

## **BARKING AND HAVERING LOCAL MEDICAL COMMITTEE**

<b>MINUTES</b> Part Two of the 247 <sup>th</sup> LMC Meeting held in the Committee Room, Admin. Building, St. George's Hospital, Hornchurch on 01 May 2008 <i>A n Open Meeting</i>
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**PRESENT:** Dr G Saini (Chairman)  
Dr M Rahman (Vice chairman)  
Dr T Bland (Treasurer)  
Drs a Deshpande, V Goriparthi, A Mittal, J O'Moore, P Patel, S Pervez,  
I Quigley, M Sanomi, S Subramaniam,  
Non-principals: Drs S De, S Hora, R Kumar, S Symon  
Madhu Pathak (LMC Secretary)  
Sue Elliott (Admin. Secretary)

Ralph McCormack, Chief Executive, HPCT  
Dev Chetty, Head of Primary Care Management, HPCT  
Eric Saunderson, Medical Director, B&D PCT  
John Goulston, Chief Executive, BHRT  
Steve Rubery, Director of Emergency Care/Hospital Director, BHRT  
Magda Smith, Ass Medical Director, BHRT  
Dr Jayawardena, Designated Doctor for Safeguarding Children, HPCT

### **APOLOGIES FOR ABSENCE:**

Alan Clarke, Interim Chief Executive, B&D PCT  
Robert Evans, Ass. Medical Director of Primary Care, HPCT  
Mr C Claoué, Ophthalmic Surgeon, BHRT  
Drs A Adedeji, B Dixit, R Kalra, A Patel, I Sudha, N P S Teotia

**120. MINUTES:** The minutes of the Open Meeting held on 3 April 2008 were approved and signed as a true record of the meeting.

### **121. MATTERS ARISING**

Dr Saini welcomed John Goulston, the Chief Executive of BHRT.

#### ***Scanners***

Dev Chetty stated that he has a spreadsheet that goes up to August covering the issue around scanners. The LMC is still awaiting feedback from the PCT regarding delivery and setting up of scanners in practices.

#### ***NHS Net***

*Havering* - Ralph McCormack said that although the PCT has an agreement that the practices concerned will be visited this clearly had not been done and he has asked David Wiltshire to visit and see what can be done.

*B&D* – Eric Saunderson said that he has spoken to the IT Department and has been told that there is a spam filter but this has not been set at default. There is a process to go through to turn this on. If the GP is not sure how to do this the IT Department will help. Unfortunately junk mail cannot be removed completely. Dr Saini stated that in reality if you have a safe net this filter should be on and not left for practices to set it..

#### ***District Nurse Aftercare***

Dr P Patel said that he has a patient whose wound has not healed eight weeks after surgery and will take a long time to heal. Ralph McCormack stated that if Dr Patel gives him the details of the patient the PCT would engage with him and try and look at the problem to stop it happening again. Fundamentally it is the GPs responsibility to sort problems out. After

the PCT has looked at the individual to see who should do what it will help stop this coming up in the future. Dr P Patel said he did not expect district nurses to work in isolation.

### **Choose & Book**

John Goulston said that C&B is something BHRT has decided to track and capture as a weekly thing at the 18-week steering group meeting. Any C&B matters across the PCTs can be raised there and they can look into how to address the issues. The potential impact for GPs if C&B goes totally electronic, and what we have agreed at the 18-week steering group, is that the PCTs will draw up a list of areas that could be exceptions to the C&B system and whether they are taking bookings outside the system and if it matches the 10%. This will be raised with the PCTs and the LMCs.

Dr Saini stated that the LMC's concerns were twofold. One is that the patients were being asked to phone back for an appointment. The GPs make a referral on C&B and the patients are told to phone back in two weeks. After six weeks the patients are told the referral time period has expired and they should go back to their GP. The problem is obviously at NHS Direct. Why should GPs be asked to do things again and again when they have referred correctly?

The second point is the 100% electronic referral. Until 31 March GPs did not have any idea what was happening. There was no discussion whatsoever as to whether their systems, or practices, could cope with it. The LMC was told in a meeting with two C&B managers that this is what BHRT is planning to do. GPs want to move to electronic referrals but there are certain things that are not present in the general practices at the moment, like scanning. GPs could say that over the next 3,4 or 5 months they may be able to move to electronic referrals but they were not given a choice.

John Goulston said that BHRT has stepped back and have not moved to 100% electronic booking. By the end of March BHRT were running at about 95% and have not made any change. BHRT will sit down with the PCTs and then ask the PCTs to liaise with GPs. They would look at exceptions and agree them. Dr Saini said that the LMC has a directive from the GPC that says, "A provider may only refuse to accept a referral on clinical grounds or in accordance with the agreement of their commissioner." No policy has been agreed and therefore how can a referral be refused.

Dr Symon stated that there are very valid reasons why there should be exceptions. Computers break down or the C&B card does not work and it can take months to get them replaced. Patients will often say to their GP they want to go to a specific hospital, e.g. Queen's, but the booking has been unsuccessful. You cannot insist on a system when it cannot be guaranteed that it will work.

Steve Rubery said that if a patient rings NHS Direct for an appointment, NHS Direct is supposed to give those patients details back to BHRT so that they can be contacted and booked on a manual basis. It is about getting the balance right between paper and electronic bookings. Moving to electronic booking all the available slots should be visible. NHS Direct will only impact referrals for BHRT. If a referral goes elsewhere they may have a different agreement. GPs should not get patients coming back to them saying we have rung and rung and not been given an appointment.

Dr Bland stated that this is a good situation where a problem can be turned into an opportunity. It was not intentional to disregard GPs and it is now apparent that there is a desire to work closely together to ensure patient care and we should be reassured by what Mr Goulston has said as the new CE of BHRT and welcome his acceptance to work together now and in the future.

Steve Rubery stated that the booking process and the movement toward full electronic booking is not a unilateral decision but has been agreed throughout the health community. We need to move forward as a whole community, including the GPs.

Ralph McCormack said that nobody is arguing about the numbers. There are obvious and clinical reasons where it would be problematic to reach the target of 100%. We need to make sure that by and large the objective of making electronic bookings should be the order of the day. The discussion we are having is reminding us that whilst the aspirations are right we need to get the mechanics right as well. We have to have a system whereby if

there is a computer problem in hardware terms we need to address this so that it does not affect patient care. If it is things like scanners, cards etc., GPs should expect that the PCT would solve it reliably and quickly. We should have a time frame by which we can move forwards towards the 100%. There needs to be a fall back position but this should be the exception rather than the rule.

Dr Rahman said that if a referral is sent back for any reason there should be communication between the hospital and the GP to make sure the patient is not sent back.

Dr Saini stated that GPs should be involved at every stage. Problems can then be resolved quickly instead of wasting a lot of time. C&B is not compulsory and nobody wants GPs to say they will not do it.

### ***Mental Health Services***

Eric Saunderson has spoken to the Manager regarding ABIT and was told all the telephone numbers have changed recently. ABIT is going to be relaunched some time towards the end of the summer and hopefully the difficulties will improve.

Dr Kumar stated the ABIT service has had a sizeable amount given to it by B&D PCT and the team will be extended. There were concerns raised about access to the ABIT service. He has raised this with the Managers and they have contacted NELMHT, as it is their responsibility to supply access for GPs.

## **122. PRESSURE IN A&E QUEEN'S & KGH**

Dr Magda Smith, Ass. Medical Director at BHRT, gave a short presentation on the problems being experienced at Queen's and KGH.

Since October 2007 BHRT has seen a decline in its performance in A&E against the 4-hour referral to treatment target. This has been a national issue and appears to have coincided with changes to discharge practices, in particular introduction of a new decision support tool and social services criteria for accepting patients into community care.

In January 2008 A&E performance declined significantly and this reduced performance has persisted for the last four months. This pressure is being seen in A&Es across NE London with no A&E consistently meeting the 98% four target.

### **Contributing factors to A&E pressures are:**

1. High acuity of patients attending A&E at Queen's. No increase in number of patient attendances. Blue light referrals to the resuscitation room have increased by 40% since January.
2. High vacancy and sickness rates in A&E – both medical and nursing
3. High vacancy and sickness rates in general medicine – up to 45% in some grades.
4. Lack of available locums
5. Lack of capacity in the discharge team to manage complex discharge pathways with the additional processes. Lack of capacity in ward teams to manage the same
6. A consequent rise in length of stay for medical patients by up to one day across the organisation reducing available beds for admission

### **Effects of declining performance:**

1. Increased length of time patients spend in A&E waiting to be assessed.
2. Patients awaiting admission spend unacceptable stay in A&E
3. Increased patient risk due to A&E being managed as a ward
4. Reduced function of capable staff
5. Increased scrutiny from SHA
6. 12 hour breeches – all investigated as SUIs
7. Constant state of high alert in BHRT
8. Diverts to other hospitals

### **Actions taken to address these pressures:**

#### **Leadership and Staffing:**

1. Executive support to A&E action plan increased with regular emergency access team review.
2. Expert input from Bernie Edwards to review A&E processes

3. Expert input from Mary Wells about managing discharge process and liaise with PCTs and social services
4. Additional recruitment drives for A&E nursing and medical staff
5. Improved clinical and nursing leadership
- Capacity and Throughput:**
6. Escalation as per bed policy to general practitioners when A&E is under significant pressure to encourage admission avoidance
7. Increase size of discharge team to manage complex discharges
8. Review of medical staffing profile in A&E
9. Implementation of A&E and Discharge planning tool – JONAH – initially at Queen’s to facilitate discharge.
10. Implementation of escalation policy in A&E for patients awaiting specialist opinion
11. Focus on managing flow from acute assessment to free beds for direct GP admissions
12. Improve weekend handover and increase weekend patient reviews for discharge
13. 7 day diagnostics for in-patients
14. Actions to reduce length of stay:
  - a. TTAs written the day before
  - b. Planned discharge date for all patients
  - c. Daily morning board rounds to agree discharge
- Whole Systems Working:**
15. Agreement with PCTs to open additional bed capacity at St George’s hospital – 52 beds by beginning of April for all patients
16. Redbridge PCT take over responsibility for UCC at KGH
17. Social care panels twice a week
18. Process agreed with LAS to manage assessment for A&E diverts. In the last month 4 diverts have occurred – 2 from BHRT, one from Newham and one from Whipps Cross
19. Development of weekly multi-agency meeting to address primary/secondary care interface
20. With PCT review of ICAT team skills to improve patient assessment for discharge
21. Weekly long stay meeting to review all patients with length of stay >100 days – resulting in reduction from 120 to 70 patients on the list

**Impact of above actions:**

Significant improvement in KGH A&E performance in line with trajectory. 97.5% performance w/e 28<sup>th</sup> April. Fluctuating improvement in performance at Queen’s.

**What is the impact for primary care?**

- Patients who require an acute admission will still be seen and treated within BHRT. Patients may sometimes be transferred to KGH for treatment if this will result in more timely admission.
- Patients are unlikely to be transferred to other Trusts for treatment.
- When the Trust is on purple alert GPs are informed and requested to avoid emergency referral where possible.

John Goulston said that B&D PCT has offered to send 6 GPs to help the hospitals for 2½-hour sessions each per week. This may be covered by salaried GPs going into practices and experienced GPs covering these sessions.

Dr Symon asked how much of the pressure is being caused by cases that can be dealt with in general practices. Magda Smith said that some patients come to A&E because they cannot access their GP. BHRT also has a major issue with nursing homes. The GP visits and the decision is made for the GP to treat the patient in the home but the home later decides to phone an ambulance. BHRT needs to look at rapid response teams for nursing homes.

**123. PROTOCOL FOR ACCESSING GP RECORDS (SERIOUS CASE REVIEWS)**

This issue was taken forward by Dr Jayawardena and a letter had been sent by the Havering Vulnerable Children’s Team Nurse Consultant on the issue of difficulties being experienced by the teams when they request medical records for the family members of the child to complete the investigation of a serious case review. These records are required as

a summary needs to be produced for a health management review. The GMC confidentiality of protecting and providing information is very clear. The paper on disclosure to protect the patient or others information is very clear. P16, Paragraphs 36 and 37 was pointed out. It was also pointed out that where it is practical consent should be sought before disclosure.

Eric Saunderson said the PCT wanted to supply some clarity for colleagues in more distressing clinical circumstances of a child who is severely hurt or a parent compromised or in hospital and there are reasons for access to appropriate medical records so the team can give a decision more effectively. Ralph McCormack stated that it is quite clear legally that if it is a safeguarding issue, under the Children's Act the PCT is entitled to access of the full records. There should not be an issue that the practitioner feels he is acting unlawfully.

Dr Saini said that the GPC has said, "There is no need to disclose irrelevant and unrelated information". Dr Bland did not think there was a problem as we were all agreed that in the case of an important need in child welfare the information should be given. He went on to say that GPs know from cases they have handled personally that our colleagues in Social Services do not see things the same way as GPs do. A very important protection is that the agency requesting the information has to provide the consent or, if consent is not possible, they have to explain in writing why there is a need for the records. If it is important and consent is refused, this should also be put in writing.

Dr Jayawardena assured the GPs that it is only when the final report is produced and the case is taken forward that Social Services and the Police are involved in serious case reviews.

**124. GPC NEWS M8**

Skin Cancer – Dr Goriparthi said there are serious implications for people who had minor surgery procedures. For skin cancer the person should be a member of the cancer network and often they are not but they carry on. They should at least attend two clinical meetings of MDT. This is something that needs to be looked into on the guidelines of skin cancer. There are serious implications to troubleshoot. BHRT should welcome, or the GP should access, these teams at BHRT.

**125. ANY OTHER BUSINESS**

***List Cleansing***

Dr Saini raised the issue of confusion at FHS level as some practices did not receive the letter and therefore have not signed to say whether they want be involved in the above issue or not and are now receiving letters to say that patients are being removed from their practice list. Ralph McCormack said that to make things clear, when the PCT have a copy they would go back to the practice to make sure of their intentions.

Dr Mittal stated that if a patient is removed from a practice what is done to ensure the patient has a GP? It should be made very clear that the responsibility stays with the person taking the patient off the list. Eric Saunderson will take this back.

**126. DATE OF NEXT MEETING:** There being no further business for discussion, the Meeting closed at 3.40 p.m. Members agreed that the next Meeting would take place on 5 June 2008.

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Chairman

