8 July 2020: Primary Care Network - Online engagement session

Facilitator	John Boyman - Head of Public Relations – Strategic Projects	**Engagement Team**	SE
Speakers	Alex Whitfield – Chief Executive, Hampshire Hospitals NHS Foundation Trust Dr Dominic Kelly – Consultant Cardiologist, Hampshire Hospitals NHS Foundation Trust Dr Lorne McEwan – GP and Locality Clinical Director for Winchester, West Hampshire CCG		
Registered participants	**7**	**Participants on Zoom**	**8**

Questions/Comment raised pre-event at registration / website [comments box on Eventbrite registration form]:

None

Questions/Comments raised during online event:

COMMENT: We shouldn't miss this opportunity. We've had such a rapid change within the last few months. 6 months ago we wouldn't have had this conversation. We're not integrated, we're just starting to look over the fence and try to work out how to become integrated. Building a bricks and mortar building isn't necessarily the answer. Getting the pathways sorted out is what is important and to understand how we work. Should community teams be working much closer together? Do we need a space for that? Is the hospital structure going to provide some of that or do we leave the community stuff to some other plan some other time? We know that it takes 15 years to get anywhere although we've been promised this on a yearly basis. If you talk to the CCG and say 'this is what we want to change' they say, 'oh no we can't change it because it was agreed 10 years ago'. There are lots of parties involved and just having this sort of conversation on its own just isn't enough. We need to bang our heads together and change things radically.

I had a conversation with the ED consultants a few weeks ago to see how we could get our Covid hotstreams going. It's gone quiet. The conversations haven't continued. I'm not sure how much enthusiasm there is from individuals but I think there is a global enthusiasm, but to cut through and create new ground is really hard. So trying to convene a new hospital seems an enormous challenge. I think it's possible but we'd all want to work together.

The risk is that we'll design it quite quickly and in a year's time we'll go, why did we design it like that?

We'll need to set some resources aside if we are going to have an integrated model.

> ANSWER: I agree a lot with this. I've been pleasantly surprised because a lot of the time we are talking about service reconfiguration.

We are acutely aware there is a real balance between doing something quickly and doing something perfectly. We're getting pressure to move as fast as we can. The government is saying build as it will help the economy, but we're also realising that this might change if we take too long.
We've got £5mill already and part of that will fund us to start having conversations about pathways. We are keen to get clinical time to discuss this now.

ANSWER: We all want integration but it never seems to progress. We just need time to get on and do it. We need to get the right people from the hospital and the primary care leads to set out how we want the service to work between primary and secondary care and let everything else fit around that. It needs to be done on a regular basis.

QUESTION: We're lucky at the moment that we've got primary care networks and the way they've set up with localities at a similar time to Covid. There's a real streamlining in primary care to get discussions between primary and secondary care.
It would be useful to look at the commissioning because if you did have the ability to have a pot of money for diabetes, you could sit down with the diabetic lead in primary care who could see that sometimes a diabetic's care is hospital and sometimes it isn't, an understand where can we use the money best. Blurring those lines might force integration.
Blue sky thinking would be to look at medicines. We've found in general practice that we work out what medicines our patients need to be on. If they get picked up by an ambulance, they take a medical history, the patient gets taken to ED who take another medical history, then gets to a ward where another medical history is taken. The hospital may change the medication not knowing that the GP has put them onto something else recently, and then the pharmacist tries to put all this together. In general practice we have almost removed paper scripts. Everything is on EPS - I can do it all from my laptop in their lounge and prescribe something.
Patients need to be able to turn up in hospital and their medicines should already be on an IT system so if they had a heart problem and the hospital makes a change to their medication, the GP will know immediately and also the pharmacist will see. All this would free up a lot of time for the pharmacist, the GP and the hospital. New IT systems - it would be a really good way to integrate that element as well.

ANSWER: I completely share your frustration. Our ability to look at the records and see what primary care has prescribed completely changes the situation as we are no longer reliant on the patient to give their history.
We do see some errors on the system. The problem within hospitals has been worsened by patients being moved around hospitals and having different consultants. Discharge papers are difficult to pull together to track the changes in medication during the hospital stay.
Developing IT to track those changes in medication is definitely one of the things we're working on and we do have various upgrades to the system happening.
Then to link that in with the discharge summary to give you [the GP] a clear map of what has happened in medication and why. We are aware of the limitations so this is an opportunity. The money is for the hospital but we are going to have to develop IT services to go in it as well.

COMMENT: In general practice there are 6 systems I've used since working in the Hampshire area. I wonder whether aligning some of these systems might help this.

ANSWER: In the hospital we have 110 systems for different things. We either need to get the systems to talk together or all move to the same system, find a new system to incorporate all but that will depend on funding.

ANSWER: I'm yet to go to a meeting where we don't talk about single clinical systems. Technology has come on across primary care in the last few months. A lot of our work will be done remotely. We just need to choose the right pathways where it's appropriate and where it's safe.
Winchester cannot get a mobile signal and Basingstoke was built pre Wi-Fi. The new hospital will be fit for the technological future.

QUESTION: 12 years ago we tried to map chronic disease pathways differently with hospital consultants - it's a piece of work trying to reconfigure the system and patient flows and to reduce some of the bed days of e.g. COPD patients. In particular patients who don't have good joined up care.
How do we play into the bigger system in terms of the STP? In particular PCN has had significant patient growth and two or three of the surgeries are bursting at the seams. We have been told to plan for a lot more patients in the next few years. The latest thing is that we shouldn't do the plan because, with the remote access and zoom meetings we've been doing through Covid, we won't need to increase the capital estate, which won't be fit for purpose. This is a real problem. This is a message which seems to be coming down from above and there should be some joint planning around our patch. This will be easier when we are mid and north and not subservient to the west CCG. But there is some bigger planning about what goes where, in terms of diagnostics in the community and bases for people to work out of.

ANSWER: I'm keen that we do join this up. If what we're saying is that we build a much smaller hospital than we thought we needed a year ago, because we can do things remotely and virtually, then we need real estate in those settings to be able to do that.

COMMENT: This needs to go to the ICP but the formation of the ICP has been put on hold since Covid. Who is going to lead us and to join it up into the bigger system, and give us permission to take that forward?

ANSWER: We need to involve the CCGs because they have some statutory roles around primary care etc. But we need to do the right thing.

ANSWER: CCGs are involved, across the whole partnership. We know we need more primary care facilities and real estate, we need more diagnostics in general practice, we need outreach clinics at the patient level and not at a distant hospital. We need real estate for those new services.

QUESTION: I'd like to reiterate previous comments about the unified clinical system. We've got a major opportunity as we have all the practices in the footprint using the same system which doesn't happen in other areas. We're not going to have an integrated service without integrated systems.

ANSWER: Every patient in our patch has a PCN record, less than 10% of patients have a hospital record and even fewer a community care record. We already have in primary care an integrated system which we can transfer amongst ourselves easily. But the Hampshire Hospitals can't see what we've got on there.

ANSWER: Solent replaced with System1, we ended up with a system with all GPs, mental health, community and adult social care all using the same system. At that point they didn't have a mental health module.
I don't know if EMIS has models that do all of the things we need it to do - we would need to investigate whether this could be used in hospitals. Our electronic patient record (EPR) is an in-house system that can respond very quickly to clinical needs, for example during Covid to develop electronic notes rather than paper notes. Maybe connect that into EMIS to make it feel like one system.

COMMENT: ICE you can do the same. A lot is getting the systems to talk to each other.

COMMENT: I'm a business manager - one of main roles is a new build and getting it going again post-Covid and seeing how we use the space differently. I would be interested to have conversations now about how we may integrate secondary and primary care, such as having the specialists within the clinics. There could be some crossover.

COMMENT: This is a fantastic opportunity and primary care want to be involved and getting hospital services out into the community where they need to be is the key part of this.
Talking about infrastructure and allocation of space. We are in a very expensive building - is that the best use of money? I don't think so. Our lease is up for renewal in 4 years time but we mustn't sleepwalk into thinking to extend for another 15 or 20 years. Is co-location onto the RHCH site something that we could consider but this will need to happen early.

ANSWER: It's a fascinating opportunity to have a conversation about proper integration between primary and secondary care and diagnostics.

ANSWER: I know some of you have been involved in the TECC project (Transforming Emergency Care Collaborative). In some of the conversations we've been having, in particular about Winchester, about the future of the A&E department, what people at Winchester need is somewhere where they can turn up to if they have an urgent care need, or book in and get treatment that day. But I think the world is moving more towards, same day primary care and minor injuries/illness with a bookable system in one place.

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Are you able to share the presentations for internal use?

Engagement Support: Hello XX, yes - the slides are available on our website: https://www.hampshiretogether.nhs.uk in the Useful Documents section

Sorry, got to go to another meeting, but would be keen to get involved and have some capacity if that helps (particularly around unified urgent care and mental health integration)

https://www.emishealth.com/products/hospital-medicines-management/

https://www.emishealth.com/care-settings/secondary-care/

just needs an API to link in with EMIS

Hampshire Together
Modernising our Hospitals and Health Services

Report written by: SE