Cam Health
Local Commissioning Group

CAM HEALTH MEMBERSHIP BOARD

Date : Thursday 22 August 2013
Time : 9.00am – 10:30am
Venue : Nuffield Road Medical Centre

MINUTES

Present :	**GP Lead**	**Practice manager**	**Other**
Arbury Rd		A. Sanderson (ASn)	
Bottisham		M. Barrett-Small (MBS)	
Bridge St	*Apols.*		
Ch.Hinton	S Mukherjee (SM)	E. Britton (EB)	
E.Barnwell	*Apols.*		
Firs - Histon	M.Grande (MG)	H. Wiseman (HW)	J. Dhaliwal (JD)
Milton		P. Vincett (PV)	
NRMC	M.Brookes (MB) (chair)	G. Evans (GE)	
Newnham Walk		B. Willis (BW)	Danielle Malan (DM)
LCO		R. Harrison (RCH)	Kirsteen Watson (KW)
LCG	M. De Smith (MDS)	A. Slatter (AS)	Arnold Fertig (AF)
Patient Rep	K. Stonell, Patient Rep		

1.	**APOLOGIES**
	Tom Shackleton (TS), Rachel Harmer (RHH), Adrian O'Reilly (AO), Sally Kaemer (SK), Nigel Smith (NS), Cain Hunt (CH), Sue Holmes (SHol), Debbie Parsons (DP), Sam Clark (SC) and Orla McGuinness (OM). MG introduced the new Firs House registrar, JD.
2.	**DECLARATIONS OF INTEREST**
	Re agenda item 4 - Older people/Brookfields/CNC virtual beds - GE declared interest on behalf of NRMC who provide medical service in the form of GP support to CNC beds. Later in the course of the meeting GE, ASn and MB raised their interest in ASSURA.
3.	**MINUTES OF THE MEETING HELD ON 18 APRIL 2013/ACTION LOG REVIEW**
	The minutes were agreed as an accurate record. The action log was noted. Re action Feb 001 (practices collating numbers of patients over 85 to assess workload implications of management plans), it was agreed to take this to the Health Group. **Action: Add this to the next Health Group agenda.**
4	**OLDER PEOPLE'S PROGRAMME**
	i. Roadshow Presentation AF gave a presentation to update the group on the progress of the procurement process. It was envisaged that the successful bidder would employ the same teams and pathways for both the under and over 65s, which would have a positive impact on community services for under 65s. AF outlined the main issues and the vision for the Older People Programme. The main stages of the process were also clarified. In particular, having vetted interested parties through the PQQ (pre-qualification questionnaire) stage, the next stages are: - ISOS (invitation to submit outline solutions) when the bidders will be narrowed down to the final three contenders; - ISFS (invitation to submit final solutions) when the final bidder will be selected; - final sign off of business cases and contracts; and

- mobilisation.

In between each stage there will be dialogue with the interested bidders.
A number of patient stories were currently being drafted as part of the ISOS stage, to test the bidders' proposals against the desired outcomes for different types of patients. GPs invited to help with these stories. These questions would be given 60% weighting. LCGs would be involved in choosing the final three bidders.

AF explained that contract payment mechanisms were being considered that would withhold a certain percentage of payment if standards were not met. The scope of the services and financial and contracting principles were also discussed.

A discussion ensued as to how prescriptive and detailed the specification should be. A balance needed to be struck between encouraging innovation and capturing important details.

KW then clarified the success criteria and older people's outcomes work stream. KW had looked at the evidence and there was nothing to indicate what would work for the whole system. All systems operated differently and there were many pilots.
KW stated that the draft outcomes framework had been tested with patient groups, commissioners and providers. KW asked GPs to look at the specification and give their input.

RCH noted that transport was a key part of the services, e.g. the ambulance service. This was noted for testing in the dialogue with prospective providers.

A query was raised regarding record keeping and what the expectation was regarding sharing information. Noted there could be substantial burden on primary care which needs to be taken into consideration. KW confirmed there was an outcome measure that required the successful bidder to have integrated information systems and must link to primary care, however the exact IT requirements were not specified. Bill Wilson is leading a working group developing the IT specification. **Action: DM to circulate draft specification to lead GPs for input.**
It was noted that the confidential nature of the document needs to be emphasised and that the specification must not be shared with the bidders at this stage.

ii. Decision making approach

AF asked whether the whole membership board wanted to be involved in making decisions on the Older People's Programme or whether they were happy to delegate this responsibility to the executive board, who would then update this board. The latter was agreed.
Action: DM would email the membership board to confirm those not present were happy with this arrangement.

iii. Brookfields – intermediate beds provision

MG referred to the memo outlining recommendations and confirmed that the plan was to re-open Brookfields beds in mid-November. There would be 20 beds, including 6 step-up beds. There would be 36 beds over the winter, and a phased reduction of the CNC beds commissioned in place of Brookfields, to give a total complement of 24 in summer. A pathways meeting was taking place on 29 August between GPs, CCS and consultant geriatrician to determine how to best use the bed complement. MG asked the board to endorse the recommendations.

Noted that there was risk of not having adequate provision for winter if nursing staff could not be recruited. Also, risk around cost of beds and CNC replacements. If Brookfields could not open in mid November, CNC beds would continue. There is limited availability elsewhere. Possibly 3 at Linton, 3 at Bottisham but potentially costly. **Action: DM to update risk register**
The Board agreed to endorse the recommendations.

5	**QUALITY STRATEGY**
	RCH explained the Quality Strategy outlined what the Quality & Safety team do on behalf of the CCG and LCGs. RCH especially noted the higher profile of the duty of candour brought about by the Frances report. The Quality & Safety team review quality standards in provider Trusts and have a role in assisting GP practices to meet standards. RCH noted that there was no primary care framework yet to replace GPSIF (GP service improvement framework), however this was being worked on at NHS England. The board was reminded about the SIL (soft intelligence line). This enabled people to raise quality concerns without raising a formal grievance, and allowed the Quality & Safety team to spot trends that could lead to further investigations. **Action: DM to email practices to confirm details of quality mailbox.** It was noted that the Quality & Safety team's input into project work was valuable but could not see link to project groups in the strategy MB noted that the Quality Strategy did not seem to mention clinical effectiveness or monitoring how it is delivered. **Action: feed comments back to Quality team.** KS noted asked for clarification on the Quality Strategy action plan objectives relating to patient engagement. **Action: DM to ask for clarification. (Objs. 1-4 and 6.)**
6	**GPS WITH SPECIAL INTEREST (GPSI) SERVICES FOR DECOMMISSIONING**
	[NRMC, Arbury Rd and Newnham Walk declared interests as members of ASSURA, GPs working in the service, host of ASSURA services] RCH explained that Jenny Brown (JB) had originally negotiated and put in the place the existing GPSI contracts. JB had now undertaken a review and identified two services that could be decommissioned. Circumstances had changed meaning that the services were no longer cost effective, and it was proposed the contracts not be renewed. In particular, MSK and heart failure procurement exercises were underway that would be replacing the services in question. JB's report was included in the meeting papers. RCH explained the reasons why Dr Redwood's cardiology and Dr Owens' orthopaedics (knee) services were recommended for decommissioning and the group were asked for approval. The decision needs to be made now so that the required six months' notice could be given. The group discussed that this situation needed to be dealt with delicately and with respect. The GPs had been skilled up to fulfil primary care needs and now they were being decommissioned when they were no longer required. Don't really want to deskill GPs. It was agreed that the GPs in question need to be kept engaged. It was agreed that Cam Health would support CATCH in delivering the message as both the GPwSIs were CATCH practice GPs. It was agreed that meetings would be set up with both GPs to thank them for their valuable contribution and to emphasise that the Cambridge system did not want to lose their expertise. **Action: arrange meetings with Dr Linehan, Dr. Redwood and Dr.Owens with a view to sending out a letter with formal notice to decommission at the end of September.** **Community ENT service run by ASSURA.** - As MB had declared a conflict of interests, MG chaired this item. MG explained that there was a high rate of savings for those patients that had been seen and a significant reduction in follow-up rate. However, the amount of patients being seen overall was increasing, leading to more costs. It was noted that it was important to have alternatives to secondary care, but they have to be affordable. The service was also reported to be popular with patients. Audit work is to be undertaken to understand and find solutions to the increase in ENT referrals. The board agreed to continuation of community ENT service contract.

	SM enquired whether there had been any developments regarding Community Gynaecology service run by Pauline Brimblecombe (PB). It was confirmed that PB had not made her intentions clear yet and that her announcement was awaited.
7	**COMMISSIONING INTENTIONS 14/15**
	RCH explained that formulating the commissioning intensions for the next financial year was the beginning of the planning process for 14/15 and formed the basis of letters to provider trusts signalling where services might change in the near future and giving notice where de-commissioning is required. The planning process is iterative. LCG plans are collated to form wider CCG plan at the end of February and finalised by the end of March 2014. The plan should then be signed off by the membership board ready for April 2014. It was noted that diabetes, health promotion and prescribing need to be included in the plan explicitly. MB asked the group how the plan should be moved forward, e.g. separate meetings or delegating to sub-groups. It was agreed that the commissioning intentions should be taken to the Health Group and Executive board for sign off. **Action: distribute commissioning intentions plan to clinical staff for comment and take the commissioning intensions to the Health Group and Executive board for decision.** MG briefly noted the Living Within our Means (LWOM) meeting that had taken place with Neil Modha (CCG chief clinical officer). This replaces the QIPP meetings. The meeting had been general to discuss with LCGs the financial position and remedial actions for the rest for the current year and going forward.
8	**EXCEPTION REPORTS FROM SUB GROUPS**
	- **Finance & Performance:** PV confirmed that the Practice Managers were meeting with Mandy Brian re dementia training. RCH explained that she had looked at the hip fracture data to try and understand why Cam Health was an outlier and discovered a data flaw. Cam Health is actually performing better than average. However, this does not change the overall level of spending and there are still a high number of hip fractures. Discussion ensured as to what factors were driving the activity, eg. Falls, people discharged to nursing homes. The current data sharing moratorium still made it difficult to drill down into exact figures and reasons. It was also confirmed that if practices had identified areas for the peer review that were not suggested they were free to do so. **Action: Remind practices to have GP present at external peer review on 26 September.** - **Health Group:** The meeting had included an interesting talk by the benefit manager from Cambridge CC, which highlighted how the benefit reforms may impact on the work carried out by GPs. The deployment of new MDT coordinator was discussed. MdS as project manager is liaising with the practices. Progress on COPD and Dermatology was considered. Recruitment to community nurse posts for Admission avoidance was still not happening. An option to combine part time posts to provide funding for one whole time equivalent has been put forward which may improve likelihood of recruitment, and, posts can now be advertised as permanent rather than short term. **Action: Ask the Executive Board/F&P to consider details of full time post and approve.** - **Prescribing Group:** The board noted the progress being made through the group on switching to cost effective products. Noted that use of bisphosphonate (bone density) could be linked with fractures/falls work. . - **Action: TS to discuss use of benzodiazepines at Clinical Governance Afternoon (now called Development Session) on 19 September.** - **Patient Forum:** KS outlined some work from the group. It was noted that many centrally written patient engagement forms are not clear. Also, it would be much appreciated if GPs

	could attend the PPG meetings. **Action: DM/Practice Managers - Ask GPs if they could attend PPG meetings.** It was noted that the Older People Programme would be on the next patient forum agenda.
9	**LCG QUARTERLY REPORT TO CCG**
	The report submitted to CCG 15 August, presents the "performance scorecard" for a collection of performance measures, quality of service, access, activity, finances, contract performance measures and delivery of QIPP projects. It was noted that the AGIS scheme is running behind plan at the moment due to a combination of factors. The assumptions in the business case were ambitious and there had been fewer referrals than expected. The average cost avoided at the moment was half of that estimated. It was noted that the amount of admissions and costs avoided may change over time, and that a second vehicle was planned to start in September. MB enquired when decommissioning needed to be considered. It was noted that this discussion would need to be had jointly with CATCH. However, this vehicle was a key part of the older people's programme. It was further noted that the board was being informed so that they were aware of the risks. **Action: Publicise services, provide contact numbers and give a real list of case studies to the practices as guide to what service can manage.**
10	**JOINT TRANSFORMATION BOARD**
	The Joint transformation board provides Cam Health and CATCH a forum to manage projects that affect the Cambridge system and therefore both LCGs, to avoid duplication and miscommunication. A quick discussion on the COPD and MSK procurement progress ensued. MSK re-commissioning exercise is now preparing for ITT stage (Invitation to tender) The Board discussed a proposal from Addenbrookes for Managing complex patients with Diabetes. Addenbrookes is fined for delayed transfers and re-admissions within 30 days. Some of this money is re-invested to avoid same in future. The trust has tested service developments that help avoid repeated admissions and after a year is now requesting support from commissioners. The proposal was similar in many ways to the Cam Health Integrated community diabetes service but focussed on Type I DM of which there are far fewer than type II DM.. The proposal would need significant investment. Initial response is that the priority is to get the Cam Health service working properly first. We have no surplus funds to invest and need to see results from existing initiatives before committing more. **Action: Send diabetes proposal to KS for consideration and comment.**
11	**RISK REGISTER**
	Add the potential lack of beds/recruitment at Brookfields to the risk register. In relation to the CDiff breaches at Addenbrookes, it was suggested that Sue Holmes could be invited to the executive board to explain progress. **Action: Invite Sue Holmes to executive Board meeting.**
13	**ANY OTHER BUSINESS**
	- Group confirmed that they were happy to keep meeting on Thursday mornings. Dates to avoid were school holidays and bank holidays. **Action: DM to plan dates from 2013/14.** - MB told the group that there would be a Primary Care Offer workshop on 18 September led by CCG, he will be attending for Cam Health. - It was noted that this was MBS's last meeting before she retires. MB thanked MBS for all her hard work on behalf of Cam Health. - Cam Health support team recruitment update – Nick Hall to start as project manager on 30 September and Anna Crispe to start as LCG manager on 4 November. **Action: organise practice visits as part of the induction process.** This was RCH's last membership board meeting and MB thanked RCH for all her hard work.
14	**Date of next meeting**
	Thursday 24 October 2013, 9.00- 12 noon, Nuffield Road Medical Centre