Kent Local Medical Committee

Supporting list based personalised care, the partnership model and meaningful collaboration

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Making Connections in NHS West Kent CCG
October 2017

Drs John Allingham, John Burke, Richard Claxton, Mark Ironmonger, Neil Potter and Daniel Kerley joined Carlo Caruso at the recent LMC/CCG liaison meeting. Mr Ian Ayres and Dr Bob Bowes attended on behalf of the CCG.

Inappropriate Work Transfer/Junior Doctors' Induction Programme
The CCG expressed its thanks to practices for sharing examples of instances when the secondary care provider has not complied with its contract with regards to primary and secondary care interface (Click here for more details).

The CCG has received around 143 letters from practices and an analysis of this has shown the following:

- 45% related to the management of onward referrals
- 14% related to management of DNAs and re-referrals
- 10% related to discharge summaries and clinic letters
- 8% related to fit notes
- 8% related to issues regarding medication and shared care

The CCGs felt that the contributions have helped to identify issues in order of priority. There was a shared view that the guidance is clear in terms of what is required around primary and secondary care interface. The CCG will be working with MTW to address the issue of onward referrals in the first order and will update the LMC of progress at the next meeting.

The group also discussed NHSE's new patient leaflet: What happens when you are referred by your GP to see a specialist? The CCG agreed to promote it via its GP bulletin with an amendment to reflect local variations to the Trust's contract.

There was no prospect of having a section on general practice in the Junior Doctor induction at MTW. The agenda was simply too full. The LMC is, however, writing a section for the Junior Doctor handbook. The CCG confirmed that it would endorse what the LMC wanted to put in the JD handbook.

Rapid Response Team (RRT)
The CCG confirmed that the referral criteria has not changed. However, the RRT will reject referrals if the Social Services component had not been completed, or if there is no capacity in the system.

The Local Care programme will be looking at the RRT, the capacity it has, and how any additional capacity can be procured.

The CCG will be adjusting the reporting requirements so that it can measure the number of referrals that are rejected and the reason for them.

Mental Health
There was a discussion around the apparent fragmentation of the system with, for example, the insufficient co-ordination between the SPA and Community Mental Health Teams. The CCG confirmed that there was system wide awareness around the current challenges and all are working together in an attempt to resolve them. The CCG will provide an update at the next meeting.

Non-prescribable items
The CCG was still trying to find a supplier. However, progress has been hampered because there does not appear to be sufficient volume for any provider to make it worthwhile. However, now with the commissioning arrangements changing over the near term there is an opportunity to find a pan-Kent and Medway solution to this issue.

Physiotherapy
There was a discussion about whether it was necessary for Physios to refer patients back to GPs if patients required a further course of physio. The CCG was of the view that there was evidence to suggest that Allied Health Professionals invariably will elect to keep patients if given the scope to do so, and so it does not see merit in changing current arrangements.

General Practice Forward View (GPFV)
The LMC was concerned that the implementation of the GPFV does not reflect the narrative surrounding it. It has been badged as the rescue package for general practice. There is a view that initiatives such as the Care Plan Management System, e-MDT meetings, and microsystem management have very little impact on practices that are struggling.

The group discussed what initiatives would help general practice. The LMC felt that there was a variety of issues that affected recruitment and retention in general practice: equitable remuneration and terms and conditions, a greater work/life balance, portfolio career options, improving workflow management, support to address workload pressures and a greater emphasis on and support with stemming inappropriate workload transfer.

The CCG welcomes suggestions on what initiatives it could pursue that would benefit general practice that fall within the scope of the GPFV; and the opportunity to develop a shared view about the future of general practice.

The group also discussed how it would be helpful for the CCG to hold an EGM setting out what it was doing to support general practice.

Primary Care Strategy
The CCG is in the process of developing its Primary Care Strategy. This will sit alongside its Local Care Plan. The Local Care Plan focuses on GMS delivery and looks at what is required from the 3 key enablers of estate, digital and workforce. The Primary Care Strategy will draw out, cluster by cluster, the direction, distance and speed of travel for primary care.

This has been informed by a significant amount of work that the CCG has done with the borough councils to identify the residential developments that are planned over the coming years and what S.106 monies were available for health to bid for.

The CCG has also been working with practices that have not coded their care home residents appropriately to ensure that practices receive the correct global sum payments. Indications thus far suggest that most practices will stand to benefit from this. The LMC agreed to put an article in In Touch about this issue.

Workforce Strategy
Much of this work is being led at Sustainability and Transformation Partnership level (STP). The STP is currently undertaking a gap analysis of the whole primary care team before further developing its strategy. The information practices have submitted via the GP Workforce Tool will be of great value to commissioners.

GP Federation
The CCG will be using the AGM to discuss the development of local care and the opportunities for general practice working at scale within this space. The CCG has been supporting the federation to develop its structure but this has been somewhat hampered by a lack of contracts. It is hoped that practices will leave the AGM with a great deal of enthusiasm about collaboration.

The group discussed the challenge for federations was having an initial catalyst to drive and sustain its development. The CCG agreed to explore how this could be done using both the Transformation and GP Access monies within the GPFV. The transformation monies may support the development of the federation structure and the preparation of a bid for delivering GP Access.

New NHS Standard Contract 2017/19
The CCG confirmed practices can report breaches of the hospital contract to james.ransom@nhs.net.

The LMC agreed to look into whether DORIS can copy correspondence sent to the hospital to the CCG with patient data removed.

The group discussed an audit carried out by Dan Kerley looking at 100 Docman entries of

which 29 related to inappropriate workload transfer.

The LMC was particularly concerned by the clinic letters. They were often very late, and this did raise concerns about patient safety. This issue appeared to affect all departments.

Unfunded Work
The LMC reported that this is becoming a significant issue for an increasing number of practices. Practices find themselves in a predicament of struggling financially and having to make decisions regarding staff deployment.

The LMC has looked at the non-core funding arrangements across Kent and Medway and has identified a significant disparity between practices in West Kent CCG and those in East Kent in terms of what non-core services are funded.

The CCG recognises that there is a disparity and is open to discussing this with the LMC. It feels that this issue has arisen because GMS funding has not risen to match the increasing workload and acuity of patients. Previously, the relatively minor number of episodes of unfunded care that practices undertake was not an issue but there was recognition that circumstances have now caused a change, and that it was keen to support practices where it can.

The LMC was of the view that if services are commissioned elsewhere from any other provider then it does not form part of the core GP contract.

The CCG accepts the principle that practices should be paid for all the work done. It has committed to working with the LMC on reimbursement for work that is currently unfunded using the 6 example items discussed as a starting point, with a view to having an agreement in place for the beginning of the new financial year.

Medway, North and West Kent (MNWK) Delivery Board
The delivery board principally deals with secondary care. It is currently exploring whether the MNWK will form one or two Accountable Care Partnerships (ACPs) (click here for a brief summary of what Accountable Care arrangements can look like).

West Kent would prefer there to be two ACP arrangements covering MNWK. It is a very highly performing health economy and it is concerned about jeopardising this by joining with other areas that are less successful. The CCG was of the view that mergers that are clinically driven are more likely to succeed and it is keen to promote changes that are beneficial in both financial and quality terms.

The CCG has 3 criteria it is using to decide how to proceed:

1. That West Kent's local care plan remains sovereign.
2. That the financial and clinical plan across the footprint makes sense rather than merely diluting the level of debt across the economy.
3. That trust collaboration makes clinical sense.

West Kent CEPN
There was a positive discussion around the progress the CEPN was making and how it is engaging with general practice and the General Practice Staff Training Team. The LMC is represented on the West Kent CEPN.

Care Home LES
Although there was support for the CCG strategy and what it is trying to achieve, there were some concerned discussions regarding the increased scale of work that the LES required of practices and whether it was feasible in the context of current pressures.

The CCG has taken a number of points onboard and has revised the specification accordingly. This includes some flexibility regarding the frequency of attendances and involving other healthcare professionals in delivering the specification. The previous specification placed a significant burden on GPs, but now allows the contribution of nurses and paramedics to deliver key components of the LES.

The group discussed how homes were allocated to practices. There was a significant amount of data analysis to support decision making in this regard and to ensure a fair distribution of labour. There was also flexibility that allowed

practices to collaborate and provide a service at cluster level.
The group felt that the changes reflected a positive dialogue between CCG, federation, practices and the LMC.

NG12 Cancer Guidelines
The LMC raised the concern amongst GPs that they are under pressure to over refer. There was also the issue with the rapid access forms with specific concerns around clinical responsibility and risk management.

Gluten free prescription
The CCG recognised that whilst gluten free products remained on licence it there was a contractual responsibility to prescribe when deemed appropriate.

All attendees were hopeful that there would be a national solution to this problem.

West Kent MDT scheme
The CCG confirmed that the scheme was currently at pilot stage and encouraged feedback from practices so that it can inform its future development.

There was a feeling amongst rural practices that the scheme feels rather top-down in its implementation which presumed there was a one size fits all solution to the issue of limited staff.

Childhood ADHD Shared Care Protocol
Practices are concerned about how care of these patients is assumed to be the responsibility of GPs and that this may leave them at increasing medico-legal risk. There was also concern about how it seems to have been ratified by the CCG without GP input.

The CCG agreed to look into this and report back to the next meeting.

Local Incentive Scheme
The LMC welcomed the decision to run the LIS for 18 months and for the interim payment made to practices, who would find it very helpful.

There was a discussion around the Cancer Review element of the LIS. It was felt that not all of the work required by the LIS would need to be carried out by the GP and can be done by non-medical staff. Furthermore, the requirement should be for patients to be invited, not to attend. There also needed to be some recognition that patients might simply value a phone call rather than coming into the practice for a review. The CCG agreed to look into this.

Flu Vaccination for Housebound patients
There appeared to be an issue with the Community Nursing Service advising practices that they would not be providing these. The CCG confirmed that this was not a commissioning issue because there had not been a variation to the contract, and that it would be following this up with the KCHFT.

Date of Next Meeting
Tuesday 20 February 2018

Carlo Caruso
Deputy Clerk