Kent Local Medical Committee

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

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Making Connections in Swale CCG
March 2016

Drs Megan Philpott, Reshma Syed and Ian Gould joined Mike Parks and Mr Carlo Caruso at the recent LMC/CCG liaison meeting. Dr Fiona Armstrong and Mr Jim Loftus attended on behalf of the CCG.

DNAR Policies
The liaison committee has been discussing two issues regarding DNAR policies. Firstly, there is a concern with the quality of DNAR forms produced by MFT; and secondly the DNAR forms being completed in the Community Hospitals.

The issue with MFT was being addressed by the CCG via the contractual route. Regarding the DNAR forms completed in the community hospital, the CCG intends to revisit this once the new provider is in place.

Discharge Notices
Ian Gould reported that there appears to have been an issue in which Docman has been automatically sending a variety of information to the deleted box. It is not known whether this has affected other practices.

The CCG has agreed to take this up with Docman and to discuss the issue with the Chief Nurse. Practices should check to see if this issue has affected them.

Co-Commissioning
The CCG confirmed that it has agreed to take on delegated co-commissioning after the CCGs received a commitment from NHSE that it will provide no less than the current number of working time equivalents (WTEs) to provide CCGs with back office support. This arrangement will only end with the agreement of all parties. The CCG is still seeking clarity relating to the financial resources that will be transferred to CCGs from NHSE for Primary Care.

NHSE has also committed to supporting CCGs with taking on delegated co-commissioning by providing £30k to support set up costs, support and advice for a period of 6 months, and fund £10k for staff training.

The CCG view remains that delegated co-commissioning will enable it to better support the development of Primary Care in Swale, which NHS England, due to it being so remote, has been unable to do effectively.

The Primary Care Commissioning Committee (PCCC) that will take on delegated responsibility for Primary Care from the board will have a majority lay membership. The CCG has consulted 2 independent GPs that felt the clinical input should come from GPs that are not part of the CCG board or on the board of the GP federation.

The LMC were of the view that having GP members of the board included in the membership of the PCCC would provide a useful link between the CCG board and the PCCC, and issues of conflict of interest would be addressed by the majority lay membership.

Paramedic Practitioner Pilot
The CCG reported that the practitioner pilot had been successful thus far for patients and GPs. The CCG was still in the process of evaluating the pilot data to determine whether it has met the CCGs objectives of reducing hospital admissions. Indications thus far appeared to be generally positive.

There have been some issues identified during the pilot. Firstly, paramedics being called to emergencies and therefore

unavailable to the service. Fortunately there is no cost to the CCG when this occurs.

Secondly, paramedics do not have access to practice IT systems and this has hindered their effectiveness due to their spending 1 to 2 hours a day travelling. The CCG anticipates that, should it proceed with commissioning the service, then paramedics will have the benefit of having a tablet computer with access to patient info.

Thirdly, Reshma Syed raised that some care homes do not accept paramedic practitioner visits. It is believed that this is because the protocols the care homes operate require a GP. The CCG has asked that any such issues are reported to it as the intention is that paramedic practitioner should reduce the demand for GP home visits. Availability of paramedics to speak to has also been an issue.

Collaborative Fee arrangements
Collaborative arrangements enable GPs are paid by the NHS for services they provide to local authorities that enable them to comply with their statutory duties. Strong collaborative arrangements support effective safeguarding processes by enabling greater GP involvement.

The LMC reported that the arrangements for collaborative fees do not appear to be working for practices. It seems that many practices are not aware of what can be claimed for or the process of claiming. Furthermore, what can be claimed for appears to have significantly diminished in recent years.

The CCG agreed to review the collaborative arrangements.

Care Home
The LMC reported that, at the Special Conference of LMCs in January, a motion was passed for the GPC to negotiate other contractual arrangements for care home residents. This group of patients often have complex needs coupled with general immobility and deserve pro-active care to keep them in the community. Investment in the care of this group of patients is likely to produce increased savings further upstream in terms of reduced admissions.

The CCG had ended its previous VMO scheme because of the complexity of the having individual practices looking after individual homes and patients having choice of who they register with. A LES is currently in place however it has generally not been taken up by practices. There was also a debate about how homes are likely to prefer having a single practice care for its residents. The group also discussed the efficacy of the matron service.

The CCG agreed to review the Care Home LES and the matron service.

Estates Strategy
The CCG anticipates completing its Estates Strategy by the end of March 2016.

CEPN
Swale CCG is considering or explore opportunities for collaboration between the North Kent CCGs.

PMS Review
The CCG has discussed using the PMS funding to support the GP Staff Training Team. NHS England did not appear to be enthusiastic about this option. The group also discussed investing the monies in mental health services, which the funds were currently being used for.

The group agreed that, because the total PMS funding coming back to CCGs was relatively small, the monies may be best utilised to support Primary Care by adding it to the Local Incentive Schemes budget.

Vulnerable Practice Scheme
The CCG was of the view that, in light of the significant workforce and workload pressure facing primary care, all practices are vulnerable and that even practices that appear to be relatively stable may be seriously affected if a neighbouring practice finds itself in serious difficulty. It was agreed that an approach considering the vulnerability of localities or towns would be far more useful.

The CCG reported that it had discussed this with practices before responding to NHSE's

appraisal of which practices it felt were vulnerable.

GP Staff Training Team (GPSTT)
There was some recognition from the LMC that there is a view amongst some practices in Kent and Medway that the GPSTT may not have been as effective as it could be.

Following the end of the service being hosted by the Commissioning Support Unit the service will migrate to WK CCG for a period of 6 months whilst a long term host for the service is identified and a review of the service delivery model is undertaken.

MRI
The group discussed the use of MRI scans in primary care. LMC representatives were of the view that this was relatively expensive and may be of nominal value.

The CCG advised that MRIs are provided by the 3 acute trusts alongside Medical Imaging Partnership. These are delivered under an AQP. It is very difficult to understand the number of MRI requests made by GPs because the acute activity is tied in with consultant requests.

The group discussed whether patients may be better served by being referred to the Orthopaedic Clinical Assessment Service (CAS), who could refer patients for MRI should further investigation be required. The CAS may also be better placed to interpret results.

There may be some funding implications associated with this and practices would also need to be informed of changes to the pathway.

Ultrasound
The group discussed a serious incident relating to an AQP provider, which had given notice, and had failed to process two referrals.

The group agreed it would be helpful if Serious Incidents were shared with the CCG and this could be done by either contacting Jim Loftus (jim.loftus@nhs.net); or the CCGs generic email address (swale.ccg@nhs.net) (¿Jim – is this ok?). The CCG is also currently reviewing the process for raising SIs and will inform practices of any changes to who should be notified.

Communication with Locums
The CCG confirmed it will seek to ensure access to CCG communications and intranet to locum GPs.

AOB
Concerns were raised at the difficulties in contacting registrars at MFT, which could lead GPs to refer patients to A&E to ensure they receive the care they need.

The CCG explained that MFT was introducing a new organisational structure from March 2016, and a communication will follow shortly to explain how this should work. The new structure has been found to work effectively in other trusts.

Date of Next Meeting
3rd June 2016

Carlo Caruso
Deputy Clerk