NHS
Dudley
Clinical Commissioning Group

Healthcare Forum
22nd March 2018
Questions following presentation

Presentation delivered by Stephanie Cartwright and Dr Steve Mann

Q: What's happened to Dudley and Walsall Mental Health and Black Country Partnership NHS Foundation Trust?
A: TCT - Transforming Care Together, had the intention of Birmingham Community Healthcare NHS Trust merging with Dudley and Walsall Mental Health and Black Country Partnership NHS Foundation Trust. That is now not happening, so in respect of the MCP development, they will stay independent and be significant subcontractors into the MCP.

Q: Who are the key players in the development of the MCP?
A: Dudley GPs, Dudley Group NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust.

Q: Dudley Group and the MCP, means two different services delivering healthcare in Dudley. Surely this is going to make treating one person harder. In experience, when two services run the show, no one will take responsibility.
A: We have had one organisation providing most of the services for the last 6 years, but it hasn't worked. Creating an organisation which integrates the GPs with the community services makes more sense. There will be two providers, but they will be working together closely. Currently the system operates separately; we're aware GPs don't always know if a patient has been admitted to hospital or discharged. By bringing these services together, along with the GP's, means the main element of care will be in an individual's home in their community.

Q: With regards to the community team, does that mean the NHS and Adult Social Care are going to work together?
A: Yes, it will be phased in between now and 2020 to ensure there is a fully integrated service.

Q: A lot of work has gone into patient access which means less people are going through the normal methods of calling up the surgery. If receptionists are being trained to direct people to the right place, what's the point in the patient access being pushed?
A: There will still be times when appointments are essential. 30% of patients presenting in A&E shouldn't be there. The same is for Primary Care, 30% presenting at their local GP shouldn't be there. There are more appropriate services for these people, we are not saying they haven't got a need, but their need can be met in a different way. A direct referral system, with more choice means people will be in the right place for the right care. There are more services available than A and E, 111, and calling 999.

Q: I originally thought it was a good idea, but now there are doubts. There are 52 dots. The area is split into 5, each with two MDT teams. 10 teams catering for 60,000 in each area. How will these teams actually work?
A: The MCP is the overarching model. The MCP is responsible for the teams. There will be ten teams across the 5 areas. This means each team will be looking after a specific population. However, there may be individuals who are providing a service across the whole borough (for example there is one nurse assigned to Parkinson's) We would assume this nurse would be able to share learning with MDT teams to support the team to care appropriately for the individual as well as developing their expertise without spending money by people working together and supporting each other.
We are aware one team may be overloaded/under loaded according to demographics, so currently it is not distributed fairly. The MCP will allow for workload to be assessed and ensure the teams are evenly distributed with the appropriate staff to cater for the population (eg, age related, some surgeries having a much higher young population and others having a high proportion of elderly patients with multiple conditions). The MCP will map the workforce according to the patient population. There are of course specialist teams which would not be needed in each area, so they will be made available by the MCP across the borough for the whole Dudley population to access.

Q: If an individual has been booted out of a number of care homes what will happen to them?
A: You would hope the MDT approach would support identifying the issue and support her care appropriately.

Q: So, will there be two MDT's in one area and where will these be based?
A: In the long run, we foresee larger premises in your area. If GPs and patients see the value of this MCP model of care, the facilities needed could then become hubs in each area.

Q: This evolves around GPs are you going to be able to see a GP quicker than you can now?
A: We would hope you will be able to see a GP quicker for the right thing. As we have said, 30% of people are not in the right place for the right service. So, those who need to see the GP will see the GP quicker, but this is about seeing the right person at your surgery. GPs see approximately 40 people in a day, if 30% are seeing the GP for the wrong reason, this means they are only seeing 12 patients a day that really needed their expertise.

Comment: You need to educate people. When they can't see the GP they go to the hospital

Q: How is the judicial review standing?
A: Consultation is happening, it is being led nationally. People are concerned around privatisation of the NHS. Paul gives evidence as to why we are doing what we are doing, please use this link to view on Parliament TV;
https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/news/integrated-care-organisation-partnerships-evidence-17-19/

Q: Performance related payments, where are the results?
A: GPs already have those types of outcomes. We have found one particular patient went to 300 outpatient appointments, this adds up to 3 full weeks of their life, not to mention the parking fee, time out of work/house. The MCP will be focusing on the outcomes they provide, so that is the shift for people getting the appropriate care.

Q: When they integrate social care, can you write in the contract that the government on the day need to increase the funding over and above?
A: In the last 24 hours you have probably heard of the NHS pay deal. You can hope that what we are doing is so different that investment will be on its way. There is a crisis every year in the NHS, with the winter crisis demand being given money which goes into acute services, but imagine that money going straight into the community. Airtime group is already reducing the demand on health services by offering a support network where individual support each other with COPD.

Q: At present at our GP service we are asked to state why we want to see the GP, then advised we can see a nurse instead. A lot of patients don't have confidence in speaking to the receptionist rather than a medically trained individual. How are you going to install the confidence into the patients?
A: Those working in Primary Care have undertaken Care Navigation training. Those working in primary care, to compliment this training, will have developed a knowledge to know where each patient should go. The receptionist is not providing a diagnosis they are to redirect you to the right place, there may be a percentage where they may over refer you, but if you refuse to share your information, you may end up waiting longer.

Comment: 'GPs behind closed doors' if anyone watched this, ask yourself this, everyone who goes in to see the GP. Do they belong with the GP? Or is there somewhere else they should've gone? They have Patient Service Coordinators who are not challenging, but they make individuals think about where they should be. These coordinators would be valuable within practices to redirect individuals.

Q: The central telephone point, don't do it. Or will each of the GPs give a receptionist over to the centre? Where will it be? How many staff?
A: If you look across the world, there are many other organisations that deal with a far greater population than Dudley borough and manage these well. I think we will only use technology like that if it will make a difference, it may be some services are central. 111 is advising patients to go to the doctor or A&E, Paramedics aren't always able to 'see and treat' so by taking them into hospital there are a large number in A&E. Paramedic is a skill set and they should be using these skills appropriately.

Q: Is it right you need at least two thirds of GPs signed up? Do you have an update on how many GP you now have?
A: It is two thirds, we need Primary Care on board, otherwise there isn't an MCP. There is now 80-90% signed up.

Q: Do you have further information about the significant subcontractors, would you share this information please?
A: Yes, we can mail this out.

Q: What about patient choice? Will there be patient choice?
A: Yes, there will be recommendation like there is currently, but patient choice will be there.

Q: In regards to structural arrangements, what will happen to the CCG?
A: The CCG will still be in place but it will reduce significantly in size.

Q: Solution to having two foundation trusts, does that increase the cost?
A: There will be cost to the MCP as a provider, but it will be shifting the cost, rather than increasing.

Q: Will there be a cap on the management of the MCP
A: There will be a Board made up of necessary individuals, including clinical leads. We don't envisage there would be a huge management structure.

Q: Since the breakdown in the merger, and now it will be subcontracted in, will there be greater or lesser influence in terms of mental health? Who will have the dialogue with mental health providers?
A: The CCG were clear in the prospectus at the point of procurement. The MCP will be more community focused. If you intervene early and it's appropriate you will prevent that person progressing further into healthcare services.

Q: Will dementia be part of that discussion?
A: Some people have very complex progressive dementia, and where possible, this could be dealt with in the community, where there are networks. However we are aware there will be a small amount of people who will need specialist care.

Q: This is a 15 year contract. It is fine at the moment, but they are telling us in the next ten years, that 30% of the population are going to be over 65, is there an increase in money to deal with this increase in age related healthcare needs?
A: Yes, this is factored into the model, as they have been looking at the model over the next ten years. But this will be dependent on the Government and what is funded. We are doing what we think is right at the moment. The idea of the long term contract, if we engage with Dudley population to make lifestyle changes and look after them, we would hope people will have less impact on the health service to deal with the growing population. Then there will be a reduction in spend.

Q: Older people will find it harder to make a choice and doctors may make changes. In terms of power of attorney, this should be discussed with family. Are GP's having these conversations to advise people to make these decisions earlier on?
A: Yes, GP's have been having these conversations with patients at the appropriate times.

Q: The timing of all of this, how long till we find out about the estates situation? Some practices are holding back in their developments and saying this is because of the MCP.
A: GPs can make their own decisions. Some will come together naturally but we have not withdrawn or stopped funding of any premises, or closed any premises, this will be a conversation over time. Sadly a number of practices aren't fit for purpose, but there are premises which can be kept and developed.

Q: How will this affect the GPs, will they be happy, will you be able to recruit new GP's into Dudley?
A: The GPs are the ones making the biggest change in this. We want to enable GPs to do the things only they can do. GPs get burnt out and stressed, so then they leave. So yes, this will hopefully ensure they are dealing with that they are trained in doing, happier on delivering the service they've trained to do. Happy people, in happy jobs, delivering better outcomes for patients.