Cam Health
Local Commissioning Group

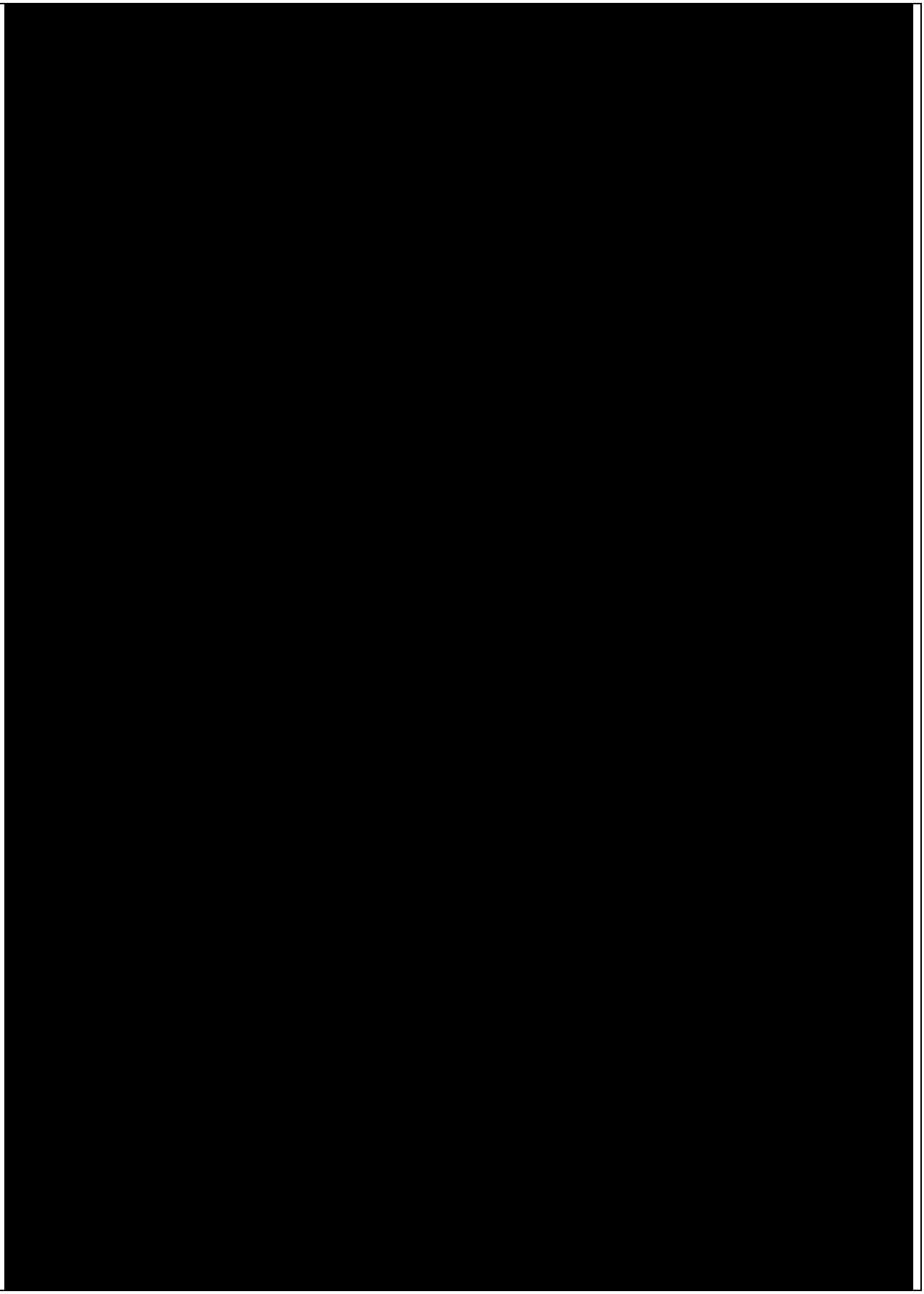
CAM HEALTH MEMBERSHIP BOARD

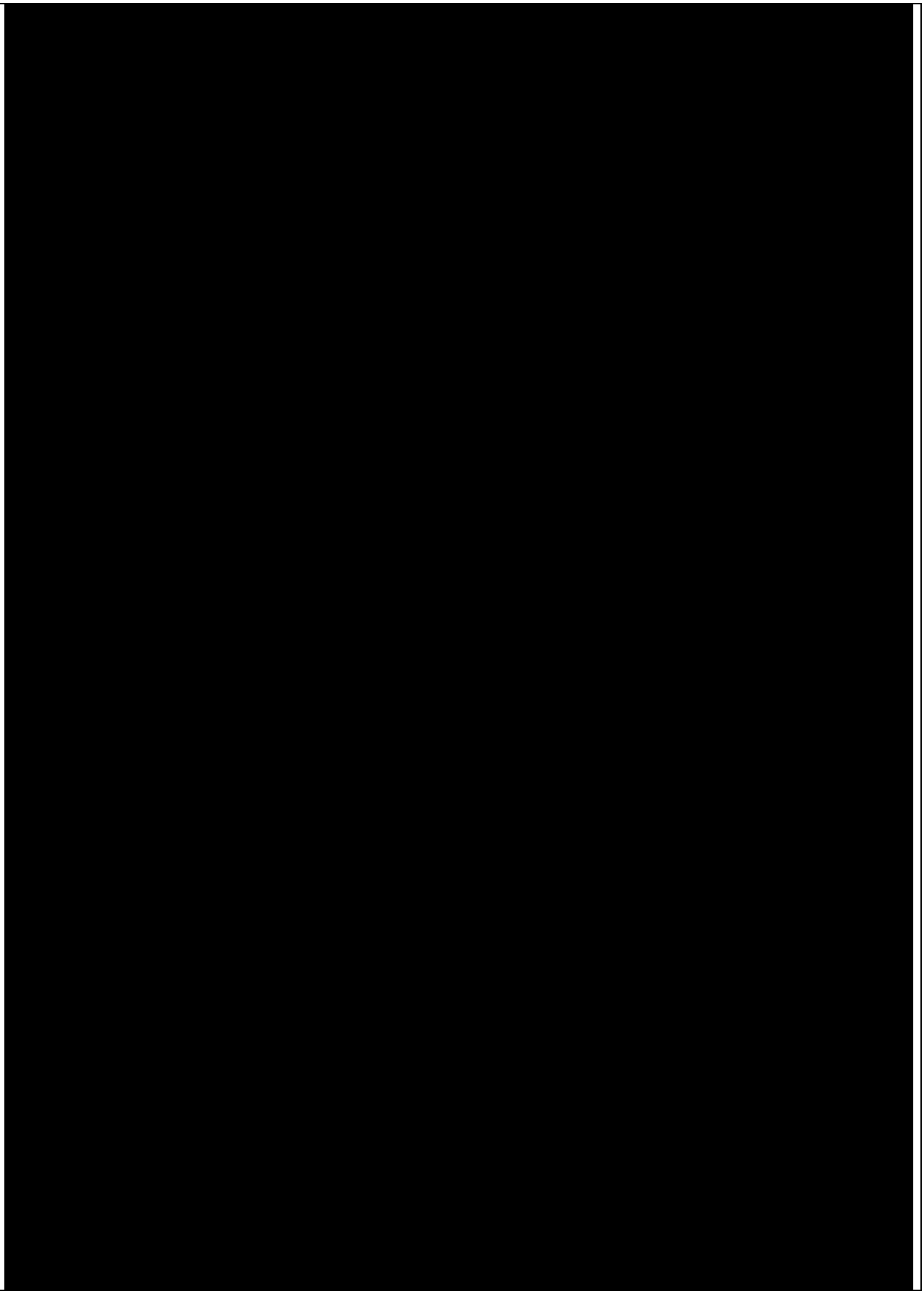
Date : Thursday 24 October 2013
Time : 9.00am – 12.00 noon
Venue : Nuffield Road Medical Centre

MINUTES

Present :	**GP Lead**	**Practice manager**	**Other**
Arbury Rd	Orla McGuinness (OMc)	A. Sanderson (ASn)	
Bottisham	Tom Shackleton (TS)	Sam Clark (SC)	
Bridge St	Sue Holmes (SHol)	Kirsty Dance	
Ch.Hinton			Sally Kaemer (SK) Lead Nurse
E.Barnwell	Rachel Harmer (RHH)	Debbie Parsons (DP)	
Firs - Histon	Michael Grande (MG)		
Milton	Cain Hunt (CH)	Pam Vincett (PV)	
NRMC	M. Brookes (MB) (chair)	Greta Evans (GE)	Zoe [ ], (New Registrar)
Newnham Walk	Adrian O'Reilly (AoR)		
CCG	Nigel Smith (NS)	Rachel Harrison (RCH)	Arnold Fertig (AF)
LCG	Nick Hall (NH) proj mngr	Amanda Slatter (AS)	Danielle Malan (DM)
Patient Rep	Keith Stonell (KS)		Anna Crispe (ALC) new LCGM
	Peter Wightman (PW) (Item 6)	Catherine Boaden (Item 6)	Andy Vowles (AV) (Item 4)
Angela Loynes (AL) (Item 5)	Sue Tolland (ST) (Item 5)		

1.	**APOLOGIES**
	Helen Wiseman (HW), Barbara Willis (BW), Melanie De Smith (MDS), Stuti Mukherjee (SM), and Emma Britton (EB).
2.	**DECLARATIONS OF INTEREST**
	Re agenda item 6 – All GPs would have a personal interest in this item.
3.	**MINUTES OF THE MEETING HELD ON 22 AUGUST 2013/ACTION LOG REVIEW**
	The minutes were agreed as an accurate record. The action log was noted, in particular: - AUG02: MB reiterated that at the meeting on 22 August it had been agreed by the membership board to delegate decision making powers for the OPP to the executive board. This would be discussed in more detail under item 4. - AUG14: DM to obtain and circulate Cam Health specific case studies as discussed with MB. It was noted that AGIS activity is up. Milton reported that the service is useful. AGIS is also calling practices every morning **Action: DM to chase actions.** **Constitution:** The amendment confirming that the chair of the membership board will have a casting vote should there be a tie was ratified.
4	**OLDER PEOPLE'S PROGRAMME (OPP)**
	[redacted]





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5	**ADVICE & REFERRAL CENTRE (ARC) – Presentation by Angela Loynes**
	NB: AL and ST had not been present during the presentation and discussion for item 4 in order to avoid any prejudice to the OPP procurement. TS introduced AL from ARC. AL explained her background as a nurse. ARC is now in the fourth phase of the roll-out – the first was in Peterborough in August 2012. AL is aware that there have been issues regarding referral management, which is why there is now a single point of access. There is a new referral form, which needs to be sent to the advice and referral centre by email (preferred) or fax. Letters can be accepted, but are not common. An email will follow next week regarding the new referral form. The form does not relate to Mental Health Act referrals. AL requested that practices call ahead when for 24 hour/five day referrals. This is to ensure that people are captured who are most in need now. The number is not a premium rate number. Option "1" allows the referrer to speak to a clinician, who will ask for the information on the referral form (as there may not be enough time fill in the form). If appropriate, the clinician may be able to call the patient later. The Crisis Home and Treatment Team will contact the referrer within 30mins to confirm the nature of the treatment being given. The single point of access also includes other services (e.g. IAP, Cameo). AL requested that routine referrals be made using the referral form. The field regarding "risk" needs to be filled in. If it is not, the referrer will be called back to confirm this information. After 8.30pm a night practitioner from the Crisis Home and Treatment Team will be available to take any calls. OMc stated that in the past, the night service always advised to call A&E. AL confirmed that they were aware of this feedback and that this practice was being actively challenged. AL described how every practice will have a named mental health consultant to discuss their cases. The roll out will take place between 14 – 28 November. It is already System1 compatible. The service cannot decline referrals, but if a referral is not appropriate, the referring GP must be informed. Also, the Crisis Home and Treatment Team cannot move the patient back to the GP/A&E – the patient must receive treatment.

	AL confirmed that 111 are not directing calls to the ARC as yet, but the ARCH is not turning down any referrals away. AL handed out leaflets to the group.
6	**PRIMARY CARE OFFER - Presentation by Peter Wightman**
	NB: PW had not been present during the presentation and discussion for item 4 in order to avoid any prejudice to the OPP procurement. PW explained that he had been an NHS manager for several years in the Cambridge area. AV had asked him to work with CB regarding the Primary Care Offer. The new GP contract was imminent, although it has not yet been defined. Discussions have been taking place nationally regarding the direction of general practice, which has been put together in a paper. Broadly, there are two option: 1. Weighted capitation method (which defines what will be done for the money received) as well as LESs; and 2. Wait for the NHS contract, with some revamped LESs. CH stated that the main question was "what is in the basket?". There was also a plea for less monitoring, which wastes a lot of time. RHH added that GPs are already doing a lot for free – the worry is that it will be expected that they will do this and more. PW stated that it was difficult to square different practices' services. CH suggested that there is a difference between what practices can/should do and what they choose to do. MB suggested that there was a third option – a federation of practices. When it was queried what this would contain, PW mentioned seven day access, which could be shared between practices. The board were concerned that this would be a waste of time and money. It would only cater for minor issues and the "worried well". It was noted that there is no slack in general practice. If more services are required, it will need greater investment in people and staff. Various other concerns were raised on this topic. PW asked the board what they would like to see within the Primary Care Offer. He needs this input within the next six to eight weeks. GE enquired whether there would be any protection for easy items, e.g. flue jabs. PW confirmed that there were no guarantees. It was queried whether IDEAL/PDMAs would carry on. PW confirmed that all LCGs wanted these, therefore they would carry on. MB asked for any queries and comments to be raised with him. MB also noted that this was not just about seven day working, but about equalising practice funding.
7	**MSK PROCUREMENT**
	NS explained that the recent Cambridge System MSK procurement had been halted, largely due to CCS estate issues. A paper had gone to the CCG management team about this. At the meeting, the LCG management teams mentioned that they could be interested in wider joined work and that they wanted to look at what the options could be. Each LCG was looking at their pathways, how to reduce costs and how to improve. They were looking at what the options were for service redesign or procurement. It was noted that the Cambridge system had been paying twice, because some referrals were being made back into the hospital.

	NH of Cam Health and Amanda Oemering of CATCH were supporting the work for the Cambridge system. Terms of Reference had been drafted. Clinical input would be needed. Sally Barnard and Justin Taylor were mentioned. MG stated that the LCG should want ownership of the project if it is a good idea. It was suggested and agreed that the executive board be given authority to make a decision, subject to getting consensus from the membership board about what action to take. This would be obtained electronically. **Action: circulate options papers to board for comment and consensus one week before decision is made by the executive board.**
8	**EXCEPTION REPORTS FROM SUB GROUPS**
	- **Finance & Performance:** PV explained that a sub-group of this group would work on finalising the actions form the September peer review. It was also agreed to finalise practice invoices quicker so that management accounts would be more up to date. The CCG overspend was also a pressing issue, which would be discussed under item 9. - **Health Group:** RHH stated that Dr Liz O'Donnell of CATCH (Children's Services clinical lead) had given an update on children's services. RHH was working with her regarding the CCG workshop in November. There had also been a useful mental health update. SM had given an excellent presentation on the cancer pathways 2ww work. - **Prescribing Group:** OMc explained that switches were being implemented, however that the LCG overspends more than others. AS stated that budgets for this year are based on last year – and last year there was an underspend. Two or three practices are the main problem. Anne Cleary is looking into data regarding temporary residents (CNC and nursing homes).The budgets for next year will not be based on this year's spending. OMc stated that they will keep going but that it was difficult to think about what more could be done. **Action: re-send de-prescribing guide.** AoR stated that Cam Health is doing well compared to other LCGs. - **Patient Forum:** KS explained that he did not have anything to add to the summary. One point of interest was that there had been an NHS England questionnaire regarding future services in the area. It was very complicated and badly worded. KS and the patient forum had given feedback and the CCG had asked for a simpler version.
9	**CCG ACCOUNTABILITY – Medium Term Financial Plan**
	NS explained that in order to become a CCG, a sustainable delivery plan needed to be developed. Recently there was pressure form the local area team to have a medium term plan. The plan is theoretical for closing the funding gap in three years. It does not detail how the plan will be delivered. NS noted that the CCG felt it was underfunded, however this was a distraction as there was no prospect of receiving more money. The plan outlines what is needed to move into the top quarter of CCGs. There are actually not many options, especially regarding the big spend areas. A possible implication is that the local area team may intervene. An emergency meeting took place on 18 October regarding what could be done to stabilise the gap. There were no surprising ideas, e.g. referral management, clinical thresholds, audits of coding and prescribing. The main issue now was what can each LCG/system do immediately,

	e.g. centralised referral management approach? MB notes that there had been a centralised referral management system in Cambridge before (like the Peterborough model), but it was stopped. PV queried whether the OPP would be affected if the local area team took control. This is not certain. NHS England would only take control of the CCG(s) that are most at risk – they do not have the capacity to be everywhere. MB asked KS whether he had any ideas from a patient perspective. He confirmed that this was a very difficult problem. Perhaps if patients were told the cost of their prescriptions they would be more careful, however many think that as they pay their taxes, they are entitled to what they get. MB asked for any ideas to be fed back.
10	**RISK REGISTER**
	The board was asked whether there were any new risks to add to the register. It was discussed and confirmed that the OPP was still the greatest risk. Depending how the MSK options developed, this may need to be added another time. Re Medihome, MG explained that Addenbrookes had changed who would be responsible for a patient on discharge. The responsibility would be going back to primary care, on the basis that a clinician cannot be responsible for a patient that they cannot see. This makes sense.
11	**ANY OTHER BUSINESS**
	Arnold Fertig stepping down as CCG rep: The co-chairs confirmed that they would not be able to be the new representative. Any new nominee could become a member of the executive board. **Action: Send job description to practice managers.** **End of Life Care lead:** SHol is stepping down. **Action: Circulate job description.** **Diabetes Business Case:** Alex Ridgeon from contracting department has formally rejected the Addenbrookes business case for continuing the diabetes service they currently run. **Brookfields**: MG explained that the beds had been closed in May. The refurbished site should re-open 11 November and it is planned for two beds to become available per day until all 14 are available. There should also be 6 step-up beds in December. **Age UK pilot:** GE explained that Nuffield Road Medical Centre were taking part in a pilot by using a referral form for AGE UK. That way Age UK does not need to wait to be contacted by the patient. It is not a clinical form. **Future meeting dates:** new meeting dates agreed. **Action: Circulate new calendar and send calendar invites to board members.**
12	**Date of next meeting**
	Thursday 19 December 2013, 9.00- 12 noon, Nuffield Road Medical Centre