NHS
Surrey Downs
Clinical Commissioning Group

Governing Body Meeting – Part 1

Friday, 29th January 2016

St Mary's Church Hall, Stoke Road, Stoke D'Abernon, Surrey KT11 3PX

Minutes

Committee members present:

Ralph McCormack	Interim Chief Officer
Peter Collis	Lay Member for Governance
Dr Claire Fuller	Clinical Chair
James Blythe*	Director of Strategy and Commissioning
Dan Brown	Head of Finance
Dr Jill Evans	East Elmbridge Locality Chair / GP member
Dr Simon Williams	Epsom Locality Chair / GP member
Dr Robin Gupta	Dorking Locality Chair / GP member
Dr Andrew Sharpe	GP Member
Dr Hazim Taki	GP Member
Dr Kate Laws	GP Member
Dr Louise Keene	GP member
Dr Russell Hills	GP Member
Dr Mark Hamilton	Secondary Care Doctor
Debbie Stubberfield	Independent Nurse
Jacky Oliver	Lay Member for Patient and Public Engagement
Gill Edelman	Lay Member for Patient and Public Engagement
Jonathan Perkins	Lay Member for Governance
Eileen Clark *	Chief Nurse

Others in attendance:

Steve Hams	Interim Director of Clinical Performance and Delivery
Ruth Hutchinson	Surrey County Council Public Health
Mr Cliff Bush	Independent observer
Vicky Francis	Governance Support Officer

Chair: *Dr Claire Fuller, Clinical Chair*

Minute taker: *Vicky Francis, Governance Support Officer*

Meeting started: 1.00 pm

Meeting finished: 3.40 pm

1. Welcome and introductions

GB290116/001

Dr Fuller welcomed everyone to the meeting and those present introduced themselves. Dr Fuller noted that the venue had not been used by the Governing Body before and asked for feedback, particularly regarding access and parking. Dr Fuller welcomed Ralph McCormack to his first Governing Body meeting as Interim Chief Officer.

2. Apologies for absence

GB290116/002

Apologies for absence had been received from Matthew Knight, Drs Wali and Moore, Yvonne Rees, Karen Parsons, Antony Collins and Justin Dix. It was noted that Drs Laws, Gupta and Williams had been delayed.

3. Quorum

GB290116/003

As the required quorum was present, the Chair declared the meeting open.

4. Register of Members' Interests and potential conflicts of interests relevant to the meeting

GB290116/004

The Register of Members' Interests and any related conflicts were noted. Dr Hills stated that, in addition to the interests listed, he was also a private GP attached at St Anthony's and partner at ICP. Steve Hams stated that he was a director of Curhams Limited and his partner was employed by University College London Hospitals. Dr Evans confirmed that she was Clinical Lead for East Elmbridge CMT. Dr Hamilton stated that, in addition to the interests stated, he was Critical Care Services Physician at St George's and Epsom and St Helier hospitals. The register to be updated as above.

5. Minutes of the last meeting, held on 27th November 2015 – For accuracy

GB290116/005

The minutes of the meeting of the Governing Body held on 27th November 2015 were considered and, subject to the following comments, were approved as a true record.

GB290116/006

Eileen Clark highlighted breastfeeding commissioning (para 043). Ruth Hutchinson clarified that Surrey County Council had been responsible for provision of Health Visitor services since October 2015 and that that service included part of the breastfeeding function.

Debbie Stubberfield (para 038) clarified that her comment regarding 100 day breaches related to the quality impact assessment of the breaches. GB290116/007

6. Matters arising

With regard to Improving Access to Psychological Therapies (IAPT) (GB271115/016) it was noted that Cliff Bush had been correct to raise concerns regarding the balance between group and face-to-face services and a comprehensive update was available upon request. James Blythe said that figures showed that, at the start of 2014/15, group therapy was the second most common method of delivery. Patients receiving psychological therapies had dropped from 90 in the first quarter of 2014/15 to four in quarter two of 2015/16, while those receiving guided self-help had increased from 34 to 179 over the same periods. Dr Evans stated that group therapy was not inferior to one-to-one therapy, and was very effective for some people. GB290116/008

It was agreed that the matter arising regarding SECAmb (GB271115/042) would be considered later in the meeting. GB290116/009

The matter arising regarding sexual orientation on the Safeguarding Adults Policy coversheet (GB271115/078) would be followed up with Justin Dix outside the meeting. GB290116/010

Action: Dr Fuller

Dr Fuller stated that she would discuss the preparation of the Members' Statement of the Annual Report (GB271115/090) with Justin Dix outside the meeting. GB290116/011

Action: Dr Fuller

Dr Hamilton noted that it would be helpful to include an action log at the end of the minutes, which was agreed. GB290116/012

Action: Vicky Francis

7. Dorking Locality – The Case for Change

Dr Fuller welcomed Dr Jonathan Richards, a GP in Dorking, Michael Arnaud, Business Director of Dorking Health Care (DHC) and Matt Jarratt from Central Surrey Health to the meeting. GB290116/013

Michael Arnaud stated that the Dorking locality had a population of 41,000 and was geographically distinct, with a mix of rural and urban areas. It was made up of five practices currently, although this could reduce to four in future. There was a very good community hospital run by DHC providing ultrasound and echo and x-rays on-site, with a 28 bedded ward and therapies department. There was also a shared IT system between practices and DHC. GB290116/014

Dr Richards stated that the current system consisted of geographically distinct areas representing provision and administration of services. GB290116/015

Current challenges included organisational boundaries, service boundaries, duplication of skills and activities, limited economies of scale, lack of knowledge of other organisational personnel and processes, a fire fighting rather than a proactive approach, and a "silo" rather than "whole system" mentality. This all contributed to a "can't do" attitude and approach, which the team sought to change. GB290116/016

The Dorking locality was integrated technologically but any other integration, including that with DHC, was limited. Each practice had its own business manager, clinical staff and business priorities. Current pathways were lengthy and involved several staff and departments. GB290116/017

With regard to respiratory care, all individual practices had nurses or GPs with an interest in respiratory care, but they did not communicate with each other, even about the same patients. GB290116/018

Administration of patients to Dorking Hospital performed functionally but there were cases that could have been admitted there rather than sent to an acute trust. GB290116/019

Michael Arnaud stated that a review of models which could be delivered had been undertaken. The recommended model for Dorking was the Primary Care Home (PCH), a form of multi-speciality community provider (MCP) model. GB290116/020

Key features of the model were a population of between 30,000 and 50,000, a combined focus on personalisation of care with improvements in population health outcomes, decisions on "make or buy" spend were made by budget holders and full integration of IT systems. The PCH model was supported by NHS England. GB290116/021

Dr Richards stated that under the future PCH system there would be one "bubble", with no boundaries between organisations. There would be seamless pathways and total integration. Personnel would be better known as they would be colleagues. Large amounts of time would be saved with the full integration of IT. There would be a detailed and agreed "Health and Social Strategy for Wellbeing". The system would be leaner and more efficient and a "can do" system would be developed. GB290116/022

Future pathways would mean requests for treatment would go direct to the relevant practitioner rather than through numerous steps. With regard to respiratory care, the team envisaged total integration between practices, community nurses and hospitals, all operating as one team. They would also seek to develop this in other appropriate specialities. There would be a team in the community assisting with admissions to Dorking Hospital. GB290116/023

Matt Jarratt stated that there would be a radical impact on care for the Dorking population, but that the view reflected the thinking of the whole country. Organisations to be involved would be identified, such as DHC, Continuing Health Care (CHC), Mole Valley District Council and Surrey County Council, local charities, other care organisations, leisure groups, patients and the general public. The team were due to start work on a business case shortly. GB290116/024

In conclusion, Dr Richards noted that the changes proposed were fairly radical but that change was required. He asked the Governing Body to consider if the proposal was the correct direction of travel. GB290116/025

Dr Fuller thanked the Dorking team for their presentation. GB290116/026

Dr Hills said that the presentation was very impressive and that the aims of the proposal would be very beneficial and would work in practice. With regard to elderly care the integration of the back office made the process work better for patient outcomes and financially. GB290116/027

Cliff Bush commented that the plans sounded good but was not sure if they were ambitious enough. There was a problem with discharge as patients generally recovered quicker at home. If the proposals were implemented he would like to see a good integrated plan for delivery stopping the need for patients to go to hospital. GB290116/028

Dr Richards said that there could be economies of scale regarding administration. A community medical scheme in Dorking would prevent people going in to hospital and would instead go to their community hospital or a rest home. There was also a need to go into the acute trusts and suggest those people that could be taken back into the community, subject to risk management and safety considerations. The goal was to prevent people from going into hospital but there must be credible alternatives. GB290116/029

Dr Evans agreed with the direction of travel. The East Elmbridge locality approach was more organic. There were already community medical teams going into the community and preventing people who should not be in hospital from being admitted. Dr Evans asked when the East Elmbridge locality would be able to give their presentation to the Governing Body and Dr Fuller confirmed that it would be added to the agenda for the March Governing Body meeting. GB290116/030

Dr Evans/Vicky Francis

Dr Fuller gave her support to the direction of travel and commended the Dorking locality on their achievements to date. GB290116/031

Dr Hamilton asked if IT systems would be bought off the shelf or from a dedicated provider and was concerned about the governance structure surrounding this. Dr Richards stated that IT was a big issue. There was currently full integration of clinical records with the Dorking practices and that he would like other community services to use the same IT system. The governance structure would need to be worked through as there were potential conflicts of interest. GB290116/032

Dr Laws noted that her practice covered three borough councils and asked if the team anticipated similar problems interacting with more than one borough council. Michael Arnaud replied that the main council was Mole Valley District Council but that others were involved and that the locality would need to work with them. GB290116/033

Peter Collis agreed with the plans and asked if it was realistically possible to achieve them collaboratively. Dr Richards said this had been discussed at practice level already. Recruitment in general practice was a problem. He encouraged the younger GPs on the Governing Body to consider this. GB290116/034

Eileen Clark was very supportive of the approach and asked if there were any issues around sourcing the workforce and providing it with the necessary skills. Dr Richards stated he had recently been involved in the merger of a neighbouring practice so was fully aware of the challenges faced with workforce. Understanding of the future vision and wanting the best for patients generally helped the workforce overcome any personal issues. Matthew Jarratt said the process was about improving systems of care rather than changing the employment status of the workforce. Eileen Clark suggested linking in with Health Education and other networks to ensure they were working ahead properly. GB290116/035

Jacky Oliver asked if the proposals would affect patient choice. Dr Richards replied that in Dorking people preferred local services so the focus was on delivering local services. However, if they did not want the local service, other options would be available. GB290116/036

James Blythe said that he was aware that the CCG had a pro-elderly strategy focused on integration and overcoming challenges. There had been some success with creating very different patient flows over three very different localities. Epsom had 200,000 residents, with the East Elmbridge and Dorking localities having between 30,000 and 50,000 residents. GB290116/037

This year work was focused on developing the second year of the strategy by working with each of the three localities on a business case for each locality, the current presentation forming part of that for Dorking. Challenges included governance, procurement and focus on safeguards. The local joining up of services was key to the process. The future business case would be presented to the Governing Body for approval upon completion. GB290116/038

8. Questions from the public

GB290116/039

Keith Francis from North Holmwood asked about the proposed closure of the local pharmacy. Michael Arnaud replied that he was responsible for the running of the North Holmwood surgery and confirmed that as it was not classed as rural the dispensary had to close. Two pharmacy applications had been rejected by NHS England but he hoped that one would be approved, although the dispensary did have to close.

GB290116/040

Dave Stephens from Glenside Care noted that a cultural change and acceptance would be required for virtual wards to work. He asked how the strategy would be communicated to ensure public buy in. Dr Richards stated that there would be public participation in the plans.

GB290116/041

Joan Howell-Jones, a governor at the Royal Surrey County Hospital said that she had worked in the respiratory specialism and that silos did exist, where there was no communication between primary and secondary care. She asked about the funding of chronic cases between primary and secondary care. James Blythe replied that there were individual integration strategies and there was a need to look at the relationship with the acute trusts. Epsom Hospital was the easiest, although there was a problem with East Surrey Hospital and Kingston Hospital as they were working with a number of distinct localities. The team must ensure that they could work with the acute hospital and their specialist teams. It was also more difficult for Dorking Hospital or East Surrey Hospital as Epsom was more central.

GB290116/042

Bob Mackison had been unable to stay for the meeting but had submitted questions to the Chair in writing. He noted that, in the past, questions from the public had been taken as the last item on the agenda and asked if the meeting could take that form again. Hilary Porter, a local resident, stated that, in her experience, questions at the end of the agenda could be cut short due to time constraints. Dr Fuller said that her preference was to take questions from the public at the end of each section. The consensus of opinion was to leave questions from the public at the beginning of the agenda.

GB290116/043

Bob Mackison asked if it was possible to include a list of acronyms and appropriate definitions within the papers, such as that included in the Quality and Performance Report, to aid the understanding of the reader. It was agreed that this would be very useful.

Action: Vicky Francis

GB290116/044

With regard to the Community Hospitals consultation document, Bob Mackison asked if copies of the consultation document were being made available at each GP practice. Suzi Shettle confirmed that copies had been made available and advertising had also taken place.

Keith Francis stated that a friend had recently used the 111 service during the night and the doctor that had attended had had to travel 50 miles, from Kent to Surrey. He asked why a more local doctor had not been sent. Dr Fuller replied that this matter could be discussed further under the Quality section of the meeting. GB290116/045

Cliff Bush asked how the CCG intended to address the apparent lack of knowledge and ability to diagnose sepsis, and whether it would be beneficial to provide patients with suspected sepsis with a course of antibiotics, as no harm would come to the patients if they did not have sepsis. He stated that sepsis was the biggest combined killer in the country. Dr Fuller agreed that there had been terrible stories reported of avoidable deaths, largely due to the III algorithm. There would now be regular locality education meetings and the GP tutor had asked for the item to be added to the agenda for all GPs. Steve Hams stated that there had been a large amount of work done with provider organisations during the last few years around recognition and treatment of sepsis. They were incentivised regarding early identification of sepsis. There was a need to ensure that patients were not required to identify it, and it was identified by professionals. The Sepsis 6 bundle was key. Dr Williams stated that most professionals would support training. Sepsis was actually the second highest killer in the country, second to cancer. There was a need to balance the issue of giving antibiotics with that of the issue of resistance to antibiotics. He noted that the sepsis issue was very tragic as progress could be very rapid. Dr Evans confirmed that it was a matter of judgement as to whether antibiotics should be prescribed. She also stated that sometimes deaths from sepsis were unavoidable if it developed quickly after clinical assessment. GB290116/046

9. Interim Chief Officer's Report

Ralph McCormack stated that his report included his reflections on his early impressions of his time with the CCG. He had a pre-existing relationship with the CCG, albeit in a different form. He believed that difficulties were being managed and the CCG was on the road to recovery. He had not appreciated the strength and depth of the ownership and determination of the staff to play their part in the financial recovery. It was encouraging to him and gave a sense of hope that the challenges faced would bring the situation back into order, particularly financially. GB290116/047

A three point plan had been drafted; setting the strategic direction based on the view of patients and the organisation to ensure the strategy was correct; the delivery of quality care and patient experience through good financial stewardship and governance, which was currently on a positive footing and viewed as strong externally; and relationships and the culture of the organisation, both internally and externally, connecting with staff and communities to show that the CCG was interested and keen to listen to views. He stated that he was inclined to walk around GB290116/048

and talk to people and was encouraged that people were keen to share their opinions with him.

GB290116/049

Following the governance review the Governing Body had accepted the recommendations and agreed to implement the suggested structural changes. The Council of Members had been asked to vote on amendments to the constitution and a 75% approval rate had been required. A large amount of work, both from clinical and management staff, had been involved but he was very pleased to report that 100% of practices voted, all of which were in agreement with the proposed structure, which was a very positive endorsement of the proposals.

GB290116/050

With regard to the community hospitals consultation, Ralph McCormack thanked staff and the public for their input into the process and encouraged everyone to give their feedback via the website or questionnaire.

GB290116/051

A petition had been delivered to the CCG before the meeting began which had been signed by over 5,000 residents who had requested that Epsom Hospital retain its stroke unit and specialised staff so that patients returning from Hyper stroke units were properly cared for and re-habilitated. As a Surrey system, residents were more likely to die of a stroke than on average anywhere else in the country, which was not acceptable.

GB290116/052

There was also an issue regarding quality of life following a stroke. To give patients the best chance of recovery they needed to be on a Stroke Unit within four hours of their stroke and to receive speech and language therapy within the first few hours. There was a problem at handover as patients appeared to get lost in the transfer between organisations.

GB290116/053

The CCG was working towards what will become a national specification and was asking providers to state how they were going to provide that level of service. Work would be undertaken with the Stoke Association and stroke patients to ensure the cover stroke from the whole pathway.

GB290116/054

There was also a need to stop people having strokes but if someone had a stroke, there had to be a seamless care provision with providers working together and with the patients, in a similar way to the Dorking locality proposal. Proposals would be taken to the Stoke Committee in Common in April for assessment.

GB290116/055

The 2016/17 planning guidance had been issued on 22nd December 2015 and the five year allocation of funding had also been received. A first pass draft of the plan had been developed and submitted for review ahead of the deadline of 8th February 2016.

GB290116/056

Negotiations had prevented any further junior doctor strikes but there was a long road to travel and developments were being monitored closely to assess future impact.

GB290116/057

Acute hospitals and A&E services had coped well over Christmas and the New Year and during the holiday period but performance had dropped afterwards. Acuity of patients was up on previous periods. The focus was now on the Easter break, which was early this year, to ensure that resilience planning was in place.

GB290116/058

With regard to digital roadmapping there was a focus on the integration of IT, with the aim to be paperless by 2020. The Local Digital Roadmap was to be submitted by June 2016. Dr Hills stated that this was a big undertaking and asked if there had been any allocation of funding from NHS England. Dr Sharpe replied that quite a lot of work was going on and a public announcement would be made in the next couple of weeks.

GB290116/059

Many of the CCG Service Level Agreements (SLAs) with Commissioning Support Units (CSUs) would be coming to an end shortly and the CCG was working with other Surrey CCGs to explore potential future arrangements within NHS England framework arrangements. CCGs were expected to have commenced a procurement process and engaged with the national team to replace SLAs by April 2016, although this could be extended to July 2016 when they were supposed to become autonomous providers and compete in the marketplace. Support for ICT was very important where both GPs and CCG have significant need. Peter Collis stated that he was surprised about the CSU arrangements, which appeared to have come up suddenly, and it appeared that the fact that "many" CCGs were involved could be risky. Ralph McCormack replied that that was why the ability to extend the deadlines had been sought as these are significant areas of support. Dialogue is currently running between Surrey CCGs about what the CCG should be done and at what scale.

GB290116/060

The national survey of primary care was discussed. The national GP survey shows that Surrey Downs has performed well when compared with benchmarks, with a third of practices scoring between 93% and 99% satisfaction rates. The CCG would continue to support NHS England to improve the quality of local primary care wherever possible.

GB290116/061

The Health and Wellbeing Board had held workshops and a public meeting since the last meeting of the Governing Body. Debbie Stubberfield noted that a recurring theme of the Board was that of the workforce, highlighting their importance and the challenges faced. She asked if there was a strategic framework in place in Surrey. Dr Williams stated that a workforce workshop had been held recently, looking at collaborative work between the University of Surrey and the University of Kent.

It was noted that there could be problems in the current workforce in the near future if actions were not taken and that he was working with Sonia Seller, Area Director for Surrey County Council, to address these. Jonathan Perkins stated that this matter had been discussed at the Remuneration and Nominations Committee held earlier in the day as part of the review of organisational risk. The committee had decided that there was an overarching risk issue regarding recruitment, retention and development of staff and this risk factor should be reviewed on a strategic basis in future. GB290116/062

10. Finance Report

Dan Brown, Head of Finance, presented the Finance Report in the absence of the Chief Finance Officer. GB290116/063

With regard to the overall financial position, the CCG was on track to deliver a cumulative deficit budget for the financial year of £28.6 million, which included £1 million overspend on acute services and £1 million underspend on non-acute services. Overspend on acute services was forecast as £211.4 million for the year compared with a budgeted overspend of £210.4 million. The figures for Epsom and St Helier Hospital had been agreed for the year which had the effect of de-risking those costs in the forecast. Underspend on non-acute services included underspend of £200,000 on IAPT and £300,000 underspend on prescribing. GB290116/064

Progress against QIPP was £7.2 million against a full year target of £9.8 million and there was confidence in achieving the savings by year end. GB290116/065

Risks of not achieving budget in 2015/16 were largely based at Kingston Hospital and Surrey and Sussex Healthcare NHS Trust where there was scope for further deterioration in the numbers. Mitigation could be non-acute spend and, overall, there was confidence that targets would be achieved. GB290116/066

Allocations for the next five years had been received, with the last two years being indicative, and the Finance Department were still working through the implications. There would be more money available in 2016/17 but it should be noted that a first call on unallocated extra funds would have to be used to pay off the historic deficit. The Department were engaging with NHS England with regard to 2016/17 funding. GB290116/067

Peter Collis reported that a Finance and Performance Committee meeting held earlier in the week had noted that the picture was very positive and that the progress for the year could be seen with some confidence. He asked how 2016/17 would look and Dan Brown replied that that was now the focus. The Chair noted that it was important to note that the Finance and Performance Committee had considered the same version of the Financial Report as that considered by the Governing Body. GB290116/068

11. Quality and Performance Report

GB290116/069 Eileen Clark presented the Quality and Performance Report and highlighted the key issues.

GB290116/070 Monitor had issued warning notices to SECAmb, with the main concerns relating to governance arrangements in the trust. North West Surrey CCG were the lead commissioners and they had invited all Surrey CCGs to join the forum at which questions were to be put to the main Clinical Quality Review Group (CQRG) to discuss concerns across Kent, Surrey and Sussex. Steve Hams stated that SECAmb were open to dialogue and wanted to improve their performance and that governance concerns were being dealt with. Additional work was being undertaken to improve governance performance.

GB290116/071 A number of trusts were still failing on cancer waits but it was an improving picture. The problems behind it were beginning to be understood, but a watching brief would be kept.

GB290116/072 With regard to Healthcare Associated Infections the main concerns were around C-Diff and use of antibiotics and procedures in place were being reviewed. There were particular concerns around hand hygiene.

GB290116/073 Epsom and St Helier had recently had a CQC inspection and a number of issues were raised. Areas requiring improvement included clinical leadership and culture and a full report would be available at the end of February or early March 2016.

GB290116/074 The Quality Committee had held a Quality Seminar in December 2015 where presentations were given by the newly established Community Medical Teams and Community Hubs about the services that were being developed. Governance arrangements to support the hubs were discussed.

GB290116/075 With regard to the question raised by Keith Francis, the location of a doctor sent to see a patient following a 111 call depended upon where the individual was located. It may have been that the call was passed to the wrong team to deal with and Mr Francis was asked to provide specific details if he required any further investigation into the matter.

GB290116/076 Cliff Bush referred to section 2.6 of the Quality report and asked how many patients were affected and how long had they been delayed. SECAmb were not meeting their contractual requirements as they were continuously missing targets. Dr Fuller asked if there were any patient representatives on the contract group and Hilary Porter stated that she would try to rejoin it.

GB290116/077 Cliff Bush stated that SECAmb were not on target with blue light response times and that he had expected feedback on this to be provided at the meeting. Steve Hams referred to the NHS Constitution metrics on page 51 which were a few months behind but showed the situation described. This was clearly

unacceptable and the CCG were using contractual and commissioning levers to apply pressure. There was an agreed improvement trajectory with North West Surrey CCG. James Blythe agreed that performance was not at the required standard, although challenges existed regarding the geography of the area and due to the CCG's location on the edge of SECAmb's patch. He wanted assurance that North West Surrey were getting robust plans in place. Action plans should bring improved performance for the CCG and if that was not the case it would be pursued further. Eileen Clark stated that there were improved handover times and that the Quality Department were monitoring potential or actual harm caused to patients by delays.

GB290116/078

Dr Laws asked for further detail on the Helios Pilot on page 39 of the report. Eileen Clark replied that it was a pilot around referrals for support for carers and that she would find out more information.

Action Eileen Clark

GB290116/079

Debbie Stubberfield referred to page 35 of the report and asked if the spike in Cdifficile was due to a new strain. Eileen Clark stated that this had been discussed at the Surrey Infection Prevention and Control Meeting and that it appeared to be a new strain, but that it was independent, not as a result of lapse of care or cross infection.

GB290116/080

Gill Edelman referred to concerns raised around management and governance issues at Ashmount, a service for people with a learning disability. Eileen Clark replied that she was aware of a number of concerns. Surrey and Borders was a large trust and was addressing issues raised. She also stated that action had been taken against the staff involved.

GB290116/081

With regard to IAPT, Gill Edelman asked if there was follow up of patients who did not follow through with the service. Eileen Clark replied that there was a review of recovery rates and sustainability and that patient experience information would be requested. James Blythe stated that self-referral was not having a negative impact.

GB290116/082

Ralph McCormack asked what the report was requiring of the Governing Body. It should highlight priority areas, set actions to follow through on, focus the attention of the Governing Body on critical areas of quality and patient experience. Dr Fuller stated that SECAmb, Surrey and Borders and IAPT were key areas.

GB290116/083

It was agreed that SECAmb would be a specific agenda item at the next meeting of the Governing Body in March 2016.

Action: Vicky Francis

Cliff Bush stated that CAMHS performance had been very disappointing. Public perception was important as referred patients discussed services provided. James Blythe reported that positive changes had been made to how CAMHS was managed and feedback would be provided on it as a specific item. GB290116/084

Action: Eileen Clark/James Blythe

12. Risk Profile

Ralph McCormack drew the attention of the Governing Body to page 4 of the Risk Profile which listed new risks. These, and the risks listed as recommended for closure, were AGREED. GB290116/085

13. Operating Plan 2016/17

James Blythe reported that the draft Operating Plan for 2016/17 had been included in the papers as NHS England had requested its early submission. GB290116/086

Commissioning intentions and national planning guidance (local versus national) had been reviewed as part of the preparation of the first draft. A revised version of the Operating Plan would be brought back to the Governing Body on 18th March 2016 for approval before its submission to NHS England on 11th April 2016. GB290116/087

Action: James Blythe/Mable Wu

The Operating Plan also included year one of five of a Sustainability and Transformation Plan (STP) which was an interlocking series of documents which built on the previous planning work. GB290116/088

Jonathan Perkins noted that risk was moderate for end of life care but was not included in the document and asked that this be considered. He also noted that parts of the report were not written in a definitive fashion and asked if fixed KPIs would be in place so that teams knew what they should be delivering. GB290116/089

James Blythe replied that the detail formed part of the project assurance process, through the Programme Delivery Boards. It would also go to the Clinical Cabinet for signoff. The Programme Management Office (PMO) ensured that a balanced set of KPIs was established, covering areas such as efficiency, equality and quality. It was noted that NHS England had set limits for the length of Operating Plans. GB290116/090

Gill Edelman asked how the progress of projects versus planned progress was reported to the Governing Body. James Blythe replied that this would be covered by the PMO reports and that these would be Red-Amber-Green (RAG) rated. GB290116/091

Dr Hills asked about investment in tablet computers and provision of Wi-Fi in doctors' waiting rooms across the NHS. He was unsure of the benefit of providing patients with access to Wi-Fi while in the waiting room. Dr Sharpe replied that it had been suggested by Jeremy Hunt and that costings were relatively small. GB290116/092

Debbie Stubberfield asked about work regarding tripartite assurance. James Blythe replied that there was a regional and national practice which allowed bodies to review gaps in submissions. It was noted that the CCG sat across a regional boundary for management purposes and this made triangulation exercises difficult, which was not helpful as they were very important. The Chair highlighted that end of life care strategy and having clear deliverables were key and the report would come back on 18th March for review. GB290116/093

Action: James Blythe

14. Chairman's Action – South West London and Surrey Downs Healthcare Partnership

Ralph McCormack stated that there was a growing acceptance that work of the CCG which interfaced with South West London on should be encapsulated in the South West London and Surrey Downs Healthcare Partnership. Surrey was of prime importance to the CCG rather than South West London, other than its relationship with Epsom Hospital. The CCG was in discussions with NHS England London and South East to find a way to bring Epsom Hospital into Surrey planning control. Governance relating to the wider programme and specific health partnership model were important. The Governing Body will retain involvement in the process. GB290116/094

Dr Evans asked that Surrey patients who viewed Kingston Hospital as their acute provider be considered and said that there should be a representative from East Elmbridge involved who could ensure that Surrey patients affected by the changes were represented. Dr Fuller agreed that this was very important. GB290116/095

Debbie Stubberfield raised questions about the lack of reference to Surrey Downs in parts the documentation and Ralph McCormack stated that it should be included. GB290116/096

Debbie Stubberfield noted that the Partnership's Finance and Activity Committee terms of reference referred to decision making powers but this was not reflected in the terms of reference of their Clinical Board. Dr Fuller stated that she was attending the first meeting of the South West London and Surrey Downs Healthcare Partnership Clinical Board on 3rd February 2016 and would raise the point there. GB290116/097

Dr Hills referred to terms of reference for the Clinical Board in the second bullet point from the bottom of point two around providing assurance of signoff of outputs, whether this was the same as GB290116/098

quality impact assessment methodology and process and if anything changed whether a QIA would be done appropriately and whether this should be made specific.

GB290116/099

The South West London and Surrey Downs Healthcare Partnership document was noted and the issues raised would be addressed.

15. Committee Terms of Reference

GB290116/100

Dr Fuller reported that a huge amount of work had been undertaken over the Autumn by the lay members, Justin Dix, Karen Parsons and Isabelle Gowan to redraft the committee terms of reference.

GB290116/101

Gill Edelman asked where the responsibility for a sound evidence base for ensuring quality sat. It was noted that this was the responsibility of more committees than just the Quality Committee and it was agreed that this would be considered as part of Mission and Values after the change of Governing Body composition in April as it should be overarching and should be added to the strategy workshop agenda.

Action: Dr Fuller

GB290116/102

Gill Edelman also noted that "The two lay members" in Quality Committee terms of reference should be amended to read "Two of the lay members".

Action: Vicky Francis

GB290116/103

Subject to the amendments above the terms of reference were approved.

16. Equality and Diversity Annual Report

GB290116/104

Dr Fuller noted that the draft report was very good, and was interested to note that while there were 160 females in the organisation and 38 males, all the Executive Team were male.

GB290116/105

Ralph McCormack stated that it was important to consider the report as Equality and Diversity was fundamentally important to the organisation and the function was a statutory responsibility. There were a number of areas where there was an important public health profile, such as new appointments. Online training modules had been introduced to widen knowledge and the importance of Equality and Diversity and to ensure that the CCG was properly considering these areas with regard to both the workforce and population. It was noted that the report was not yet in final form but progress had been made on a significant area and set the CCG on a path of improvement around the right principles.

GB290116/106

Cliff Bush noted that, with regard to patient access and experience, Surrey Carers Group was referred to but not patients. He noted that this was a user-led organisation and should be involved.

GB290116/107

Dr Hills asked how the CCG ensured that it was getting a representative view from Patient Advisory Groups. James Blythe replied that the Comms Team would write out to their full contact list for the appropriate type of work asking for people to come forward. This was quite self-selective sometimes and some patients would not want to discuss subjects in public so other forms of consultation were required such as questionnaires. As the CCG became more experienced it could be more proactive.

GB290116/108

Dr Hills said the CCG should identify gaps and specifically engage with appropriate patients. With regard to service redesign proposals if there were specific equality issues they should be reviewed again. Community hospitals consultation would require the engagement of specifically affected groups.

GB290116/109

Hilary Porter said that she was concerned that, following the change of Patient Advisory Groups, there were more members of the community to select from but a number of people who came forward were scared to voice their concerns and could only do it through groups who were no longer part of the Patient Advisory Groups. The new chairman was in place and concerns now had to be raised through the Communications Group. There was a gap in patient knowledge as to how to voice concerns.

GB290116/110

Jacky Oliver stated that Pollymarch Mather was re-establishing forums as a small group of people tended to be overused. It was noted that the traveller community did not often take part in the processes.

GB290116/111

Dr Evans stated that Elmbridge Borough Council had a citizens panel to ensure representation from all minority groups and ages. It was important to obtain a view from as many of the general population as possible.

GB290116/112

Matt Jarratt said it was important to keep a live understanding of patients' views and the CCG should contact him if assistance was required from Central Surrey Health.

GB290116/113

Gill Edelman stated that Patient and Public Engagement (PPE) should be revisited and Ralph McCormack agreed to action this as, having reviewed how the CCG worked in so many areas, PPE must also be reviewed.

Action: Ralph McCormack

17. Audit Committee Report

GB290116/114

It was agreed that it would be helpful to include a note of proceedings at the Governing Body seminar in the Committee Reports in future.

Action: Vicky Francis

GB290116/115

Dr Fuller reported that she had attended her first Audit Committee meeting and had found it really good.

Peter Collis reported that work was required on the members' section of the Annual Report and that the Finance Team were on schedule with the timetable. GB290116/116

The independent audits of Individual Funding Requests and Safeguarding Adults raised significant issues but the Committee was reassured by actions taken and would ensure that actions were pursued. Concern regarding pursuit of actions had been addressed by putting tracking in place and there were now only a few outstanding issues. GB290116/117

The CCG would be required to procure external auditors in 2016 via the appointment of an Audit Panel. The Committee would be asking the Governing Body to approve the appointment of the current Audit Committee members as the Audit Panel. GB290116/118

18. Finance and Performance Committee Report

Jonathan Perkins reported that the Finance and Performance Committee had spent a large amount of time on the finance report for the Annual Report. There was a new focus on debtors, with the creation of a debtor profile. GB290116/119

There was less focus on current year QIPP projects as plans were now in place and focus was shifting to plans for QIPP for the next financial year, with the challenging target of £19.6 million. The Committee were challenging the Executive Team on their plans and would be reviewing this again at the February 2016 meeting. GB290116/120

19. Quality Committee Report

Debbie Stubberfield noted that there were a couple of inaccuracies in the minutes as they were currently in draft form. Otherwise there were no points to raise in addition to the report circulated with the papers. GB290116/121

20. Remuneration and Nominations Committee Report

Jonathan Perkins reported that the Committee had met that morning and had agreed the principles behind the new induction process and induction pack for the new Governing Body members. These would be rolled out as the new posts were filled. It was also thought that the new induction pack would be a useful reference tool for all Governing Body members going forward. GB290116/122

The NHS Clinical Commissioners were focusing on lay members and this would be taken forward. GB290116/123

A paper on women in clinical commissioning leadership roles was considered by the Committee and it was agreed that future leadership programmes should include the suggestions raised in the paper. GB290116/124

Action: Ralph McCormack

Jonathan Perkins also noted that the there was an overarching risk relating to workforce retention. GB290116/125

21. Any other urgent business

Dr Sharpe noted that at the previous meeting of the Governing Body stop smoking services in Surrey were discussed but he had not heard more since then. Ruth Hutchinson stated that the new provider would go live on Monday, 1st February 2016 and that she would update the Governing Body at the next meeting under Matters Arising. GB290116/126

Action: Ruth Hutchinson

22. Meeting dates for 2016/17

Dr Fuller noted that the meeting to be held on 18th March 2016 would be the last with the Governing Body in its current format. The meeting dates for 2016/17 were noted. GB290116/127

23. Date of next meeting

It was noted that the next full meeting of the Governing Body in Public would be held on 18th March 2016 at 1.00 pm at a venue to be confirmed. GB290116/128