

CAM HEALTH MEMBERSHIP BOARD

Date : Thursday 20 June 2013
Time : 9.00am – 10:30am
Venue : Nuffield Road Medical Centre

MINUTES

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

1.	APOLOGIES
	Arnold Fertig (AF), Tom Shackleton (TS) MG chaired the meeting in AF's absence and made a vote of thanks for all AF's hard work. MG also welcomed Maureen Donnelly, chair of the LCG.
2.	DECLARATIONS OF INTEREST
	None noted initially, but in the course of discussion (Agenda item 8 Older people/Brookfields/CNC virtual beds) GE declared interest on behalf of NRMC who provide medical service to CNC beds.
3.	MINUTES OF THE MEETING HELD ON 18 APRIL 2013/ACTION LOG REVIEW
	<ul style="list-style-type: none"> a. Apr 01 – Declaration of Interest Forms – to be returned to RCH. b. Apr 02 - The Accountability Agreement has still not been signed. RCH is awaiting a response to a budget query first. c. Feb001 – practices to collate data on no. of patients aged over 85 w.e.f. 1 April 2013 re workload implications of management plans. Action: All practices d. Feb002 - End of life vision: This is a work in progress. Nothing specific in IDEAL which says it is an obligation to look at everyone over 85. e. Feb009 – The decision not to invest in the Alcohol Worker for next year was confirmed
4	PROPOSAL FOR NEW STRUCTURE
	The suggested restructure of the sub-groups and membership meetings was agreed.

	<p>It was agreed that the membership board will take place every two months and the executive board would meet every two months (alternating months) with delegated responsibilities. It was further agreed that there will be a finance group meeting every month.</p> <p>MG outlined the structure of the new meeting plans:</p> <ul style="list-style-type: none"> - Membership Board meetings would be chaired by one of Cam Health co-chairs - The two other co-chairs would chair the Health and (vice-chair) Finance subgroups - The practice manager role to be developed as a nominated spokesperson and the nurse rep and patient rep would also have voting rights <p>CH requested that all Membership Board meetings take place in school term time. Agreed that diary will be reviewed as requested, though summer meetings will be unavoidable.</p> <p>Action: Danielle Malan</p> <p>KS queried whether he was to attend the Executive Board meetings. His recommendation was that it be kept as small as possible. RH explained that the invitation extends to him and to the nurse representative but that there is no compulsion for them to attend. SK stated that she would like to attend.</p> <p>MD commented that it was good idea to have Executive Board, but that the Membership Board should be taking things to the Executive Board and making requests. Executive Board has delegated responsibility from the Membership Board – not the other way round. The power is with Membership Board.</p>
5	MEMBERSHIP BOARD TERMS OF REFERENCE
	<p>Correction section 2: should say changes to structure effective from 1 July rather than 1 June.</p> <p>SHol queried what AF's role would be in future. MG confirmed that AF remains the LCG representative to the CCG and also CCG GP lead on care of the elderly. SHol's concern was that if he ceases to be involved in contract work she would hope to be supported by one of the 3 Co-Chairs in the contract work that she carries out; she does not have enough time to be the contract lead.</p> <p>MD commented that all positions are time limited on the CCG and the LCG representative role would be re-elected in April 2014.</p> <p>No further queries. The Membership Board approved the terms of reference.</p>
6	CONSTITUTION
	<p>A point was raised to clarify the majority vote: why is it 66%? This had been suggested because it equates to 6 out of 9 practices, however, there are another two votes; the patient and nurse representatives. Though one view was that the share needed to carry a vote ought to be higher than 66%, there was agreement to use the proposed terms of reference.</p> <p>It was queried whether the constitution should include anything about the relationship with CATCH. MD's view was that this was not necessary (relationships with CATCH would be covered through the Joint Transformation Board recently set up).</p>
7	NOMINATIONS AND ELECTION OF THE CO-CHAIRS
	<p>RCH confirmed that nominations for co-chairs had been received for MB and MG. SC nominated RHH. RCH asked if there were any additional nominations. None were made.</p>

	<p>The nominations were seconded and the following 3 Co-Chairs elected:</p> <p>MB (as chair of Membership Board)</p> <p>MG (as vice chair of the Finance & Performance Group)</p> <p>RHH (as chair of the Health Group)</p>
8	<p>JOINT TRANSFORMATION BOARD</p> <p>It was explained that while Cam Health must have an individual identity, it must also work in unity with CATCH when a united view was required for the local system. A joint transformation board (JTB) has been set up to support this.</p> <p>It is hoped that the joint strategies and workstreams will cut down on the number of meetings and speed up decision making, as well as avoiding duplication, for example the Brookfields closure was discussed at the last JTB meeting and a set of options discussed and agreed.</p> <p>Terms of reference and a diagram to show flow of authority and delegation were tabled to explain how it would work.</p> <p>SHol suggested that the End of Life programme is an example of a need for a unified programme, and queried whether this could go to the JTB. NS agreed that this would be ideal.</p> <p>Dermatology was also suggested as a good example of work that can be taken to the JTB. The group welcomed this approach of working together with CATCH.</p> <p>It was suggested that the JTB be a standing item on the Membership Board agenda.</p> <p>MG commented that the direction of travel is that major pieces of work will be done as a system but that Cam Health (/CATCH) may choose to do individual work as well.</p> <p>The approach and terms of reference were approved by the board.</p> <p>Cambridge System - Older People's programme:</p> <ul style="list-style-type: none"> - There has been a CCG level decision to procure whole-system service for older people's care for the whole CCG in 4 locality lots. - It has been agreed to publish a PQQ – (Pre-Qualification Questionnaire) which would ask general questions to establish whether organisations are fit to provide the service - Will be published 1st July with responses back end of July - PQQ responses will be considered and then would proceed to ITT stage (Invitation to Tender). - One reason for speed was the end date for CCS, although the current date of April 14 might slip. CCS might be able to exist in its current format beyond April 14 but we await DoH direction on what happens to trusts which can't become foundation trusts. <p>Concern expressed locally :</p> <ul style="list-style-type: none"> • How to get non-clinical integration (organisations co-operating) • Acute provider may only be focussed on admission avoidance and might neglect Community care <p>The CCG has agreed</p> <ul style="list-style-type: none"> - that the work will go to an organisation that delivers clinical services, (rather than a management company). - The successful provider will need to collaborate with community and primary care services.

	<p>There has been a meeting with Addenbrookes to discuss future structures but they didn't fully discuss core role of community services.</p> <p>CH expressed concern about retaining experienced nursing professionals and local knowledge. Losing good people would be very painful for the service. Quality is the most important thing, it is not just about admission avoidance. Community services and primary care problems need to be solved.</p> <p>MG confirmed that petitions were made to Matthew Smith concerning the procurement process and a request to have a different type of involvement.</p> <p>MD confirmed the CCG is committed to good, safe, clinically sound services for older people and breaking down the barriers between organisations.</p> <p>Discussion ensued concerning the different organisations who could deliver services and how the process had worked so far.</p> <p>NS explained that in the early discussions, Cam Health and CATCH were keen to keep clinical commissioning at the heart of the programme. Though the decision will not be made by Cam Health clinicians, they will be able to heavily influence it.</p> <p>There was some discussion on why the new contracting arrangements were being put in place. MD observed CQUIN incentives failed to promote integration of services. PbR was only designed for acute care episodes. There was a need to incentivise joint working- the capitated budget model was a form of 'disruptive innovation' which sought to achieve this.</p> <p>Brookfields Closure Brookfields beds were closed from 17 May and are unlikely to open again until January 14 when refurbishment completed and unit fully staffed.. A decision whether or not to reopen [20 beds] is required, in the meantime CNC has been contracted to expand winter capacity in the form of virtual beds. It was agreed that we still need more information to find out if Brookfields is necessary, particularly around numbers and complexity of patients needing step up/down care.</p> <p>MSK procurement update:</p> <ul style="list-style-type: none"> - It was explained that CATCH are leading on the re commissioning process – predominantly adult physio. - They will be inviting expression of interests shortly. At the moment there is a 6 week public engagement process, Cam Health is involved, gathering views from PPGs. - It would be helpful to have a Cam Health clinical lead to input into the clinical evaluation of bids. SH asked for an estimate of the number of sessions that would be required. <p>Noted: Sally Barnard from Newnham Wal has been approached and Justin Taylor from Bridge St, might be interested.</p> <p>Action: RCH to provide estimate of no. session required for MSK clinical lead</p>
9	EXCEPTION REPORTS FROM SUBGROUPS
	<p>Finance and performance –</p> <ul style="list-style-type: none"> - Correction: Q4 report, prescribing costs: 'not' missing- should say 'not' be relied on for next year - Alcohol services - not going to be renewed - Medihome, additional virtual beds – it was decided against adopting this proposal. <p>Health Strategy</p> <ul style="list-style-type: none"> - Working on inequalities in CHD. RHH is working with GE on securing some support from

	<p>the British Heart Foundation and will take this to the next meeting</p> <ul style="list-style-type: none"> - Dementia DES – need to clarify what is expected of practices <p>Prescribing group</p> <ul style="list-style-type: none"> - iCare switches progressing well. Although MG noted that Firs House are switching patients to microdot rather than iCare because they had found that patients didn't like iCare. Other practices had not found this. A review had shown that microdot did not perform as well as iCare which was why the decision was made to switch to iCare. - OM asked whether she could share the Cam Health prescribing group minutes with CATCH as she gets the minutes from the CATCH meetings. Agreed. - A Cam Health prescribing strategy has been produced and links in with other Cam Health workstreams. <p>Patient Forum</p> <ul style="list-style-type: none"> - There was a discussion on how best to communicate between the Forum and the Management Board. - It was suggested that the subgroups (especially Health Group) were of more interest than the management board for the patient forum - The MSK procurement was discussed at the last patient forum (15th May) and resulted in 2 invitation to discuss at local PPG meetings - Now that he has meet them, KS commented on the high level of commitment and intelligence of the patient group. - Confirmed that KS has been formally elected as the lay representative
10	CCG ACCOUNTABILITY
	<p>A two page note was circulated about accountability agreement between the CCG and NHS England Area Team. The CCG is assessed at quarterly intervals, with three core elements:</p> <ul style="list-style-type: none"> • Delivery , against national standards (NHS constitution and NHS outcomes framework) • Capacity and Capability – skill, knowledge, capability • Support for problem areas <p>NHS England will RAG rate the CCG against a range of performance checks. NS outlined the criteria in which the NHS England might take action if the CCG was not on track. Intensive monitoring will be triggered if two or more measures are Red. Activity levels against plans and variation from financial plans will be strictly monitored.</p> <p>Consequence is that LCGs will need to:-</p> <ul style="list-style-type: none"> - take performance information very seriously, - have robust local scorecard set up which needs to be predictive. - seek assurance that remedial actions are in place - be clear about when performance will be restored to standard.
11	RISK REGISTER
	<p>It was agreed the register would be kept in the new format (as defined by the CCG). This will be a regular item on the Membership Board agenda. RCH pointed out the key risks:</p> <ul style="list-style-type: none"> - It was noted that CCGs/LCGs cannot legally share patient level data and that this is restricting the use of secondary care data for the risk stratification tool and other project evaluation. The CCG is working on solutions with relevant national bodies. Expected resolution by October 2013. - There remains uncertainly over the future of community services which impacts on

	<p>staffing, recruitment and service delivery.</p> <ul style="list-style-type: none"> - A new risk is the potential impact of changes at PSHFT . The future of the hospital is in the hands of Monitor, NHS England contingency Planning Team. Who are working up options for what services continue to operate from PSHFT to keep the hospital viable and sustainable for the future. This may result in overspill into Cambridge locality, but uncertain exactly what at this point (grade as Amber) <p>Different risks will be attributed to different owners – e.g. subgroup chairs sand clinical leads.</p>
12	ANY OTHER BUSINESS
	<ul style="list-style-type: none"> • Contract feedback: (S.Holmes): There is a new e-mail address for feedback on services commissioned from local trusts. It is hoped this will give powerful examples for contract management meetings. SH suggested that if necessary patient initials are used in emails and if more information is required then specifics can be communicated by NHS mail. <p>Example of useful feedback might be:</p> <ul style="list-style-type: none"> - Example of poor discharge summaries received (or not received) - Experience with patients attended by Medihome (CUFHT service) • Childrens Services: - commissioning plan being delayed to enable engagement with LCGS. OMcG noted that one of the midwives had expressed an interest in future of childrens services (patient at Arbury) . A clinical lead is needed to represent Cam Health. <ul style="list-style-type: none"> - ensure dates of forum meetings are circulated (action DM)
13	Date of next meeting
	Thursday 22 August 2013, 9.00- 12 noon, Nuffield Road Medical Centre