Kent Local Medical Committee

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Highlights from Kent & Medway Partnership Trust/Kent Local Medical Committee Interface Meeting
April 2019

Drs Simon Lundy, Mark Ironmonger, David Lawrence,Katja Philipp and Zishan Syed joined Donna Clarke at the bi-annual KMPT/LMC interface meeting. Dr Rosarii Harte attended on behalf of KMPT, and Drs Katie Collier, Joe Chaudhuri & Jihad Malasi joined on behalf of the CCGs.

Incorrectly addressed letters
KMPT are planning to operationalise the system so that the staff member that sees the patient will note the name of the referring GP. They will feedback at the next meeting on progress.

Feedback from meeting with Helen Greatorex & Catherine Kinane
The issue of referral rejection rates is a work in progress, and they will feedback further at the next meeting. Dr Katja Philipp commented that referrals from the SPOA have been known to be rejected as inappropriate and sent back to the GP. KMPT requested examples to be shared. A question was asked as to whether someone telephones the client when a referral is received from SPOA. KMPT agreed to investigate further.

Advice from consultants
Dr Katie Collier reported that in West Kent Kinesis has been introduced to get email advice and KMPT is on there. It was suggested that this could be extended Kent and Medway wide. It was noted that the use of Kinesis is not mandatory and not all West Kent practices use it, however it was felt that it should still be an option available to all.

GP Requirements for Dementia Referral
Dr David Lawrence reported that currently the diagnosis of dementia is happening but there is very little in the way of support afterwards, and once someone is diagnosed it often results in their GP consultation rate increasing. It was noted that K&M has a low diagnosis rate compared to national rates. Dr Katie Collier commented that she has also had feedback on the lack of service post diagnosis and West Kent are about to appoint some nurse specialists (1 per 40-50,000 patients) for post diagnostic care. The CCG are also working with the local Hospice who also have dementia specialist nurses. There are also voluntary services by organisations such as Alzheimers Society. However, these can be patchy and not well known.

It was noted that there were services in DGS but what exists currently do not meet the needs of the patients. Admiral Nurses are also now in short supply.

It was highlighted that carers are the ones who are often forgotten and most in need. Dr Joe Chaudhuri commented that the role of those in this meeting is not so much in continuing care. It was noted that there is a visiting consultant who currently attends the practice and is very helpful.

It was felt the Care Navigators that are being introduced will probably have a role in signposting to continuing care services.

Dr Collier introduced a presentation written by Dr Farnaz Sharief who leads on mental health in Medway CCG and which details Improving Dementia Diagnosis Rates and Referral Pathways.

The aim is to define who does what and tighten up criteria for referral but also remove any barriers. One of the main changes is that GPs are no longer required to do an ECG prior to referral. This will now be done within secondary care only if patient is symptomatic, however if one has been done in the last 12 months it should be included. There will also be an email address for referrals. Once referrals are received they will be triaged by a consultant and any

CT/MRIs etc. needed will be arranged prior to appointment with the psychiatrist.
KMPT agreed to look into the IT issues that exist in West & North Kent but have been resolved in East Kent around KMPT staff having access to pathology results.

Dr Chaudhuri reported that East Kent GPs are occasionally still being asked to do an ECG despite the agreement that it is not necessary being made a few years ago. KMPT agreed to investigate.

KMPT agreed to look into the differences between the pathways between East Kent and West/North Kent to try to ensure that they are the same across the county.

A discussion took place about GPs diagnosing dementia and initiating treatment. Dr Collier explained how she does this using Kinesis to discuss with the consultant. However, it was acknowledged that not all GPs are able to do this and there are also Shared Care implications and the fact that it is not a contractual requirement.

A question was raised about those that present very late and are already seriously demented. Dr Collier commented that there is a tool available from Diadem which is currently validated for nursing and care home use: (https://www.alzheimers.org.uk/dementia-professionals/resources-gps/diadem-diagnosing-advanced-dementia-mandate).

This is a very simple 4 step process and at the end of it you can write dementia as a diagnosis as a GP. Dr Collier provided an example of a local practice who used the tool on 16 patients in a Care Home and 8 were subsequently diagnosed with severe dementia, improving the practice dementia diagnosis rates. Dr Simon Lundy commented that it need not necessarily be a GP that does this and requested that this is added to the diagnostic pathway.

It was noted that dementia nurses will not currently be prescribing. KMPT are implementing prescribing training for as many of their staff as possible.

Dr Zishan Syed commented that support is often not really needed during early diagnosis, but there is a need as the disease progresses and has heard reports that people in crisis are being told they cannot access anything. Dr Collier reported that their next piece of work is looking at those that need this kind of input and they are working with KCC as a joint commissioning piece of work. The dementia nurses should help to spot the deterioration before it becomes a crisis.

Dr Malasi commented that was originally a function of the Home Treatment Team in East Kent a few years ago. KMPT agreed that was the case and they are now working with Dr Richard Brown to look at this. Dr Lundy asked that this should be a K&M wide service not just East Kent. Dr Collier commented the STP are looking for a K&M clinical lead in mental health.

Crisis Intervention
Dr Mark Ironmonger commented that there seems to be no alternative to A&E for mental health patients in crisis. Then they are bounced back out to the GP. Dr Malasi reported that in other parts of the country they have a liaison role that straddles Primary and Secondary Care which can access mental health services. KMPT reported that they are looking at such a service with the STP that would sit within A&E and Urgent Care.

It was suggested the EDN could include the report from the liaison person.

It was reported that in DGS it appears that there is a disconnect between the crisis team and CMHT. Dr Rosarii Harte stated that this should not be the case and that people should be seen within 7 days of seeing the crisis team for follow up and she will investigate further.

It was suggested a virtual ward could work where the MH team keep the patient open on their books and follow them up regularly.

SPOA Quality Visit
Dr Malasi reported that the CCG Quality Team had visited the SPOA and found there was one person answering the calls for the

whole of Kent and Medway and the individual had lots of calls waiting and the calls were also not being recorded. Dr Harte stated that she understood there should be more than one person and that there is quite a large team on the site and committed to investigating further and bringing a report and comments to the next liaison meeting. Dr Harte commented that she is also aware that they are currently reviewing the SPOA.

Frustrations were shared on how often people are not seen because the service states they could not reach them, and the GP has explained that they must take the call and can see no reason why they would not have done. Dr Ironmonger pointed out that there could be a medico legal question around accountability if people have been left and the letter to the GP does not arrive until a few weeks after the referral.

Date of Next Meeting
Tuesday 5th November 2019

Donna Clarke
Practice Liaison Officer