wait until we know the results (expected mid March) before deciding what actions to take next. Next meeting of working group to be held in April to consider next steps

2. Develop education support sessions. Organise 4 patient education/support sessions over the year for patients diagnosed with a selection of chronic illnesses and/or who currently use a lot of Practice resource to help educate and support them to live well	• Agreed that we probably need to concentrate on those groups of patients where we can have the most impact and who may need the most support – eg older patients, young families, teenagers or those with a chronic disease such as diabetes, stroke or COPD. • Agreed to trial concept with the over 75s to start with.	• The first education/support session took place on the 20th September 2014 for patients over 75 who currently have no major chronic illnesses. Working with Wellbeing Enterprises, a varied programme of health talks coupled with demonstrations/talks from local social and wellbeing organisations was put together. A large number of local organisations also attended to run "market stalls" advertising their services and giving patients support and advice. Invites were sent to xx patients (see attached copy of the invite). Although numbers attending were disappointingly low, both those patients who did attend and the representatives from the various support/local organisations thought the concepts was excellent and could see how it could work effectively on an ongoing basis.	• The work done so far at Grove House has led to the concept being included as a project within the CCG bid for the Prime Minister's Challenge fund. If successful, the funding will enable the trial of these sessions to be extended – both in terms of groups of patients targetted and including other Practice populations locally.

3. Improve Patient Access to a GP Look at ways to deliver more availability of GP advice/treatment.	• Agreed to introduce Emis appointments system which will impact on access and should make some things easier to achieve. • Employed a temporary (12month contract) GP to improve the number of appointments offered whilst also giving the GP Partners some time to look at alternative ways of delivering our services • Agreed not to use locum GPs for a trial period (as patients often see the locum and then book so see a permanent GP, just to check locum advice – which is wasting an appointment)	• Emis appointment system is now in place • New online booking service in place • The new GP (Dr Rees) started in August 2014 and, in addition, the Practice started our first registrar GP (Dr Coogan) in September 2014 for a 6 month period • No locums have been used since September 2014	• Although access is a regular agenda item for the Patient Group meetings, agreed that we will make a whole meeting about access to appointments early in the new financial year (once the results of the PMCF are known and any actions needed as a result are taken care of)