Dartford, Gravesham and Swanley
Clinical Commissioning Group

CLINICAL CABINET
Notes of the Meeting held on 13 August 2013

Present
Dr Chirag Patel (CP) (Chair) – Board GP, DGS CCG
Dr Bhaskar Bora (BB) – Clinical Chair (By Telephone)
Dr David Short (DS) – Board GP DGS CCG
Bill Jones (BJ) – Chief Finance Officer DGS CCG Swale CCG and Medway CCG
Debbie Stock (DS) – Chief Operating Officer DGS and Swale CCGs
Vinay Sangar (VS) – Head of Service, KCC, DGS Locality
Karen Barkway (KB) – Deputy Chief Operating Officer, DGS CCG
Jabeen Egan (JE) – Lead Pharmacist, DGS CCG
Jackie Ardley (JA) – Independent Governing Body Board Member (Nursing) DGS CCG
Lindsay Bowring Coombe (LC) (note taker) – Business Assistant DGS CCG

In attendance:
Chris Singleton (CS) – Commissioning Project Manager – ophthalmology update
Anne Gibbins (AG) – Commissioning Programme Manager – EpaCCs update
Val Miller (VM) - Public Health Specialist, KCC – weight management update
Jo Hare (JH) – Practice Support Commissioner DGS CCG - observer
Amanda Gowers (AG) – Practice Support Commissioner DGS CCG - observer

1.	**Apologies for Absence** Dr David Woodhead, Dr Liz Lunt, Patricia Davies, Dr Bali Chalapathy, Rosemary Bolton, Su Xavier, Jane Barnes.	
2.	**Declarations of interest** No declarations of interest were noted.	
3.	**Notes of previous meeting** These were agreed.	
4.	**Matters arising** Key action points discussed: • Safeguarding – Practices will be asked to review their safeguarding training as part of the next practice closure. Andrew Coombe will provide a summary of training and contact details for GPs. KB to link with Kimberley Spicer at Swale regarding this information. **ACTION: KB source Safeguarding information** • COPD – This will be carried forward to the next agenda due to staff having been on leave.	**KB**

	• Neuro Rehab – KB will share an update when available. Sufficient senior representation is needed at the Steering Group and needs to fit with Commissioning Intentions development from September. • Medicines Optimisation – Matt Toth has liaised with JE regarding existing patients and it has been agreed that recommendations need to be on an independent patient basis with referrals. • DXS – Conversations are taking place regarding guidelines and usage. DW is in discussion with system providers regarding primary care system developments, which may provide further options for this information. . Following feedback from practices, the use of disclaimers was discussed.The CCG cannot be removed of liability despite any disclaimers being signed if DGS CCG holds the contract. Legal advice would be required. Guidelines, pathways and directory of service have been uploaded onto the intranet by the practice Support Commissioners and practices have been informed. It was recommended that a full review, including practice feedback be undertaken and presented as soon as possible. **ACTION: KB to bring back the DXS proposal when ready** • Education – Professor Talby to be invited to attend to discuss education in the locality. PD will make contact with him. **ACTION: KB to link with PD** • DES update – DS raised the issue of the development of online booking for practices in order to be able to deliver the DES. There were concerns that the cost of implementing / upgrading systems to support this would exceed the DES payments. KB reported that this issue had been highlighted within a recent GPIT meeting, and confirmation was awaited on whether the necessary IT system development would be funded from core GPIT funding. **ACTION: KB to share details once available**	**KB** **KB** **KB**
5.	**Diabetes** In the absence of BC, the guideance shared was discussed. The aim of the guidance shared was unclear, with JE confirming that NICE guidance and care plan pathways are available. The guidance presented is comprehensive around diagnosis and treatment pathways, however there has been no input from the medicines management team around treatment pathways. One of the Insulins listed has not yet been considered by the CCG. It was suggested that there is a need to revisit the diabetes action plan and check the aim of this document, cross referencing clinical guidelines and treatment pathways, with an emphasis on self-care. **ACTION: JE to link with BC around amendments** **ACTION: BC to link with Bev Dennis and consider next steps**	**JE/BC** **BC**

	ACTION: Paper to then be brought back to Clinical Cabinet	**BC**
6.	**Weight Management Services** The background to the paper was discussed prior to presentation. VS confirmed that KCC has commissioned respite beds for bariatric patients in the Ashford locality. Val Miller provided an update on procurement for weight management services following previous agreement by the Clinical Cabinet on procurement plans. New National Guidance requires patients seeking bariatric surgery to undergo Tier 3 intervention before proceeding to surgery(Tier 4). VM provided an outline of the pwathway. Entry to the system is via GP referral with agreement sought for cross referral from teir 3 to toer 4 as required. The service consists of amultidisciplinery team including psychotherapists, Clinicians and exercise professionals. A team has been recruited around NICE Guidance with Clinicians making the final decision. Refrrals into the service are limited to 400 patients pan Kent. Demand may be greater within the West Kent locality as some need is being met in East Kent already. 24 referrals have come from the DGS locality since 1 April but the service needs to be monitored to establish areas of demand. Predictive models have been populated but these do not take into account areas of unmet need as they are based on historical activity. Modelling can be undertaken to identify need but may not match the numbers of people who wish to access the services. 4healthyweight provide psychotherapy as part of an MDT including exercise professionals. Funding has been released following the Public Health Business Case currently standing at 300K per annum for 3 years secured as funding. Concern was raised regarding referrals from other (e.g diabetic) teams and the potential volume of referrals. KPIs include a demographic profile which requires regular reporting linked in to needs assessments. Public Health information will also be required for a seamless delivery for services commissioned below a surgical level. DS asked for clarification on the time from referral to assessment. Waiting times between tiers were discussed in relation to surgery budgets from specialist commissioning and it was agreed that timeframe and locality were key. Tier 4 will have a waiting list and lists will be variable depending on the tertiary centre chosen by the patient. The local authority receives funding for Tiers 1&2 and work is being undertaken by Public Health around weight management programmes. There is a need to review and share updates which VM agreed to enable further discussion. This should include a review to ensure those individuals from	

	deprived areas are included. DS would like regular reporting to enable targeting practices linked to the JSNA. One of the KPIs is that 4healthyweight will provide the CCGs with reports. The provider working with Primary care will identify 2 areas within the locality to operate from. Evaluation will ensure monitoring of the service. The HWBB are undertaking discussions around Tiers 1&2 and information sharing would be welcomed. VM is involved in the process including visits where necessary. **ACTION: SX is accessing data on local areas and risk involved and the number of patients using local services** **ACTION: VM to share KPIs for circulating quarterly** The proposal was agreed. An increase in referrals is expected. DS also expressed concerns around health checks. **ACTION: VM to confirm the number of practices signed up and services available and how these are provided**	**SX** **VM** **VM**
7.	**Ophthalmology** CS provided an updateon plans to secure local ophthalmology provision following the dissolution of South London Healthcare Trust. The vast majority of DGS patients attend South London for Ophthalmology treatment, and Kings will be taking over all Ophthalmology services from South London. The transfer to Kings will have a number of impacts for DGS, not least a financial impact due to the higher MFF paid to Kings. There is also a potential risk that Kings will look to centralise the Ophthalmology service on one or two sites, which may affect provision at Sidcup. For these reasons, therefore, it makes sense to consider other options for Ophthalmology. Darent Valley have been considering developing an Ophthalmology service for some time, and already provide a significant amount of outpatient activity delivered by South London from DVH. Significant progress has been made over the last few months, and DVH have now entered into a partnership with Moorfields to provide Ophthalmology services from DVH. Moorfields consultants will treat patients at DVH, with inpatient activity being undertaken at the Moorfields City Road site initially.We have been clear with DVH that we will want services to be provided locally. There are a number of legal and contractual considerations that the CCG has had to take into account. However, we have taken advice on the best way forward and we plan to provide six months contractual notice to Kings in September of our intention to repatriate significant volumes of	

	Ophthalmology activity to local provision. Patients will still be able to elect to be treated at Kings. We have also confirmed that there was no minimum activity guarantee given to Kings at the time of the contract award of the South London activity. There are a number of significant benefits of the DVH and Moorfields service, not least the fact that we can work closely with DVH to build the service as we want it to be, which is a unique opportunity. Moorfields have agreed that all treatment for DGS patients will be at the DVH MFF as opposed to their higher MFF, which will mean a significant financial benefit to the CCG. This represents a saving on tariff price of circa 9%. All parties are very keen to work collaboratively to develop the service, and we will be working with them over the coming months to develop the detail of the service and provision. We will look to agree a contractual service specification which will set out the expected service model etc. Clinical Cabinet will be kept fully updated as this develops. All agreed that this was a positive development. KB asked whether it would be necessary to go out to procurement for the Ophthalmology service in the long-term. CS said that advice had been sought from the Procurement Team on this subject, who had advised that commissioners are not required to go out to procurement but that this can be a good option to ensure that a broad range of providers have the opportunity to bid to provide the service. However, as all providers locally are open to DGS patients (including independent sector providers) this will not be necessary. BB noted that the Community Opthalmology Team (COT) will need to be notified of this new service.. DS highlighted thata North Kent wide review of community Ophthalmology is taking place, and CS confirmed that the CCG is working closely with West Kent CCG to address concerns with the COT. **Radiology Reporting Delays** BB also raised the delays in Radiology at DVH and said that this was a significant concern for GPs. CS said that he had been working closely with the General Manager at DVH and had been providing regular updates to practices. The issue at DVH was part of a Kent wide issue linked to the introduction of a new Radiology system across the county. CS said that he had spoken to the General Manager today who had reported that the situation was improving, with the Trust reporting on scans within around five days as opposed to a number of weeks during the worst periods. CS said that he was regularly liaising to get updates on the situation. BB commented that waits for some patients remained excessivce patient in his practice had waited over four weeks for the results of a scan. BB said that this should be raised formally with the	

	Trust under the contract. CS agreed and said that he had informed the General Manager that this was likely to happen. DS said that this would be raised and asked CS to get weekly information from the Trust on the backlog and reporting times. **Action – CS to obtain backlog information and reporting times from the Trust and DS to raise with the Trust at the next contract performance meeting**	**CS**
8.	**EPaCCS (Electronic Palliative Care Coordination System)** AG gave an update on progress with the development of EPaCCS A review of systems has been undertaken. Reablement monies can be put into planning costs and played into baseline. Following discussions the preferred option would be to the adastra stand alone system. Discussions will need to take place with KMCS as the system is compatible with the 111 system but not with IC24 'share my care'. The link between this system and GPMIS / IBIS was discussed. BJ raised a concern regarding integration with other systems. We would need to look at whether this links with MIG. Interoperability needs to be considered. It was discussed regarding finances that we can capitalise the first element if need be. This could be used for other areas e.g. special patient notes. However advice will need to be sought from KMCS on the need for full procurement. A brief discussion with McKesson will be required as well. Following discussions it was confirmed that the proposal for ADASTRA STAND ALONE SYSTEM was agreed subject to confirmation of interoperability. **ACTION: AG to discuss with David Woodhead**	**AG**
9.	**Palliative care Pharmaceutical services- update** KB and JE gave an update on the issue following KCHT giving notice on provision of the specialist palliative care service for Elenor Lions Hospice DVH have been providing interim cover until April 2014, with the cost removed from the KCHT contract. Clinical pharmacist input and pharmaceutical supply have both been key aspects. Revised service specifications are required. DVH have wholesale licences to supply and will need to give notice regarding changes particularly regarding drugs supplied to hospices.	

	DVH have suggested that they would not want to continue the supply side of the service going forward. A service specification is in place for the supply side whilst the service specification is being developed for clinical support. Development of the clinical service specification is in progress. The executive team will need to discuss any notice served due to the current funding arrangements of Bexley patients who form 1/5 of the patient cohort.	
10.	**LES Review** Commissioning managers have been asked to review enhanced services and work is currently making progress. The findings will go to the Enhanced Services Primary Care Strategy Group for consideration at the end of the month. Discussions are taking place regarding the potential future format of LES' and feedback will be forthcoming after the next meeting of the group. **ACTION – GC to provide update following discussion by Primary Care Strategy Group**	**GC**
11.	**Social Services Update** DS provided an update on the integrated front end team at Darent Valley Hospital. This has been piloted and is being extended to provide cover over the winter period. Capacity planning is needed and updates will be brought to this group. This is currently being managed through the Urgent Care Group. It is planned that consultants will be put in the front end of A&E with additional bed capacity pending the results of the pilot. Recruitment for 4 consultants is currently taking place to support these changes.	
12.	**Medicines Optimisation** 1. New drug for *C difficile* infection has been recommended by PH England and NICE with strong clinical evidence. The cost per patient is £1350 per patient for 10 days treatment. The DVH microbiologist would like to use this for recurrent *C difficile* infections however, it also has indication for primary treatment. Microbiologist has not horizon scanned this. AGREED FOR USE IN SECONDARY CARE ONLY. 2. MMC update – for noting 3. PGRC recommendations – brought back for decision. Linaclotide (new treatment) - no comparative data only placebo therefore there is no evidence base. AGREED NOT FOR PRIMARY CARE PRESCRIBING. BB commented on the need for quarterly updates on usage	

	quantities and who is prescribing. NICE guidance is contained within some reports on HISBI – this data is reported to the Finance and Performance Committee and can be shared with locality meetings. Insulin degludec – benefits not clinically significant. AGREED NOT FOR USE. **ACTION: JE can examine future budgets and feedback to DVH MMC meeting**	**JE**
13.	**Update on Small Value Contract Changes** KB confirmed that there were none to report.	
14.	**GP Update on lead areas** No specific updates were available. KB gave an update of Primary Care. The contract for the walk in centre has been reviewed and it is expected to be extended until September 2014. The proposal was briefly discussed at the Primary Care Strategy Group. Locally Enhanced Services and Primary Care Assurance data is also being reviewed.been looked at and the former will be presented at the next Clinical Cabinet. Primary Care data extraction was discussed, further requirements need to be confirmed. **ACTION: GC and DS to raise in the Primary Care Strategy Group the need to establish requirements around Primary care data extraction**	**GC/DS**
15.	**Workplan** It was suggested that the community model update be moved to October.	
16.	**Any Other Business** BB raised the subject of setting of objectives with GP Board members. It was discussed that objectives are currently being drafted. There is a need to incorporate information governance guidelines.	
19.	**Date of next meeting** Tuesday , 10 September 2013, 1pm-3pm, Meeting Room 1, 2nd Floor, Gravesham Civic Centre	

Action Log:

Date	Item	Action	Lead
Aug-13	matters arising	KB source Safeguarding information	KB
Aug-13	matters arising	KB to bring back the DXS proposal when ready	KB
Aug-13	matters arising	KB to link with PD re Professor Talby invitation to clinical cabinet	KB
Aug-13	matters arising	KB to share details once available , in relation to GPIT funding for DES	KB
Aug-13	diabetes pathway	JE to link with BC around amendments to diabetes paper	JE
Aug-13	diabetes pathway	BC to link with Bev Dennis then consider next steps	BC
Aug-13	diabetes pathway	Paper to then be brought back to Clinical Cabinet	BC
Aug-13	weight management pathway	SX is accessing data on local areas and risk involved and the number of patients using local services	SX
Aug-13	weight management pathway	VM to share KPIs for circulating quarterly	VM
Aug-13	weight management pathway	VM to confirm the number of practices signed up and services available and how these are provided. Post meeting note: Services are provided by 4healthyweight at: 1. Gravesend - Pelham and St Gregorys. 2. Dartford - Horseman's Place.	VM
Aug-13	radiology reporting delays	CS to obtain backlog information and reporting times from the Trust and DS to raise with the Trust at the next contract performance meeting	CS
Aug-13	EPaCCS	AG to discuss with David Woodhead around EPAACS	AG
Aug-13	LES review	GC to provide update following discussion by Primary Care Strategy Group	GC
Aug-13	medicine optimisation	ACTION: JE can examine future budgets and feedback to DVH MMC meeting	JE
Aug-13	GP update on lead areas	GC and DS to raise in the Primary Care Strategy Group the need to establish requirements around Primary care data extraction	GC