Epsom Downs Integrated Care Services

Minutes of the meeting of the EDICS and MEDLInC Patients' Forum held at 12.00 pm on Wednesday 1st April 2009 in the Roseberry Room, Ebbisham Centre, Epsom

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
Mrs Mary Raw, Member of local health consultative committees, Ex Paediatrc Nurse EGH
Bess Harding, Epsom Medical Equipment Fund
Cll Chris Frost, Surrey County Council, nominated substitute member of Surrey County Council Health Scrutiny Committee
Rosemary Najim, member project team women and children's services
Bess Harding MBE, Epsom Medical Equipment Fund
Lena Wanford, LINk
Paul Jordan, Chair LINk, Member Epsom Program Board
Jo Forrest, Patient Representative
Kate Harper, EDICS
Dr Peter Stott, Medical Director, EDICS
Dr Anne Hollings, Medical Director, EDICS
Dr Liz Barr, GP and Paediatric Lead, Tattenham Clinic

Apologies for absence:
Dr J O'Connell, Paediatrician, Epsom General Hospital

1. **Introductions:**
Mr Paul Jordan and Lena Wanford were welcomed as members of LINk. Mary Raw (past paediatric nurse at EGH) was welcomed as it was her first attendance.

2. **Minutes of last meeting**
The minutes of the last meeting were read and approved.

3. Matters arising:
None

4. EDICS provider issues:
4A: Intermediate Care Paediatric Clinic (Tattenham Clinic)
The chair welcomed Dr Liz Barr, a GP from the Tattenham Clinic and clinician link for the EDICS paediatric clinic held there. She described her previous training which included GP specialist training, including a period in paediatrics at Epsom General Hospital and then 18

months as a community paediatrician working predominantly in schools. Her main job is now as a GP at Tattenham Clinic where the EDICS paediatric clinic is held. This is a purpose built health centre on one level with a local chemist, free parking and close to buses and trains. The paediatric clinic started in October 2006. It is managed by a Nurse coordinator who has extensive past experience as a health visitor. She acts as the clinic administrator, assessing the referral letters, managing appointments in such a way that the most urgent are seen first, and coordinating with the parents of children who are due follow-up. Two paediatric consultants from Epsom General Hospital attend the clinics, Drs John O'Connell and Janet Nicholl. Dr Barr supports them, working to individualised care plans and managing the follow-up cases. Dr Barr is NOT a GPSI (i.e. not a GP with special interest). So she does not manage patients without consultant input. The clinic does not run if no consultant can attend. Another GP in the clinic, Dr Helen Cotton, also has paediatric background and can act as back-up if Dr Barr is unavailable.

If patients need further care, then the nurse coordinator acts as their point of contact, following up the DNAs (Did Not Attend) and providing health education.
As with other EDICS clinics, referrals are triaged twice – first by the generalist triagers and second by the paediatric team themselves. When investigations are needed prior to the child being seen, the parents will be contacted by phone and this will be arranged either in the child's practice or on Ebbisham ward (i.e. children's ward) or X-ray at Epsom General Hospital. At the clinic, each clinician will see 4 to 5 children in a session. The consultant is always available for an immediate second opinion if needed. After the clinic, every child is discussed by the team.

The nurse coordinator is responsible for identifying those cases which need follow-up. These are often contacted by telephone and then the cases will be discussed in a 'virtual clinic'. Liaison with the paediatric nurse outreach service from EGH is good and hospital notes are used throughout the clinic to facilitate longer-term communication. Each clinician in the clinic is able to prescribe on EDICS FP10 prescription forms. Alternatively, where a longer-term prescribing is involved, a letter will be sent to the child's GP.
The clinic has no fixed clinical protocols since in reality every child is unique. Nevertheless, the fact that each child is discussed individually enables a joint management plan (care plan) to be created for each child. A patients survey (GPAQ) was performed 18 months ago which showed high levels of satisfaction with this clinic. A further questionnaire is currently under way. There have been no formal complaints in the 3 years since the clinic started.

4B: A possible future for Children's Care
Dr Anne Hollings, Medical Director EDICS, outlined her view for the development of children's' services in the Epsom area. She viewed intermediate care as providing services to maintain child health, maximising their potential and keeping them safe from harm. To this end, intermediate care services would ideally be closely allied to county council child catered services. Intermediate care clinics like the EDICS clinics, can help to de-institutionalise care by integrating it at home, work and school. She referred to the recent JAR report on children's services in the area which in her view pointed to the need for greater integration of services.

In comparison, hospital services at EGH are where acutely ill children were managed; preventing disability and premature death, providing special care baby units and neonatal services, surgical services and sharing a link with the Tadworth Court Children's Trust and paediatric oncology.

SBM felt that the ability to integrate care was a feature of hospital services too and referred to her own experience of a specialist hospital service and where social services personnel had become involved when parents had asked for help. AH suggested that a link worker was important to achieve this. RN felt that there was great need to think seriously about new ways of allocating resources because otherwise good ideas could often fail to materialise into action. PS said that cross-funding and integration of care between health and social services was one of the targets for the integrated care pilot (MEDLInC). SBM referred to the South Thames Cleft Palate Society as an example of good practice. In this organisation, link workers coordinate care, integrate and individualise patient pathways and generally 'hold hands' with parents as their children grow through childhood.

RN felt that specialist input was most important to achieve in both secondary and intermediate care and did not wish care to be devolved to GPs. Dr Barr pointed out that via the EDICS system, a consultant was always 'on tap' and that they could be involved if the management plan was not working out as planned. JF felt that in the case of children with diabetes, it was important to deinstitutionalise care wherever possible. Otherwise young people with diabetes often defaulted from care. She saw this as needing a centralised resource. AH introduced the idea of a Children's Centre at EGH – one point of contact for parents and children, with a link into A&E, social services yet maintaining a primary care flavour. Such a unit would be able to provide ongoing care for children with long-term conditions yet decentralise it to intermediate care clinics in practices wherever possible. SBM said she would like to see such a centre at EGH and the rest of the group did not disagree.

The group debated whether it was better to allow for alternatives to be pioneered individually (evolution) or whether it was better to have an end point in view and to change everything in one go (revolution). RN and BH pointed out that such debate often centers' around current workload and that current statistics were now unrealistic, much care already having been transferred to St Helier Hospital (e.g. stroke, major trauma, acute surgery). The group were surprised to find that some of their members who were members of Surrey PCT working parties and subcommittees were unable to discuss these issues in full having signed confidentiality statements with SPCT. PS felt that since their role as patient representatives was to act as watchdogs, signing confidentiality agreements was an undemocratic imposition which should be resisted.

The group began to discuss how the Denbies proposal might stimulate change at EGH. This debate was limited by the confidentiality agreements which some of the group had signed. It was noted by RN and PJ that MEDLInC had been mentioned within this proposal.

5. MEDLInC Commissioning Issues:

5A Update on MEDLInC: PS gave an update on MEDLInC (Integrated Care Pilot) which had gone live that very day (i.e. 1st April). He reiterated some of the information given in the previous meeting relating to the development of the Public Health Gateways, extended clinical pathways and improved GP access to diagnostics (such as CT and MRI scanning). He reported that as well as giving MEDLInC the go-ahead for a pilot project in urgent care at A&E at Epsom Hospital, the Assuring Access Board had (possibly unknowingly) also commissioned a further work study from another organisation (IHP). The remit of this second project overlapped with that of MEDLInC. Whereas the MEDLInC project was to make modest savings which would support their project ideas, this second project aimed to make greater savings for the PCT. The confusion surrounding this situation had yet to be resolved; but in

the interim, MEDLInC was working with IHP and their neighbouring Practice Based Commissioning Group (the Mid Surrey Commissioning Group) to achieve common goals.

Constitution: A copy of the draft PBC constitution for MEDLInC had previously been circulated to the group for comment. DH had made several suggestions which were to be included in subsequent drafts. In particular he felt that the lay representative on the PBC board should be an observer with no voting rights. He further suggested that in order to avoid conflict of interest, this post should not be remunerated but that expenses should be paid. (His suggestions were subsequently accepted by the PBC group the following day.)

5B: Nomination of Lay representative to MEDLInC PBC Board
David Heal was nominated as lay representative on the MEDLInC PBC Board. Paul Jordan was nominated as his deputy. Paul Jordan was invited to attend PBC meetings in his role as Chair of LINk. Both DH and PJ are patients in MEDLInC practices (noted as 'desirable' but not 'essential' in the MEDLInC constitution).

6. Assuring Access – what next
Diagnostics: PS described how the MEDLInC pilot would extend GP and patient access to an extended range of diagnostics – notably CT (computerised tomography) and MRI (Magnetic Resonance Imaging). To access these investigations, GPs would in future refer for these diagnostic tests using a clear protocol by way of a letter to the consultant radiologist. The radiologist would then decide which test was most appropriate and schedule these to take place. This would avoid a situation in which the radiology department became swamped by inappropriate referrals. Dr John Lowes (GP, Ashtead) was heading a group to devise these protocols.

Patient Choice via the Gateway: PS pointed out that the new Public Health Gateways, to be piloted through MEDLInC, would create an engagement between patients and the Gateway team. He further asked the group to consider how patients might be involved in extending Choice access via the Gateway. He envisaged a situation where patients who had received an appointment with a hospital or clinic which they did not want, were able to contact the Gateway team by telephone for advice on their personal care pathway. DH and PJ felt that such an arrangement would change the nature of the patient's relationship with their GP. PS felt that there were also problems of confidentiality and medical indemnity but that nevertheless it could be possible for both relationships to benefit from this interaction. The group resolved to consider the concept further at some point in the future.

7.Any other business
None

8. Date and time of next meeting
To be advised.

The meeting concluded at 1430.