# 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 2019

Drs John Allingham, Richard Claxton, David Lawrence, Ian Jones, Neil Potter and Kevin Tan joined Mr Carlo Caruso at the inaugural Joint West Kent/DGS CCG/LMC liaison meeting. Mrs Gail Arnold attended on behalf of both CCGs, Dr Bob Bowes attended on behalf of West Kent CCG and Dr Sarah McDermott and Mrs Debbie Stock attended on behalf of DGS CCG.

**West Kent:**

**QOF (Quality improvement monitoring)**

The CCG is keen to ensure that it has a light touch and supportive approach to monitoring the quality improvement aspect of QOF, in line with the contract. It has been investigating whether Eclipse might be used to support practices with pre-defined audits and will provide an update before the next meeting.

**ADHD meds for children**

The CCG and LMC confirmed that there have been early stage discussions about including shared care prescribing under phase 2 of the Primary Care Quality Scheme. Consideration will also be given to prescribing ADHD medication for adults.

**Physio referral**

GPs queried why it was necessary for them to re-refer a patient for a further course of physio when the physio service has recommended continuation of treatment and the patient is already in regular contact with them. According to the CCG, this is because it was concerned that there may be occasions when physio and patient seek to continue treatment when there is unlikely to be a long-term benefit.

LMC recognised this point but indicated the pathway could be improved if the patient was referred to orthopaedic triage service instead. Furthermore, it would probably only be a minority of patients for which the condition did not improve from further physiotherapy.

The CCG agreed to change the pathway so that if the patient is not discharged, the physio will complete the orthopaedic triage form

**Medicines Optimisation Scheme (MOS)**

The LMC was concerned that the gains from the MOS' gain were not sustainable because moving patients from branded generic medications eroded stock levels giving rise to increased prices. Furthermore, as stocks are depleted patients return to their GP for alternatives causing additional workload for practices.

The group did discuss how it would be helpful if the pharmacist would also recommend alternatives to their patient if they are out of stock of a particular medicine. The LMC agreed to explore this with the Local Pharmaceutical Committee.

**iPlato emailing facility**

The CCG was still looking into whether iPlato could be used for email communications and would report back before the next meeting.

**Primary Care Networks Update**

GPs were concerned that the advent of PCNs has led to the CCG locality meetings evaporating, and whether this has made it difficult for PCNs to liaise with CCGs now. WK CCG acknowledged that the decision to stop the locality meetings may have been premature and it would be exploring how to ensure communications with PCNs are maintained.
The LMC also wanted to ensure that practices that have decided not to join PCNs continue to have a voice in the system; and that the system ensures that sufficient support is given to PCNs that are hosting practices that are not part of the membership due to the associated workload.

**Primary Care Quality Standard (PCQS) Update**

Practices in West Kent have been positive about the PCQS scheme but there has been some uncertainty about the precise commencement date. West Kent CCG advised that all services were available to practices from the beginning of October 2019 except for those that required a notice period (for example, phlebotomy delivered by MTW). Practices are advised to code their activity and once the software has been rolled out it will extract activity and payments will be made. The CCG also confirmed that practices that have been providing additional phlebotomy capacity to complement the MTW service will be paid under the new scheme.

The start date of the PCQS in DGS was still to be confirmed.

The CCGs were reviewing the returns from practices about which services will be delivered individually or in collaboration. CCGs will continue to have a dialogue with practices where the approach to delivery was not clear.

DGS GPs were concerned that demand for the phlebotomy service may exceed the capacity that practices are able to provide. The CCG advised that the specification does set out which patients are excepted from accessing phlebotomy through this route and how activity can be sub-contracted.

**Local Care Updates**

**DGS CCG**
The CCG reported significant progress with establishing a Home Visiting Service, with almost all positions filled. GPs have been surveyed but less than 50% had responded. Both the CCG and the LMC emphasised that GP feedback is important to understand the benefit and value that this service is delivering. However, anecdotal feedback was that GPs have been benefiting considerably from the additional support provided by this service.

The CCG was looking at commissioning an enhanced service for care homes.

The Rapid Response service is currently staffed at 84% overall, with the therapy team currently around 70% occupied. The CCG is also in the process of reviewing the referral criteria to ensure that continues to be suitable. The LMC was complimentary about the work of the Rapid Response Team.

The CCG is also looking at the Accident and Emergency (A&E) department to look at the number of patients and nature of presentations attending there.

The Community Navigation service is performing particularly well, with the service currently exceeding the number of patients it was expected to see so far. The CCG is optimistic that the service is delivering for both patients and practices. The CCG has also adjusted the Social Prescribing Pilot to put 3 Community Navigators in Darenth Valley Hospital (DVH).

The CCG would like to run a learn and share event at a future PLT in order to showcase and reflect upon how the Local Care initiatives have been delivering.

The CCG will be reviewing the impact of the MDT meetings. However, this has been delayed due to issues with data extraction with Optum. There was a discussion about how MDTs could be used to keep high risk groups out of hospital. For example, there has been particular pressure due to COPD emergency admissions. This was discussed at the recent Clinical Cabinet meeting between DVH and the CCG.

Practices serving predominantly young populations are finding identifying patients for MDT meetings quite difficult. the CCG recommends that any practice that is experiencing some difficulty with the MDT meetings should contact the CCG's MDT lead for advice and support.

**West Kent CCG**
The LMC asked whether there has been a review of the new MDT approach in West Kent. The LMC had previously expressed concern at the impact the new approach had on the arrangements that practices had. The CCG believed there may not be enough data for it to be statistically significant for each individual practice to ascertain the impact it has had on unplanned admissions. The CCG agreed to share the data it held with the LMC in advance of the next meeting.

**Direct booking for Hospital at Home Team (DGS)**
LMC representatives are reporting experiencing issues with the transfer of care between DVH and Virgin Care. Another issue is that arrangements for following up patients for Us and Es are often not made by the hospital causing additional workload for GP practices. The LMC agreed to provide the CCG with examples to investigate further.

**Integrated Care Partnership (ICP) Board Meetings**
It has been reported that the ICP Senior Responsible Officers have interpreted the recent joint letter (click here) that the LMC should not be present on the board. Bob Bowes of West Kent CCG and Gaurav Gupta of the LMC, who co-authored the letter, have been clear that it states that the LMC is to be invited to board meetings.

**Data Protection Officer (DPO)**
As per the 2019 GMS contract settlement the CCGs have collectively appointed a DPO service for general practice. This is hosted by Medway CCG and can be contacted via mccg.northkentgpdataprotection@nhs.net.

**Flu – Housebound (DGS CCG)**
The CCG confirmed that it has signed a contract variation with Virgin to perform flu vaccinations for housebound patients. Practices are advised that they can start referring patients to Community Teams.

**Wound Care (DGS)**
Practices in DGS have been exploring different approaches to delivering the Wound Care element of the PCQS. The funding envelope is not enough for the federation to continue running it from the 3 locations it is currently delivered from. Instead it is looking at having a single base complemented by either a mobile service to do home visiting, or a mobile nurse to travel between practices. The principle reason driving this is that the federation does not have space reimbursed.

**West Kent Virtual Multidisciplinary Team Meeting – Future Plan**
The LMC was reporting that enthusiasm for the virtual MDT model does not appear to be improving over time. GPs appear to be experiencing increased workload as a result of their involvement. Issues include Community teams not bringing patients to the MDT, and GPs need to submit the patients they want discussed 10 days prior to the MDT meeting.

The LMC asked what will happen to the MDTs when new commissioning arrangements are introduced in April 2020 and whether there will be an opportunity to look again at how it is being organised in West Kent.

The CCG was of the view that the new process has brought about a culture change from looking at high demand housebound patients to identifying patients using a frailty score. However, it also recognises that other teams do not provide referrals. There is also the issue about how it was introduced, making practices feel like it was an additional burden and not an improvement to current arrangements. There needs to be data showing significant benefit in order to ensure confidence.

Merger of the CCGs does provide an opportunity to learn from how MDTs are being delivered across Kent and Medway. The positive reports from areas that work with Imago and where the meetings are face to face has been noted.

LMC representatives shared that all West Kent clusters were of the view that the virtual approach to MDT meetings have been unsuccessful and damaged the arrangements practices had prior to its introduction. There were some benefits in terms of specialist involvement from geriatricians, and the involvement of the fire service in the virtual MDTs. However, this only benefitted a minority of patients. Whereas the relationships and strong local teamworking between practices and District Nursing and Community matron colleagues was lost.

It was noted that with ICP working there may be opportunities for acute providers to refer patients to the MDT.

**KMPT – Discussion regarding performance**
At the previous meeting GPs shared concerns had regarding the responsiveness of the emergency mental health service. The CCG explained that this is being looked at across Kent and Medway. KMPT has indicated that it is not commissioned to provide an emergency service to meet immediate need. The CCG did not believe that this was specified in the contract and it will be seeking clarification of this in advance of the next meeting.

GPs also voiced concern that the emergency service appeared to be operating as a telephone service and this may cause access problems for some patients.

The LMC stated that it would also be following this up at its next liaison meeting with KMPT.

**Single CCG – Arrangements for West Kent Locality**
There was a discussion about how primary care teams in the single CCG would be organised. Both CCGs agreed there was significant value to practices to not disrupt current relationships and to continue to have local teams where possible.

It was anticipated that the core GP contract and enhanced services would be commissioned at the Kent and Medway CCG level. However, as relationships in the ICP develop it may be sensible for locally commissioned enhanced services to be determined by ICPs to ensure that local variations where appropriate. However, it was expected that Co-commissioning would only be delegated to CCG level to ensure that if local health economies did reach crisis core general practice would not be affected.

It was thought to be reasonable for the Education remit to fall under ICPs as they develop. There is the challenge of managing the need to achieve consistency in what is being delivered but also to balance this against the benefits of local flexibility.

Date of Next Meeting
To be confirmed.

Carlo Caruso
Deputy Clerk on behalf of Kent LMC