Cam Health
Local Commissioning Group

CAM HEALTH MEMBERSHIP BOARD

Date : Thursday 19 December 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	Stuti Mukherjee	Emma Britton	Sally Kaemer (SK) Lead Nurse
E.Barnwell	Rachel Harmer (RHH)		
Firs - Histon	Michael Grande (MG)		
Milton		Pam Vincett (PV)	
NRMC	M. Brookes (MB) (chair)	Greta Evans (GE)	
Newnham Walk		Barbara Willis (BW)	
CCG	Nigel Smith (NS)	Anna Crispe (ALC)	Arnold Fertig (AF)
LCG	Nick Hall (NH) proj mngr	Amanda Slatter (AS)	Danielle Malan (DM)
Patient Rep	Keith Stonell (KS)		Melanie De Smith (MdS)
	Peter Mercer (PM)	Lisa George (Item 6)	Tammy Murer (TM), Holly Gagen, Jane Tobin, Ewan Kelsall (Item 5)

1.	**APOLOGIES**
	Helen Wiseman (HW), Debbie Parsons (DP), Adrian O'Reilly (AoR), Cain Hunt (CH).
2.	**DECLARATIONS OF INTEREST**
	Re Primary Care Offer – All GPs have a personal interest in this item.
3.	**MINUTES OF THE MEETING HELD ON 24 OCTOBER 2013/ACTION LOG REVIEW**
	The minutes were agreed as an accurate record, save for amending one reference to AF in item 6 (primary care offer) to AV (Andy Vowles). Action log was noted and outstanding actions discussed.
4	**OLDER PEOPLE'S PROGRAMME (OPP)**
	[redacted]

5	**MEDIHOME**
	Medihome were commissioned by CATCH using transformation fund monies to provide emergency admission avoidance care. This has now been extended to Cam Health. TM explained that the Medihome service consisted of a multi-disciplinary team providing a framework of care around the patient. They have a two-hour target time and will inform the referrer directly if there are any delays. TM explained Medihome: - fits in &enhances patient care (for over 65s) & is integrated into existing community services; - can support carers (on an individual assessment basis); - referral process (by telephone – Medihome fills in the two-page referral form); - relies on a clinician-to-clinician assessment; - assumes patient consent given if referred by a GP – only the GP can make the diagnosis; - consent incudes consent to share info to other health care professionals and voluntary orgs; - informs and agrees a review date with referring GP if patient/family changes their mind and patient needs to go to hospital; - do not provide 24hour care – hospitalisation may be required initially until patient is stabilised; - equipment can be provided to the patient; - fits in with existing care plan with an aim to provide care between half a day up to two weeks (average six days); - works with out-of-hours GPs during the relevant times; - sends a letter at point of discharge, which copies in other bodies involved in patient's care; - not offering IV at this time due to capacity and resource issues – Brookfields step-up beds hopefully available soon; - also work in residential homes; - Service operates Mon – Sun 07:00-23:00. Referrals accepted Mon-Sun 08:00-20:00; and - Dr Cathy Bennett of CATCH has been involved in agreeing protocols for the IV antibiotics. The pilot ends end of March 2014. If a GP is seeing a patient after morning surgery and it is suspected that it could be late afternoon before the GP would be referring to Medihome, the GP could call ahead to give as much advanced warning as possible. It was suggested that even though the service provided a good bridge over the service "gap", this still represented additional responsibility for GPs for very ill patients.
6	**COUNTER FRAUD TRAINING**
	LS presented slides to the group to raise awareness of the potential of bribery and fraud within the NHS. The guidance covered the Fraud Act 2006 and the Bribery Act 2010. LG noted that it was a defence for the NHS if it had appropriate prevention policies in place. The most noteworthy policies to note are those regarding gifts and hospitality. If in doubt, the group were urged to declare any gifts and hospitality on the gifts and hospitality register. LS outlined the NHS counter fraud principles, main risks, key issues, penalties and real examples of fraud and bribery and the consequences in those cases. It was discussed and noted by the group that they only needed to report where there was a noticeable pattern or trend. The slides and guidance would be provided to the group for reference.
7	**INTEGRATION TRANSFORMATION FUND**
	NS referred the group to the papers and explained that the transformation fund money was from the Government. However, this is existing money, not new money to be bid for. The aim was to invest in integrated working with health and social care. A decision needs to be made by February 2014. To date, all that has been agreed are the principles for using the money. In particular, the money cannot be used just to plug the deficit gap. It was discussed that nothing can be done to stop the process, but that the Cambridge system can influence the schemes. If the money is not used, it could be lost to other local beneficiaries if they have better schemes. The Health and Wellbeing Board (comprising CCG and local authorities) has oversight of the fund.

	If there is disagreement as to allocating the fund, there will be a process of arbitration, which is why early work went into agreeing principles. There will probably be a focus on preventative activities. NS asked the group for thoughts on how to spend the money. There is no formal process yet for feeding back the responses. It was agreed to discuss this further at the next Health and Service Redesign Group meeting. NS confirmed that these would be recurrent funds that may vary over the years. Longer term schemes can therefore be considered. It was queried and confirmed that this money will come from the bidder pot when the OPP procurement takes effect. **ACTIONS:** Discuss at Health & Service Redesign Group meeting on 9 January 2014. Arrange meeting with Neil Modha and David Roberts (CCG reps on Health and Wellbeing Board) before Health and Wellbeing Board meeting February 2014. Clarify February 2014 decision deadline.
8	**MSK**
	It was explained that a paper had been presented to CMET the day before, suggesting that it would be better for Cam Health and CATCH to tighten up their contracts and stop onwards referrals to Addenbrookes than to pursue a procurement for another service. The focus should be on smaller things, e.g. more procedures in the community and reducing unnecessary referrals form GPs. NS noted that the CCG needed to save £14m, and that it was thought £6.8m of this could be achieved through better enforcement of contracts. Other solutions will need to be found to make up the remaining shortfall. It was discussed that the CCG and its predecessors had been trying to tighten up the contracts for years. Also, concern was raised that CCG-wide solutions would not benefit all locations (e.g. historic Cambridge difficulties integrating with Addenbrookes). It was further noted that other than the double payment in Cambridge, which should be solved by adhering to clinical thresholds/ contracts, there did not seem to be any increase in unnecessary activity. NS confirmed that other than immediate work re local contracting, the CCG would give a steer in the next 3-4 weeks on any wider work. It was suggested that the LCGs should be giving the steer, not the other way round. It was queried what other systems, e.g. Bedfordshire, were doing and whether their methods were working better. It was agreed to continue working with CATCH. **ACTION:** NS to update board re contract tightening measures 13 February 2014 meeting. Research approach other systems are taking to MSK and feedback learning points.
9	**2014/15 PLAN**
	Further to an email that had been sent to all practices on 17 December 2013, it was reiterated that Cam Health needs clinical leads for work on ophthalmology and ambulatory care sensitive conditions. Currently, the CATCH clinical lead for ophthalmology is acting on behalf of Cam Health. It was queried whether there was any gain to having a separate Cam Health clinical lead in this area. ALC wanted to avoid the board feeling at a later stage that they have not been part of the process, and confirmed that the Cam Health management team were more than happy to attend ophthalmology meetings. It was suggested that Cam Health could commission an optometrist, although there may be problems in relation to CQUINs. It was agreed to continue liaising with and supporting the CATCH ophthalmology clinical lead. Any ideas for local improvement were encouraged to be sent to the Cam Health mailbox.
10	**RSS (REFERRAL SUPPORT SERVICE)**
	The first month's Choose and Book results would only be available in January/February 2014, which was when the new RSS could be evaluated. The service would probably not run past the end of the current financial year as research indicates that this type of service has diminishing returns after 3-6 months. The RSS seemed to be making extra work for the practices.

	It was queried whether the RSS could be delaying patient care and going against patient choice. Also, whether internal peer reviews were being suspended while the RSS was operating. **ACTION:** Discuss/ask for ideas at next Health Group meeting on 9 January 2014. TS suggested that ideas that worked elsewhere needed to be considered. SC noted that ideas could be gathered from the commissioning network. **ACTION:** ALC to work with TS and SC to gather ideas from other networks.
11	**GOVERNING BODY REP**
	A paper from Jessica Bawden (CCG Director of Corporate Affairs) on this topic was noted. As the CCG has a duty to consult with the LMC for GP CCG governing body elections, Sharon Fox (CCG secretary) had been liaising with ALC and Guy Watkins (LMC) to agree a voting method that would reflect the democratic nature of Cam Health's structure. A response was still outstanding from the LMC, although it was likely that they would require an election of some sort. NS confirmed that the time commitment of the role would require a minimum of eight hours per month to prepare for and attend the monthly governing body meetings. The role could involve as much more as the individual feels appropriate. AF suggested that a session per week for Governing Body, CMET and the occasional other meetings would be the minimum requirement. It was suggested that each practice would continue to nominate a representative onto the LCG Membership Board. There would then be an election for the Governing Body representative from those nominated MB individuals and any other GPs within Cam Health who wished to be considered for that role (which would include locums and/or salaried GPs). The final list of candidates for the election would be subject to prior Membership Board approval. If the final Governing Body candidate was not already a Membership Board Member, they would be co-opted to the Board. **ACTION:** Circulate list of candidate criteria. AF to assist in revising the criteria if required. NS confirmed that a report had gone to Remuneration Committee for review in January 2014. **ACTION:** NS to provide update on remuneration as soon as available.
12	**EXCEPTION REPORTS FROM SUB GROUPS**
	The board was referred to summaries forming part of the papers. Additional comments raised: - **Finance & Performance:** Wendy Lefort (Quality & Patient Safety) would be giving quarterly quality updates at these meetings (quarterly written updates to be provided to the membership board). Management costs currently on track, however this would probably change as the OPP ISOS evaluation GP costs would be coming out of LCG budgets. This was not originally budgeted for. The group had considered some trend analysis for areas that were causing concern. There were no conclusions yet and further work was being done. The six pathways being used for QP purposes were: liver function tests, ENT audit, 2ww cancer referrals, falls assessments, dementia carer packs and heart failure (latter three for admission avoidance). - **Health Group:** Praise for efficiency of ARC responses. MG highlighted that the Medihome service is a bridge – GPs would continue to be responsible for patient, with the support of Medihome. GE noted that there was a crisis in health visitors at Nuffield Road Medical Centre. It was confirmed that these were commissioned by the local authority. ALC will feed back. **ACTION:** Circulate info re who to report health visitor issues to. **ACTION:** NH to highlight to RSS reviewers that Caroline Cooper is **NOT** taking gynae (heavy menstrual bleeding) referrals (it was stated in the meeting that she was). - **Prescribing Group:** LCG and CCG meetings had taken place. Looking at ways to save, e.g. central store rather than prescribing. Cam Health focussing on dispensing practices and therapeutic switches. ALC, OM and Sue Marchant (Cambridge System lead pharmacist) had reviewed prescribing strategy document. Assistance to be provided to overspent practices to help find out why and find solutions. SC noted that Bottisham is technically overspent but have

	been making savings year-on-year. OM confirmed that the aim was to help, not blame. It was noted that increased prescribing costs was an inevitable product of increased community care. - **Patient Forum:** The group was a little concerned at the rate of change (losing AF and Rachel Harrison at the same time). The challenge was to make the meetings useful and productive. ALC noted the valuable skill and resource of the group. Work is being done on comparing the practices' patient surveys to look for common trends.
13	**RISK REGISTER**
	ALC suggested streamlining the Risk Register, as even the summary was currently complicated and unwieldy. KS agreed. ALC explained the following headline risks: - Finance: increased risk due to CCG financial climate – forecast £4m overspend at year end for Cam Health; - Organisational Development: decreased risk due to full recruitment to management team; - Inability to track PbR spend: increased risk as no understanding of some of the overspend; - QIPP delivery: ALC noted that Cam Health hopes to be able to achieve around 60-70%. However, this can be evidenced by robust figures and Cam Health is not the worst LCG. ALC noted again that Wendy Lefort (Quality and Patient Safety) will be giving quarterly quality updates to the Finance group to supplement the monthly quality reports. SK described an unannounced visit to Addenbrookes last month. The frontline staff were very good and overall the message was positive. MG added that the Brookfields beds had opened on schedule, which was also positive. There has been a delay in recruiting to reach the full 20 beds, but the contracting team were doing what they could in the circumstances.
14	**ANY OTHER BUSINESS**
	Alcohol Treatment Tendering Service Exercise: Update noted. This will include the CRI service and Cam Health will not fund this from 1 April. MB noted that Ruth [Bustable] gave very good training on alcohol. MB can pass on her contact details. **Primary Care Offer:** A paper had gone to CMET the day before outlining the CCG's options for investment. The funding envelope will be the same as now, however the allocation had been changed. It was discussed that GPs were again being expected to do more for the same money and that the CCG would never be able to bridge the MPIG gap. The group noted that any action in the new year needs to be organised by the practices as providers, not the GPs as commissioners. **ACTION:** MB to obtain CMET paper to see what was agreed. **Development Session (formerly Clinical Governance Afternoon) 20 March 2014:** Consider alcohol presentation/training. **ACTION:** ALC discuss funding for non-clinical staff training with GE. **A&E Performance:** Addenbrooke's had failed the 95% 4 hour wait target for the third month in a row. Remedial action plan in place. Addenbrooke's argue system issues are to blame (i.e. dealing with the number of people from 111 and transfer of care), but these are historic ongoing issues.
	Date of next meeting
	Thursday 13 February 2014, 9.00- 12 noon, Nuffield Road Medical Centre