**WIRRAL LOCAL MEDICAL COMMITTEE**

**Minutes from the meeting held on Monday 3 September 2018**

**In the Hughes Room, The Lauries**

**OPEN SESSION**

**2.25pm – 3.15pm**

**PRESENT:** Dr B Quinn Vice Chair

 Dr A Adegoke Hon. Secretary

Dr B Ali Dr K Cooke

Dr G Francis Dr S Jarvis

 Dr R Millard Dr M Mottram

 Dr F Newton Dr M Syed

 Dr L Towersey

**ALSO PRESENT:** Mrs M Carrol – Wirral LPC

Mr P Lear - Wirral LDC

Mr D Hammond – Wirral CT

 Mr I Stewart – Wirral CCG

 Dr I Taylor – GPST3

 Dr T Wyatt – PCW Federation

 Mrs S Lepts - Wirral LMC

The Chair welcomed Mr David Hammond, Mr Iain Stewart and Dr Thomas Wyatt to the open session.

163. **CCG Update**

 The Chair invited Mr Stewart to provide an update.

Mr Stewart provided an update on:

* Directions - w.e.f 20 August 2018 the CCG are under directions by NHSE until 31 August 2019 due to last years’ financial performance and estimated gap for March 2019. It is NHSE control around CCG decision making until financial performance improves. It will be for a minimum of 1 year but could be revoked if financial performance improves. There are 3 simple areas:
1. Delivery of QIPP plan for 2018/19.
2. Addressing overspends on continuing healthcare and joint packages of care.

 3. Reducing acute contract over-performance.

A Turnaround Director will be appointed and sit with executives to effectively monitor, influence and agree decisions at governing body level and any appointments to vacancies of any executive post or AD level will be with NHSE agreement.

A short Q&A session followed:

***What are the implications of this to service provision?***

More scrutiny on financial decisions from the Turnaround Director to ensure decisions with increase in spend can be afforded.

***Any danger to Prescribing Incentive?***

Prescribing incentive budget is nationally dictated but may come under remit to ensure funded appropriately.

***Are there any risks to patient care?***

No. Predominately around financial management due to CCG poor financial performance.

***Is there a risk to practice income? PCQS, LES?***

Transformation and PCQS are a given and under GPFV. Current LES run to March 2019 and will be reviewed before Christmas and Mr Stewart will come back to LMC to share and ask if clinically still right thing to be doing and is the funding right value for money. There is contractual protection as LES contracts are signed – 18/19 contract will be honoured. Turnaround Director will be in post by the time of review so will be invited to LMC for further discussion.

* Care Home Scheme – Second phase, year 2. Enhanced plan for 18/19 to expand the scheme from April 2018 but challenges and allegations were made and the scheme was paused while NHSE investigated. Now that has concluded the scheme is underway and practices have been invited to pull their implementation plans together. The minimum requirement of 20 patients is still included and Mr Kent has added a care home counter signatory requirement for extra assurance that the work has been carried out*.*

*The Hon. Secretary expressed LMC’s disappointment that the CCG have failed to inform LMC of the start of the service and also not addressed concerns raised by the LMC, which the CCG said they would do once the NHSE investigation was over. The Chair summarised LMC concern regarding GPs being allowed to see patients that are not registered with them and the risk of patients being poached or leaned on to move when there is published evidence that people are best placed to be looked after by a GP that knows them.*

Mr Stewart informed members that the scheme is in place but he will feedback LMC concerns to Dr Sian Stokes and Mr Kent.

* Primary Care Committee – Meeting on Thursday 6 September, 2018 for Primary Care Committee to consider 3 things:
1. Homeless Service – local service Mr Kent has designed with input from some practice for committee decision as to whether investment will be made.
2. Delegated Co-Commissioning status – NHSE have approached the CCG again regarding this. The CCG will formally note a response to NHSE, who

will be in attendance at the meeting, that the CCG have no intention of applying for fully delegated status.

1. Paper on CoaguChek machines – the CCG have received complaints from practices of machines failing so CCG will put proposal to committee with costings for options to either replace one for every practice or rent on behalf of the practice.

E-Consult

A member raised a query regarding E-Consult and how the first 7 surgeries were picked for roll out as a practice that expressed early interest have not heard back. The member was advised to inform the practice to contact Ms Sarah Boyd-Short. A few members discussed their practice experience with the service as being simple and straightforward to use, good when it works as get a very detailed medical history but any hint of red flag it defaults to call 999/go to A&E so wary of how many patients will end up going to A&E because of this, not sure how many patients are going on and just getting advice, instead of phone call tag e-consult at end of morning surgery so makes consultation slick and easy, one practice is getting monthly feedback of steps, it is very concise but issue with Paeds as have to finish with face to face consultation.

The Hon. Secretary added that Ms Boyd-Short mentioned to LMC that she would like for practices that were using E-consult to give feedback to practices who may wish to join and asked if this had been done. Mr Stewart will chase this up with Ms Boyd-Short.

Phlebotomy

The Hon. Secretary informed Mr Stewart of concerns received from practices regarding the phlebotomy service mainly realising that paying for their consumables is not contractually viable and, although the contract has been signed, asked what can be done. The Chair added that it is for patient care ultimately if the contract fails due to viability. The Hon. Secretary added that LMC raised this concern with Ms Hawker before the contract was signed and asked if there was a way consumables could be made available rather than practices paying, as if practice runs into difficulty making it viable they could be made to reduce blood tests which might compromise patient care. Also the Chair informed that the hospital service blood request forms handed out in outpatients are being offloaded to Primary Care which should not be happening. A number of surgeries have made the decision not to do this work and sent the patient back. Mr Stewart replied that investment is in place, same as given to the old provider, and would be difficult under directions to provide further funding. He added that GP’s should not accept the transfer of workload and to keep rejecting it as a message to the Trust not to offload the work.

A member commented that historically consumables were covered by the lab but was then taken out of the WUTH contract. As the lab dictates which consumables are used there is a risk to smaller practices if there is a change to the consumables required and they cost considerably more. They asked if the CCG could look at this, benchmark across other areas and let LMC know what that benchmark is. There is also concern that primary care are paying for cost of consumables for phlebotomy and worry what practices may have to pay for next; urine bottles, swabs etc.

There were no further questions and the Chair thanked Mr Stewart for coming.

**ACTION:**

* **Mr Stewart to report back to CCG regarding LMC concerns with Care Home Scheme and Phlebotomy.**
* **Mr Stewart to chase up MS Boyd-Short re practice feedback on experience with E-Consult.**

164. **CT Update**

 The Chair invited Mr Hammond to provide an update.

Mr Hammond provided an update on:

* Multi-disciplinary team working – a feature of the neighbourhood developments. Set MDT’s and successful Primary Care Network bids of which there are 5 locally. Elsewhere in country where they are forging ahead with place-based care and neighbourhood working, a real focus on multidisciplinary teams; what they look like and how they operate. At the moment the CT have the locality MDT or Integrated Care Co-ordination team particularly for complex patients. A piece of work leading on at the moment is looking at how multidisciplinary team working works most effectively:
* Are the locality MDTs as good as they could be? Good feedback from neighbourhood leadership team meetings about what is the quality of information sharing, the co-ordination strength of relationships of people in neighbourhoods and are those locality teams working better in other areas? There is room for improvement and development.
* What does effective MDT working look like? What are features of the relationships between the practice, Matrons, social worker, therapist etc. that enables care to be co-ordinated most effectively?

Proposal and guidance notes to be provided for MDTs as to who the people are in terms of cases, there is the opportunity to use the CCG risk stratification (in process of being redeveloped) that could be foundation for taking a cut and then suggesting a group of patients that might benefit from an MDT review and then practices confirming who those patients are and at same time working with practices and colleagues to identify what are the most effective features of neighbourhood level MDT working. CT are planning to develop a survey to gain views and will probably send out via neighbourhood leads with guidance notes. Also to add that through neighbourhood meetings picked up the value of relationship with Matrons. The CT is currently actively looking at developing Matrons role to hold a case load, not as it was which was unevenly spread across practices, but how best to manage across the 9 neighbourhoods.

There were no questions and the Chair thanked Mr Hammond for coming.

165. **WUTH Update**

No representative present.

166. **PCW Federation Update**

Dr Wyatt provided an update:

* Neighbours are way forward.
* All schemes are going well.
* Attending Expo on Wednesday in Manchester for ideas.
* Health foundation paper - health and wellbeing not about GPs, think about the wider determinants, transport, poverty etc. could be done at neighbourhood level.
* Elderly frail short admissions, some sort of service to sit between organisations for transition out of hospital.
* Collaborating with Dr Rowlands (WUTH) re development of single Wirral system.

167. **GPW Federation Update**

Dr Mottram informed members that Extended Access, Phlebotomy and Dermatology projects are going well.

A member asked how well the two Wirral Federations were working together and said they hoped that one day Wirral will have one Federation as more practical and will be in a stronger position as one voice to get integrated provider contacts so Secondary care don’t get them.

The Hon. Secretary replied that LMC have met with both Federations about working together and agreed specific areas to facilitate working together for the advantage of general practice.

 168. **Any Other Business**

None.

 169. **Date of next meeting**

 The next LMC meeting is Monday 1 October 2018, commencing at 1.15pm and finishing at 3.15pm.