Epsom Downs Integrated Care Services

EDICS Patient' Forum Meeting

Venue: Tuesday 2nd December – 12.30pm: Ebbisham Centre

Present
Mr David Heal (Ex Epsom & St Helier PPI Forum, Vice Chair Mid Surrey Transition LINk)
Madeline Boissiere, member project team women and children's services
Sonia Begley Moore, member project team women and children's services
Jo Forrest, Epsom Branch Diabetes UK
Mr Peter Raw, Member of local health consultative committees
Rosemary Najim, Surrey Transition LINk
Bess Harding, Epsom Medical Equipment Fund
Cll Chris Frost, Surrey County Council, nominated substitute member of Surrey County Council Health Scrutiny Committee
Mr Alan Barnes, patient representative, Walton on the Hill
Dr Elena Cochrane, GP and Gynae Lead, Tattenham Clinic
Dr Peter Stott, Medical Director, EDICS
Ms Kate Harper, Administrative assistant, EDICS

Apologies
Cll Nick Harrison, Deputy Mayor, Reigate and Banstead, nominated substitute member of Surrey County Council Health Scrutiny Committee
Mrs Mary Raw
Dr Anne Hollings, Medical Director, EDICS
Dr Liz Barr, GP and Paediatric GPSI, Tattenham Clinic

1. Introductions

2. Minutes of the last meeting
In section 5: Title should read 'Integrated care PBC+ pilots'
In the last sentence of section 6: Last sentence – insert 'PS replied that 'EDICS is''
In the last sentence of section 6: Change the word 'metrics' to read 'measurements'.
Otherwise the minutes were accepted as an accurate record.

3. Matters arising from the minutes
Section 5. Integrated Care PBC+ Pilots

Dr Stott informed the group that 18 practices (the MEDLInC group) in the Epsom, Leatherhead and Elmbridge area has been successful in their bid to become a PBC+ Integrated Care Pilot and that he would be speaking on this topic later in the meeting.

4. What do patients want from women and children's services?

Bess Harding presented the results of a survey she had personally conducted on behalf of the group with women attending Epsom General Hospital. She split her report into three sections: maternity, paediatrics and gynaecology.

(a) Maternity: Women liked the continuity of care that midwives could provide, and particularly the idea of having a named midwife to whom they would related throughout their pregnancy and delivery. The majority wanted a consultant-lead hospital birth, feeling that this was safer than giving birth at home and that provision of pain relief and epidural analgesia was more certain than in a midwife-lead unit. Women with previous problems valued the 'pregnancy nurse specialist' who they could speak to early in pregnancy.

Bess felt that the women she had spoken to liked Epsom General Hospital because it friendly and cosy with helpful staff. They felt larger hospitals were more impersonal. Several of the mothers were from out-of-the-area and had chosen EGH as their first choice. There was dislike of low midwife staffing ratios and having to change rooms during labour. Some patients felt that acupuncture, yoga classes, and reflexology would be helpful.

Women wanted their ante-natal and post-natal service to be available locally, ideally in their GP's surgery with midwife and ultrasound provided. They would not be adverse to check-ups at a local clinic provided there was continuity of staff. On returning home after giving birth, some patients wanted more visits from the midwife. Others were happy to attend the GP's surgery.

Paediatrics: Mothers liked the drop-in clinics at their GP's surgery which were useful if they had minor problems. Shadbolt Park Surgery was mentioned as one which has a clinic on Monday afternoons where there is a health visitor, GP lead and consultant paediatrician from EGH. If there are more significant problems, the consultant can then refer them back to the hospital environment for further tests. EGH also runs a busy day-case unit for children who need urgent care or surgery and has inpatient beds for local children receiving cancer therapies and sick children from Tadworth Court. EGH also has a Children's Home Care Team which manages many types of long-term conditions in the patient's own home. Moving children's inpatient care for surgery and orthopaedics to St Helier Hospital has resulted in longer travelling times for parents and can be damaging for families. Thought should be given to moving this back to EGH.

Gynaecology and General: Bess Harding expressed a number of concerns which were of relevance to community based clinics (such as the EDICS clinics).

(a) Patients would like to know more about the triage process, where they have been referred and why

(b) When referred, patients expected to see a consultant. If they are to see a 'specialist' (eg a GPSI or specialist nurse) then they would like further information about this clinician so they can make an informed decision. They would like to know their insurance cover and training.

(c) They would like to know that strict protocols are in place to give them confidence and trust. This is particularly important in respect of premises, cleanliness, appointments, privacy, dignity.
(d) If medication is needed as a consequence of the consultation, then a prescription should be issued at the time. It is a nuisance having to go to their GP to get one. Patients attending EGH are given two weeks supply of medicines.
(e) If minor surgery is needed then the patients want to know that the back up of the general hospital is available.
(f) Siting of clinics: Having to attend a clinic in Tadworth is difficult for patients in Worcester Park.
(g) If blood tests, XRays or ultrasound are needed, patients would like them to be done at the time – the one-stop shop as happens at EGH
(h) Patients would like to know of any patient surveys which have taken place.
(i) Patient would like more information on the alternatives to hospital

There were many issues raised by this presentation. Rather than debate them directly, PS suggested that Dr Elena Cochrane should give her presentation on the workings of the community gynaecology clinic and that this might answer many of the issues raised.

5. Intermediate Care: EDICS Gynaecology Clinic

Dr Elena Cochrane is a GP with special interest in gynaecology (GPSI). She is the lead for the EDICS intermediate care gynaecology clinic at Tattenham Clinic. She outlined her training and background in gynaecology describing how she now works with consultant gynaecologist Miss V Kakumani who is present at all sessions. When Miss Kakumani cannot attend, a deputising consultant is usually available. The consultants come from EGH and work through their Trust contract, subcontracted to EDICS.

Dr Cochrane described the process of triage and how cases are selected as suitable for the intermediate care clinic. Where she feels that more investigation is needed prior to the patient being seen, then this is arranged. The clinic takes gynaecology cases which are clearly medical or which involve simple surgical techniques such as insertion of a vaginal ring or an intrauterine device. Many of these cases could be managed by an experienced GP in general practice. Cases which are clearly surgical or more major are passed directly to EGH or other preferred hospital. Where the patient and GP have expressed a clear choice of provider, this is respected. Overall, the clinic takes about 30 percent of all gynaecology referrals. Dr Cochrane manages each case according to agreed protocols. Each case is discussed individually with the consultant before the patient is seen, and again afterwards.

Medical Indemnity: Dr Cochrane is covered by her personal medical indemnity (as are all GPs). Working on contract from the Trust, the consultants are covered by Crown Indemnity.

The clinic is purpose-built for general practice but is ideal for the purposes of the intermediate care gynaecology clinic. It has modern consulting rooms and a minor surgery suite. The facilities at Tattenham Clinic are inspected annually by Surrey PCT. The clinic has performed a previous patient survey which showed above average satisfaction and is currently performing its second survey.

EDICS clinics have a limited prescribing allowance. Where a patient needs an urgent prescription (eg antibiotics or the morning-after contraceptive) then this is prescribed immediately. Where the treatment is longer term, the preference is for the patient's own GP to

be involved so that this medication can be added to their computer record and potential interactions checked.
Investigations: Since this is an intermediate care clinic, it is impractical for all investigations to be immediately available. Blood tests, Xrays and ultrasound are often requested prior to the patient being seen. Where more complex investigations are needed (eg as an in-patient or day-case) the consultant arranges these directly at EGH.
The Tattenham gynaecology clinic is one of two intermediate care clinics. The other is at Leatherhead Clinic. Dr Stott said that improve access for the whole EDICS population, then ideally one could also be run in the Bourne Hall area. However, facilities are not available for this at this time.

There was considerable debate following this presentation which was helpful in putting Bess Harding's queries into context. There was clarification of the qualification and ongoing accreditation of GPSIs which is managed by a subcommittee of Surrey PCT. The group discussed the type of cases that would be seen in a community setting noting that liaison with the acute provider was essential. Ultrasound provided at Shadbolt Park Surgery and Heathcote Surgery were felt to be inconvenient for some patients. There was also a general feeling that patients would like more information on what would be happening to them in this new type of clinic. It was also felt that there was more likelihood of information going astray between intermediate care and EGH. Dr Cochrane said that while there was a common medical record for both providers for paediatrics, this was less of an issue in gynaecology where the community and hospital notes are separate. However, when a patient needs to go to hospital, the whole record is photocopied and sent with them.
The group felt that patients should get a copy of the letters written about them. Dr Stott said that he too felt this was appropriate, but that there could be legal problems with paediatrics when parents were separated or issues relating to parenting were involved. He promised to raise the subject of patients receiving copies of letters with the appropriate groups of clinicians.
Jo Forrest felt that there were particular issues in relation to patients with diabetes. From her work with Diabetes UK, she felt that the most important thing for patients was continuity of care, and that patients should get to know their clinicians, and see the same person each time they attend. Dr Stott felt this was an important part of intermediate care, which was in effect a hybrid of the personal GP style with a specialist touch. He felt it was important that compared with hospitals, intermediate care should offer an enhanced level of access. He encouraged his staff to be available on the telephone for patients with long-term conditions and to use the telephone to facilitate follow-up.

6. Intermediate Care: EDICS Paediatric Clinic
In the absence of the relevant clinicians, it was agreed that this topic be postponed.

Dr Cochrane left the meeting at this point.

7. MEDLInC (Molesey, Epsom Downs and Leatherhead Integrated Care)
Dr Stott outlined the principles behind a new development in the area – MEDLInC. This is a Practice Based Commissioning Plus Integrated care Pilot (PBC+IC pilot). In this 2-year pilot, Surrey PCT has given 18 practices in the area more ability to innovate and create new services. IC status gives the practices the ability to act both as commissioners and providers

of care. This obviously brings the potential for conflicts of interest. One of the tests of the pilot will be its ability to create transparency and manage these conflicts to the satisfaction of all involved. To do this, a strong audit committee with investigative powers will monitor all contracts between MEDLInC and provider organisations.
The project will create innovation in 7 public health areas, in urgent care (ie A&E), in prescribing, and in enhanced care pathways. The project will develop new Gateways into services and will be expected to bring together the many providers in healthcare, local authorities, private and voluntary agencies. The 18 GP practices will be expected to create savings to fund the costs of this project.
Dr Stott emphasised that so far, the Patients' Forum has concentrated on EDICS' provider function. He asked whether the group wished to move to consider MEDLInC's commissioner role, or whether it felt it should divide in order to avoid conflict of interest. David Heal suggested that in his experience, separation of the two roles might be more satisfactory in the long run. Overall however, the group were eventually unanimous in feeling that combining a view on both commissioner and provider functions would make their role more useful. In future, therefore, and for a trial period, meetings will be arranged in such a way as to create clarity when these roles are involved.

7. Next meeting: the next meeting will be arranged in around 2 months time and will focus on services for children and the developing arrangements for MEDLInC.

PCS
12 December 2008