

CAM HEALTH LCG MANAGEMENT BOARD

Date : Thursday 18th April 2013
Time : 9.00am – 10:30am
Venue : Nuffield Road Medical Centre

MINUTES

Present :

	GP Lead	Practice manager	Other
Chair	Dr. A. Fertig (AF)		
Arbury Rd	Dr.O.McGuinness		
Bottisham	Dr.T.Shackleton	M. Barrett-Small (MBS)	
Bridge St	Dr.S.Holmes	D. Parsons (DP)	
Ch.Hinton	Dr.S Mukherjee	E. Britton (EB)	S. Kaemer (SK) Nurse lead
E.Barnwell	R Harmer (RHH)	S. Clark (SC)	
Histon	Dr.M.Grande (MG)	H. Wiseman (HW)	
Milton	Dr. C Hunt (CH)	P. Vincett (PV)	
NRMC	Dr.M.Brookes (MB)	G. Evans (GE)	
Newnham Walk	Dr. A. O'Reilly (AO)	B. Willis(BW)	
LCO	N. Smith (NS) LCO	R. Harrison (RCH)	
LCG	M. De Smith (MDS)	A. Slatter (AS)	
Patient representative	K. Stonell,		

1.	Apologies	
	<p>No apologies were received for this meeting</p> <p>AF welcomed the group to the first official board meeting of the LCG as this was the first following authorisation; the LCG had until then been operating in shadow form. He also welcomed Keith Stonell, patient member designate, to the meeting and explained that though Keith has begun conducting this role, the patient forum has not yet had an opportunity to formally elect a representative.</p>	
3.	Declarations of Interest	
	AF reminder the group that conflicts of interest should be declared for the coming year and returned to Rachel Harrison.	
4.	Minutes of the meeting held on 14th February 2013/Action log review	
	<p>QOF QP - this has expanded to include dementia, a meeting is being planned to discuss how to progress</p> <p>Away day - funding is to be discussed at the Finance Group</p> <p>Diabetes - Mechanism for practices to share soft intelligence is in the LES/IDEAL agreement</p> <p>Mental Health – TS reported that the funding for the trust remains low but a proposed £3m funding cut has been scrapped and though the contract remains unsigned and may go to arbitration, he sees that the not much more can be done by the LCG.</p> <p>Dermatology – As far as AF knows, the dermatology proposal is not going ahead;</p>	MB/ TS

	<p>Addenbrooke's is not willing to pursue it. He suggested that we might want to progress something locally ourselves and that the dermatology leads meet, with some data, to discuss how to take this forward. SM agreed. AO asked whether the furore over payment and commissioning from ourselves had been resolved and AF believed that it had. AO was concerned that we may face barriers again and SM was also concerned that there may be clinical governance issues because the GPs are not GPSIs and the consultants will not have enough confidence in them. AF understood that consultants in other areas of the country are more supportive of this type of scheme but the group acknowledged that concerns over clinical governance would need to be addressed. It was clarified that there would not be a dermatology LES and MG told the group that he understands that the consultants at Addenbrooke's are unhappy that the LES is not going ahead and that it had been stopped by the commercial arm of the hospital.</p> <p>Election of a chair – AF will continue until the end of June and hoped that this issue would be addressed at the session to follow the board meeting.</p>	
4	CCG/LCG Accountability Agreement 2013/14	
	<p>NS explained that the document has not quite been finalised. Any comments are to be collated by the end of the week.</p> <p>The CCG is now live and is accountable for an £850m budget. The accountability agreement is the document that delegates responsibilities to the 8 LCGs. NS invited comments:</p> <p>TS asked for clarity on the requirement for a 'monthly transformational plan update' and wondered whether this meant that practices would be required to make submissions every 4 weeks.</p> <p>RCH and AF explained that monthly updates have been submitted by RCH on behalf of the board for some time and are necessary to hold the LCG to account for delivering its plan and to track progress against the business cases. As one of the LCGs, Cam Health has applied for and been granted funding for its business cases from the £5m Transformation fund which the CCG has set aside for investment in this financial year.</p> <p>RCH asked NS about the 'Scheme of delegation' referred to in the document but not clearly explained. NS agreed to take this back for clarification.</p> <p>MG pointed to section 3, number 5 which says that the LCG is given responsibility for the whole budget but notes that it only has power through business cases. He does not see that the responsibility and available budget match. NS told the group that the LCG also has some say in contracting e.g. the community contract and that this is another way of having responsibility for the budget. AF accepts this and believes that were the LCG to fail to deliver to budget, this would be accepted.</p> <p>TS and RHH also expressed concerns that the LCG was being asked to carry responsibility without an according authority.</p> <p>AO raised a concern with section 3, number 3; the requirement LCGs to have for PDMA's in alignment with CCG guidance and wondered what the CCG guidance was and whether it required practices to undertake time consuming tasks such as going through hospital data. He expressed concern that these types of things use a lot of time whilst GP funding is going down.</p> <p>RCH explained to the board that the PDMA requirements for the coming year have</p>	

	<p>been changed. Practices will be asked to focus their efforts on any significant trends that have been identified by the management team. AF reminded the board that the CCG is made up of the LCGs so unsuitable guidance ought not to be issued by the CCG.</p> <p>MB expressed some concern about the accountability of LCGs working together and what the escalation process was. AF told the board that Cam Health have moved forward in their relationship with CATCH and that he thinks reciprocal arrangements peer review and joint working arrangements are much improved.</p> <p>AF asked the group for their permission to sign the agreement on their behalf and reminded them that LCGs have a say in the structure and content of the agreements being on the governing body with a veto if necessary . No objections were voiced and AF stated that he will sign on behalf of Cam Health unless any significant changes are made.</p>	
5	Cam Health PDMA/IDEAL Agreement 2013/14	
	<p>AF asked if there were any changes that the group would like to make.</p> <p>MB suggested two changes</p> <ul style="list-style-type: none"> • that people who were identified as frail/elderly on their discharge summary to be discussed at MDT (to align with Addenbrooke's CQUIN) and • to make some slight changes to the COPD requirements following the Cam Health clinical leads meeting next week. <p>A discussion followed about whether each section was matched to specific £/p payment. RCH told the group that Cam Health has resisted doing this and are instead trying to work on a more outcome focused basis.</p> <ul style="list-style-type: none"> • MBS asked whether returns could be submitted six monthly rather than quarterly, unfortunately this will not fit with quarterly progress reporting to the CCG. • EB asked that sign-in sheets be used for meetings and this was agreed. • SC asked about the risk stratification tool and MDS said that this is on the way. • DP asked about the QP peer review process and queried how this would work this year as there had been some issues last time, MB told the board that a working group is being convened to draw up a plan. <p>AF took an opportunity to welcome Adrian O'Reilly as the new Newnham Walk representative. With regard to the IDEAL agreement, AO's commented that the origin of hospital admissions is often not the GP and that he sees that the LCG is signing up to change something over which GPs have limited direct influence. The group agreed that this was true and also mentioned that demand management was never talked about.</p> <p>The group agreed that with the minor changes, as discussed, RCH will circulate for signature and AF will take to the CCG board.</p>	
6	2013/14 Cam Health Business Plan	
	<p>This has already been circulated and the one change that has been made is to take into account a share of the AGIS business case for the Cambridge system. AGIS is a one year pilot that replaces the falls vehicle. A £1.2m potential saving was identified</p>	

	<p>with an investment of £450k needed. Cam Health will contribute £150k of investment with a likely saving of £350k. RCH said that she has expressed some concern because of the overlap with the Cam Health Emergency Admission Avoidance project but recognition of a share of this investment was necessary as the project covered the Cambridge system. RCH remembers that Cam Health showed early support of the AGIS project in principle but had not been involved in the work up of the larger business case.</p> <p>AF asked for feedback on the AGIS service. RHH had used the service and found it to be very efficient. MG felt that a GP might not always know whether an admission had been avoided.</p> <p>A case is classed as an avoided admission based on a judgement from the geriatrician (Viveka Kirthasingha). Last year a significant number of admissions were judged to be avoided and this provided support for the one year pilot.</p> <p>Evaluation was agreed as important but to be difficult. An Evaluation must be sensible and not look solely at figures. The Emergency Admissions Avoidance project and AGIS will hopefully complement one another. TS commented that the service might be better but more expensive and queried what would be done in this event.</p> <p>The plan overall was endorsed.</p>	
7	Exception reports from sub groups	
	<p>i. <u>Finance & Performance Group (21 March 2013)</u></p> <ul style="list-style-type: none"> • There is still no delegated budget • We are doing quite well with prescribing • QOF QP planning in progress <p>NS explained that delegated budgets were not yet released and if a fair shares budget is adopted some LCGs will have a surplus and some a deficit (did not know Cam Health's position). The finance department are looking at smoothing the differences and hope to release budgets to go to the governing body next week.</p> <p>The figures show that Cam Health is underspent on management costs but there remains a problem of manpower.</p> <p>SH gave an overview of the Addenbrooke's contract for 12/13:</p> <ul style="list-style-type: none"> • Activity went over plan but not severely • Finances were £14m over budget and the expectation was an £8m overspend and £6m QIPP savings planned were not realised in year. • Overspend was planned to be paid for by a contingency fund which will not exist in future so overspend will not be planned for and the contract value will be raised by £6m this year. <p>And 13/14:</p> <ul style="list-style-type: none"> • Cam Health are expected to deliver a £500k saving • Echo clinics and specialist rehabilitation bed days will be charged at a higher rate • Some services are being transferred to NHS England • Local CQUINs focus on frail/elderly 	

	<p>The chair thanked SH for her summary and also noted that ENT and Orthopaedics are not meeting the 18 week wait target.</p> <p>CH mentioned that he found it time consuming responding to letters from the hospital asking him to refer a patient, rather than one hospital department referring straight to another. OMcG argued that if you were to relax this process, inappropriate consultant to consultant referrals will be made</p> <p>There was some question whether unnecessary extra referrals were being generated eg. Referral to echocardiography and back to rheumatology being counted and charged as new referrals. Members were asked to forward any such examples felt to be unreasonable to Sue Holmes or Rachel Harrison to be pursued through the contract review process.</p> <p>In connection with emergency admissions pressures, the CCG aim is to reduce bed days for elderly people to be in the lowest quartile for the country. This has been modelled and equates to a reduction from 357 bed days per 100,000 to 350 per 100,000. The target needs to be converted into real bed days per practice per month to be useful.</p> <p>A clinical summit was held following the increase in C Difficile rates at Addenbrooke's. The event included microbiologists, infectious disease nurses and a Director of Quality & Patient safety. The result will be the production of a system wide implementation plan. Practices were reminded they have a responsibility regarding prescribing of antibiotics and PPIs.</p> <p>AO asked whether the chemo overspend is the responsibility of the LCG, RCH has asked for clarification on which elements of service are the responsibility of specialist services commissioners.</p> <p>ii. <u>Health Strategy & Redesign Group (7 March 2013)</u> The next meeting will be held on 9th May and will be an important meeting. The End of Life Care vision and strategy will need to be developed.</p> <p>iii. <u>Prescribing Leads meeting (10 April 2013)</u> The prescribing group continues to meet regularly.</p> <p>SC asked about medicines management support and RCH was able to tell the group that the medicines management team have appointed a replacement to the Pharmacy technician vacant post the previous day.</p> <p>iv <u>Patients Forum (20 March 2013)</u> The group was given feedback on Keith Stonell at the last meeting. GE added that she had attended the Arbury Road patient forum and they were very positive about the appointment. KS intends to put some thought into how he will get the patients' view</p>	
8	Cam Health Diabetes LES	
	<p>The appropriateness of the payment for education section was discussed (bearing in mind that GPs are essentials commissioning themselves through the LES). The group were keen to retain this aspect of the LES as it enables them to provide better care to diabetic patients and support the Cam Health integrated community service. A Primary Care Diabetes Society course was recommended for addition to the list of</p>	

	suitable courses. The LES was agreed subject to minor changes.	
9	Review Risk Register	
	<p>A new format for the risk register has been adopted by the CGG. The most significant risks are those relating to budget/ finance. Most of the risks are classed as amber or yellow.</p> <p>Although the overall picture is yellow, Cam Health does not have a chair which is potentially catastrophic. The deputy chair put fears at rest and this matter was discussed in a development session immediately following the meeting.</p> <p>RCH clarified with TS whether the MH risk level could be downgraded to amber but he was happy that the risk remain as it is.</p>	
10	Any other business	
	DP asked about DSN hours and whether we are paying for hours that are not used. RCH asked practices to feed back any DSN concerns.	
11	Date of next meeting	
	Thursday 20 th June 2013, 9.00- 12 noon, Nuffield Road Medical Centre	