NHS
Surrey Downs
Clinical Commissioning Group

Governing Body Meeting - Part 1

Friday, 18th March 2016

1.00 – 3.30 pm

St George's Christian Centre, Barnett Wood Lane, Ashtead, KT21 2DA

Minutes

Members present:

Dr Claire Fuller	Clinical Chair
Ralph McCormack	Interim Chief Officer
Peter Collis	Lay Member for Governance
James Blythe*	Director of Strategy and Commissioning
Matthew Knight	Chief Finance Officer
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
Mr Cliff Bush	Independent observer
Vicky Francis	Governance Support Officer

Chair: Dr Claire Fuller, Clinical Chair

Minute taker: Justin Dix

Meeting started: 1.30

Meeting finished: 4.25

1. Welcome and introductions

Those present introduced themselves. GBP1180316/001

2. Apologies for absence

Apologies had been received from Ruth Hutchinson and Dr Wali. GBP1180316/002

3. Quorum

The meeting was declared quorate. GBP1180316/003

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

Dr Evans noted that she was clinical lead for East Elmbridge community hub for which there was a presentation. GBP1180316/004

5. Questions from the public

There were no questions from the public. GBP1180316/005

6. Presentation: East Elmbridge Locality and its Partners GBP1180316/006

Dr Richard Strickland introduced himself and colleagues who were representing the East Elmbridge community hub and speaking about its development. GBP1180316/007

The hub was a team of clinicians across several disciplines targeting particularly, although not exclusively, the frail elderly at home and in community hospitals. The aim was to reduce inappropriate admissions and offer more appropriate care. GBP1180316/008

Dr Strickland gave an outline of the patch which had a population of 58,000 patients, 20% of whom were over 65, and seven GP practices and almost exclusively faced Kingston Hospital. GBP1180316/009

There was a long track record of joint working in the patch, which had also been a pilot site for community matrons. GBP1180316/010

Helen Cook, Clinical Lead Manager, CSH Surrey, then spoke regarding the Community Medical Team and the Community Multi-Specialty Provider ("CMSP"), although the latter term was to be phased out. GP practices were sub-contracted to the team and cover was provided to Molesey Hospital and had been since July 2015. The transition to the new system had been smooth as the GPs were already quite familiar with the network of people they were working with; the additional element had been visiting patients in the community. GBP1180316/011

The CSH Surrey element included community matrons. The Referral management centre was being used by the hub. 129 patients had been seen since July 2015, the majority since November 2015. The active caseload was around 35 people. It was thought that of those 120 patients, at least 71 people were diverted from A&E. Most had a history of multiple hospital admissions, which indicated 2-3 admissions per person avoided on an annual basis. GBP1180316/012

The End of Life Care ("EOLC") element had been higher than anticipated and it was hoped that there would be more proactive work in future for this group. Other presenting conditions included Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Pneumonia, Dementia, Heart Failure and Neurological issues. GBP1180316/013

Helen Cook highlighted a number of key successes of the hub including: enabling people to stay at home to die; improvement in quality of life; reducing acquired infections; reviewing medicines and significantly reducing the number of drugs patients have been prescribed; reduced the number of falls; improved relationships between patients, their relatives and carers; greater trust; improved collaboration and joint inter-agency working; improved systems resilience (although there was more work to be done in this area); and improved patient satisfaction, as evidenced by patient satisfaction survey results. GBP1180316/014

A key learning from this was that patient care was better when services worked together and barriers had been broken down between services. GBP1180316/015

In terms of collaboration, CSH Surrey and community matrons were educating, enabling and inspiring the health team to work in a better way, in the patient's home and with better management of risk. The team were now seen as one hub with staff working alongside each other. There was some therapy input. The relationship with the local authority was also greatly improved with frequent communication taking place. GBP1180316/016

Nora Lewis from Surrey County Council ("SCC") then spoke. She would be moving to Elmbridge shortly as Operations Manager but described SCC's reablement service, which sought to improve people's independence and capacity to do things for themselves in their own homes. There was a focus on discharge planning meetings and advice on timely services. There was also training on the vast range of services available for the care co-ordinators to improve access to services. GBP1180316/017

There was a direct link to joint agency safeguarding procedures in place. GBP1180316/018

Dr Evans then spoke. There was access to GP records for medical history, medicines and other information. The records could be updated by the hub which was important to ensure that drugs were kept up to date and to avoid negative side effects, particularly with the elderly, resulting in an improvement in patient safety. There were links into Kingston hospital but more work was needed on the hub's offer, particularly supporting step down from A&E and acute assessment units back into their homes, thereby avoiding potential infections, confusion and falls. GBP1180316/019

There was a geriatrician of the day at Kingston that could be contacted and who would often see patients the same day or urgently in out-patients. There was also liaison with acute care physicians. Closer liaison with both those specialists was being GBP1180316/020

developed.

GBP1180316/021

The pharmacists added considerable value to the hub's work in terms of creating more rational drug regimes. Parkinson's disease was quite a common problem that the hub was coming across and specialist nurses and pharmacists often knew the patients already and could work effectively with the team to provide a better outcome.

GBP1180316/022

Dr Evans then worked through a case study – "Betty" – that illustrated the way the team worked when an individual had a crisis. As Betty was already under the care of the Community hub and out of hours contact numbers had been provided for her family the service not only enabled the patient to be supported but identified areas for diagnosis. A rapid response enabled her undiagnosed conditions to be identified. There was also learning about this case about the patient's how care could be improved. In future it was hoped that the hub could call in the occupational therapist, physiotherapist and community matron to allow the patient to stay in her own home.

GBP1180316/023

There were a number of constraints to be worked around. GPs were working weekends and bank holidays but there were issues with shortages of community matron input.

GBP1180316/024

Beds at Molesey Hospital were used by out of area patients and this was a limiting factor as the hub needed enough beds to support its work.

GBP1180316/025

The hub theoretically has capacity for 33 patients but was currently carrying 43.

GBP1180316/026

Dr Strickland then spoke about some key issues:

- Lack of multi-disciplinary care at weekends
- Limited hours (eight to eight) to address out of hours admissions to hospital
- The range of services – although the team was overcoming silo working a lot of professional input e.g. OT was "Borrowed".
- Lack of community pharmacy
- Social Care team cannot cover early mornings and late nights and a need to extend the current 72 hours of input
- CPNs for the elderly were needed to address dementia and other mental health issue sin the elderly
- Molesey Hospital bed use would require ring fenced beds
- The capacity needed to be increased from 33 to 100 patients on the active caseload. This would require a bigger staff base that was more able to manage issues such as staff sickness.
- More referrals were needed from low referring areas.

GBP1180316/027

The hub's aspirations were to progressively increase staffing capacity over the next year to address the needs of 100 patients in future. This had economies of scale built into it. The hub had used a number of initiatives to encourage referrals. There were

also additional areas of integration that the hub was pursuing.

Dr Strickland noted that there was a real crisis in GP recruitment and he felt the way the hub worked was very attractive to both GPs and other professionals. GBP1180316/028

Dr Fuller thanked everyone for their presentations and in particular highlighted the track record of delivery. GBP1180316/029

Cliff Bush praised the work of the hub and highlighted the x-ray machine at Molesey. He felt this capacity needed to be increased. He suggested the Red Cross could do more directly with the hubs rather than working via acutes. GBP1180316/030

He also queried how young carers could be supported to access services particularly in relation to EOLC and in particular after the death of the person they had cared for. Helen Cook welcomed this observation and noted there were gaps in EOLC as previously mentioned. The evidence base was however improving. The issues with carers were noted – the hub was now established and would seek to identify young carers more proactively. GBP1180316/031

Dr Sharpe noted the avoidance of admission and said it would be useful to have more information on the figures. GBP1180316/032

Debbie Stubberfield commended the presentation and asked about workforce which was a key concern of the quality committee. She felt that workforce resilience was currently fragile and needed strengthening. GBP1180316/033

Jonathan Perkins said that, as a trustee of Princess Alice, he was surprised not to see this mentioned and recommended meeting with them on their five year strategy. GBP1180316/034

Dr Fuller thanked everyone for their contribution and invited Governing Body members to visit the hub by invitation. Dr Strickland said that this would be welcome and highlighted that the hub did not want to expand until it felt the workforce was resilient and that the CCG supported the business plan. GBP1180316/035

Resilience was highlighted as a significant issue. Community hubs were being promoted across all three localities and resilience needed to be seen across these through cross cover as well as individual hubs. Smaller localities would never be big enough to have sufficient capacity in its own right. GBP1180316/036

Dr Strickland finished by commenting that clinical governance was effective but would need to be developed further. GBP1180316/037

Peter Collis asked about ratios of investment relative to other services. Helen Cook said that the statistics on avoidance of admission did give a clear picture of potential savings based on the current cohort of patients. It was difficult to say exactly how this impacted on Kingston Hospital although it was noted that at the local whole systems board, Kingston Hospital Board had highlighted a perceived significant impact. GBP1180316/038

7. Receipt of Petition

The Chairman gratefully acknowledged the receipt of a petition from Molehurst Women's Club in respect of Molesey Community Hospital, as follows: GBP1180316/039

"We would like to register our objection to the closure of Molesey Hospital. Molesey Hospital offers a vital service for the community. Cobham Hospital for many Molesey residents would be hard to access, especially by public transport. Option one is our much preferred choice. Please save our longstanding local community hospital and keep it where is should remain, in the community." GBP1180316/040

The Chairman noted that the reference to option 1 referred to the options set out in the CCG's consultation on the future of local community hospitals. GBP1180316/041

8. Minutes of the last meeting, held on 29th January 2016 – for accuracy

These were agreed as an accurate record. GBP1180316/042

9. Matters arising and action log

010 – Cover sheets in relation to equality and diversity policy – agreed for closure. GBP1180316/043

011 – Members statement for annual report – agreed for closure. GBP1180316/044

012 – create an action log for the Governing Body – agreed for closure GBP1180316/045

030 – East Elmbridge presentation – agreed for closure GBP1180316/046

043 – Glossary – agreed for closure GBP1180316/047

078 – Healios pilot – Eileen Clark gave an update on this which was a mental health service for skilling up carers. Agreed for closure. GBP1180316/048

083 – SECAMB on March agenda – agreed for closure GBP1180316/049

084 – Changes in CAMHS Management - Eileen Clark would circulate information to the Governing Body. She noted there was a cabinet office best practice visit to the county today. GBP1180316/050

101 - Consider where sound evidence base for quality falls when drafting Mission and Values in April – being included in work on Quality Strategy. To be kept open but transferred to Debbie Stubberfield. GBP1180316/051

102 – Amend terms of reference of quality committee – can be closed. GBP1180316/052

113 – Patient and Public Engagement. Ralph McCormack spoke to this and said that there was a meeting scheduled in early April to agree the way forward on this. Action can be closed. GBP1180316/053

114 – Include seminars in reporting for future Governing Body meetings. Completed, agreed for closure. GBP1180316/054

124 - Women in clinical commissioning. Ralph McCormack said this had been included in the Organisational Development strategy – can be closed. Dr Fuller noted that there were a large number of female clinicians in the new clinical cabinet. GBP1180316/055

126 update on Stop Smoking Service – Ruth Hutchinson was not available to update, action to be kept open. It was noted that the existing service was under significant pressure. GBP1180316/056

Cliff Bush asked for information to new mothers on sepsis. Eileen Clark agreed to take this away for action. GBP1180316/057

Action Eileen Clark

Dr Sharpe noted that GP clinical systems had recently been updated to include questions on sepsis for pregnant women. Educational work was also taking place. GBP1180316/058

016 - number of people receiving face to face and telephone counselling via IAPT. This had been completed – action can be closed. GBP1180316/059

Dr Laws noted that Read codes were not available for IAPT self-referrals. This would be a useful development of EMIS. Andy Sharpe highlighted the system constraints; Andy Sharpe to pursue outside the meeting, and to look at potential audit with the CCG's clinical director for mental health. GBP1180316/060

Action Dr Sharpe

042, 079 and 090 were all duplicate entries and could be closed. GBP1180316/061

10. Chief Officer's Report

Ralph McCormack began by acknowledging the work of the CCG in its first three years, particularly the challenges that it had faced during this time. The CCG had amended its governance structure which meant that some people would no longer be on the Governing Body going forward. He thanked them for their work in the last three years, specifically the Governing Body GPs and the Secondary Care Doctor. They had been responsible for providing clinical leadership over this period. He also thanked Cliff Bush for keeping the CCG focused on patient and public issues and for acting as an advocate for patients. GBP1180316/062

Karen Parsons was leaving the CCG at the end of May and had done a huge amount to prepare the CCG for transition and to hold the organisation together during difficult periods. GBP1180316/063

The CCG would attempt to build on the previous work of these significant contributions. GBP1180316/064

Ralph McCormack noted that there had been a lot of work on appointing the new Governing Body and clinical cabinet, new locality leads, and the new clinical director roles. These would be very positive developments for the future. GBP1180316/065

Other points included: GBP1180316/066

- The community hospitals consultation had been GBP1180316/067

progressing and finished on the 5th May and would come to a future meeting for decision. There were some very tight timescales ahead.

- Reviews of collaborative arrangements were continuing to ensure they gave the best level of support to collective CCG responsibilities. This would build on what was working and review those that needed changing across the six Surrey CCGs. GBP1180316/068
- There had also been continued work on the services provided by the South East Commissioning Support Unit (CSU) and it had been agreed that GPIT and CCG corporate IT would be procured by the CCGs, therefore giving notice to the CSU. A detailed procurement process was to be developed. GBP1180316/069
- The national maternity review was noted. This had been published on the 23rd February and identified a need for more family friendly service. There was much still to be done in this area. GBP1180316/070
- The End of Life Care report was recommended to the leads in this area. GBP1180316/071
- Information Governance – the CCG was close to achieving 95% of staff trained. There were training sessions planned for the next two weeks to achieve this. Currently the CCG was at around 83%. This was being monitored on a weekly basis. GBP1180316/072
- Paperless Governing Body – there were many good reasons for doing this and other organisations had successfully implemented it. GBP1180316/073

Jonathan Perkins said that he did feel that EOLC needed more attention as the avoidable costs were disproportionate in this area. He asked about progress against the strategy agreed in September 2015. Ralph McCormack agreed that there would be a proper update on the EOLC strategy for the next meeting. GBP1180316/074

Action Ralph McCormack

Dr Laws noted that EOLC progress was significantly linked to the development of the hubs. GBP1180316/075

Debbie Stubberfield noted that paperless working would require encrypted devices. Cliff Bush expressed some scepticism about this but also noted that there was a need to ensure the public could still access the papers. This was acknowledged. Ralph McCormack said there would need to be solutions for the public as it was a legal requirement of the CCG's public meetings and may still involve some use of paper. Cliff Bush noted that the CCG did not provide large print, audio and other accessible material. GBP1180316/076

Jacky Oliver agreed about access but said that digital media could be better for people with disabilities. Dr Fuller acknowledged this and said that special arrangements would be put in place for meetings that required it. GBP1180316/077

There was a brief discussion about IG compliance for Governing body members; Justin Dix said that those who still had not completed the training had been contacted. Lists would be validated from April for new Governing Body membership and other roles. GBP1180316/078

11. Finance Report (Month 11)

Matthew Knight noted that the deficits at month 11 was £26m with an outturn expected of just under £29m – including the deficit of just under £11m from 2014-15. This was in line with agreed expectations and NHS England had acknowledged this achievement. He noted the various pressures and offsets in the report, of which acute trusts – mainly Epsom and Kingston – were the significant pressure areas and primary care and mental health the areas that had helped to mitigate these. GBP1180316/079

The CCGs reserves had been used in a planned way from the beginning of the year to address the overspends in the acute sector as it was expected these would be difficult to manage. There had also been a release of funds from the settlement of the EDICS dispute resolution process. GBP1180316/080

Risk and mitigations were balanced, as you would expect at this stage of the year, and QIPP was on target for delivery of the £9.8m target (£9m year to date). GBP1180316/081

Next year's plan was to use additional allocations to address additional costs and in-year deficits. The rules set out by NHS England for addressing pressures were complex but in essence they meant that there was no impact on recovery in terms of the historical deficit. Cost savings of around £20m were planned for 2016/17. The target for next year was still under discussion with NHS England. GBP1180316/082

Debbie Stubberfield welcomed the explanation of non-compliance with business rules. This had been discussed with NHSE and Matthew Knight noted that the CCG was required to rate itself against an NHS England Financial Controls Assessment, which include both performance and governance. He was seeking further clarity on where this left the CCG, particularly as it tended to make difficult links between financial performance and financial governance. For example, did hitting your control total mean you had complied with business rules? GBP1180316/083

Dr Gupta highlighted the issue of plan vs actual activity. It was acknowledged that the plan may not have been wholly accurate due to the disconnect between GP referrals and actual attendances. This would be fixed in the following year's plan. GBP1180316/084

Dr Moore asked about the full year effect of 2015/16 schemes, the QIPP gap in 2016/17 and the work in hand to address this. Matthew Knight clarified the full year effect position with regard to 2015/16 schemes and said that the CCG was planning to hold formal workshops once a quarter with Heads of Service to address the remaining gap. There may need to be a mixture of non-recurrent and recurrent ways of addressing this. GBP1180316/085

Dr Williams noted that the CCG was not the lead for Kingston Hospital but the resources and risks involved were significant, and asked how this could be addressed in future. Matthew Knight said this was a difficult issue; there would be agreement on this year, possibly with mediation, but there were still issues with the revised baseline for 2016/17 which would also be subject to mediation. GBP1180316/086

12. Epsom Health and Care Integrated Business Case GBP1180316/087

Dr Hilary Floyd gave an overview of the Epsom Health and Care (EHC) approach. This was based on a number of factors: GBP1180316/088

- The need to address the needs of an elderly frail population
- Uncoordinated existence provision
- Pressures on primary care
- Lack of a proactive approach

There was a five year plan to address these issues which focused on preventing people going into care but if they do, getting them home as quickly as possible. GBP1180316/089

A three tier model was in place, focusing on the tier 3 cases initially as these had the highest and most complex needs, with long term conditions and needing more care at home. IN time the aim was to look across all three tiers to minimise the duration of high care needs. GBP1180316/090

The service implementation for next year focused on GP services, the community hub, and assessment, response and discharge. It was important to ensure more appropriate interventions and a greater focus on the more complex cases. GBP1180316/091

The CARRDS team would be a community team situated in secondary care, working at the front entrance to A&E, helping to free up beds and improve discharge. Length of stay should be significantly reduced if this works as intended, but there would be a better discharge team within the trust to support this. CADU had been running for several months as a multidisciplinary team that was working to get people home. GBP1180316/092

The business case reflected the above approach. There was an emphasis on integration and workforce, particularly rotating staff between hospital and the community. GBP1180316/093

There were three options in the business case with Option 2 (partial implementation) preferred. The implementation plan was now based on a July go live date. GBP1180316/094

Dr Evans noted that this was a business case and asked about projected savings and how these would be delivered, given that this only happened over time. She expressed some concern about the proximity of the model with secondary care. She also asked how quality would be monitored. GBP1180316/095

Dr Floyd said that the model was being kept under review particularly avoiding over-diagnosis. There was a focus on the community hub which was in place already. Thirza Sawtell (Programme Director, Epsom Health & Care) noted that the contract was outcomes based and that patient experience was a key part of this. City University had been commissioned to lead an evaluation of the work. It was however noted that sometimes it was difficult to demonstrate how changes had impacted e.g. on admissions. There was a discussion about which Key Performance Indicators (KPIs) needed to operate across all three localities. GBP1180316/096

James Blythe noted that the business case was notable as it was predicated on a contract model that involved suppliers working together, with the providers taking on the risk of non-delivery. It was likely that the final delivery would differ from that set out but that the risk would be contained within the whole system. GBP1180316/097

Cliff Bush welcomed the focus on the patient and commended the proposal. He felt that the acute trust should release the funding up front to address this. GBP1180316/098

Jonathan Perkins asked about governance and interaction with the partnership board. It did need everyone to sign up and asked if this was likely. Gill Edelman said the presentation was exciting but asked for external evaluation of all the projects involved. GBP1180316/099

James Blythe said that the business case did effectively reduce Epsom St Helier's income which they were prepared to do if it released costs. The governance was effectively a standard NHS contract for the alliance with the CCG which was legally binding. Thirza Atwell said that Surrey Downs was as advanced as the vanguard sites and was still pressing for evaluation monies from this national resource. GBP1180316/100

Ralph McCormack highlighted sign-off processes and the nature of the consortium arrangements which each partner was confident would be adopted. GBP1180316/101

Dr Evans asked for a continued focus on the quality of care for patients and not just the financial benefits. GBP1180316/102

Jacky Oliver said that with three different approaches, there was a need to ensure equity across the localities. GBP1180316/103

James Blythe noted that the Governing Body was being asked to sign off the IBS with the following there caveats: GBP1180316/104

- Assessment against most capable provider criteria and consideration of the appropriate procurement arrangements; this would provide assurance that the alliance met the necessary criteria as opposed to going down a competitive procurement route. GBP1180316/105
- Designing contractual arrangements that reflected the scale of the contract GBP1180316/106
- Conclusion of the contractual arrangements with the alliance GBP1180316/107

Antony Collins noted that the first year benefits were assured but asked about the subsequent years. James Blythe said that this would need to be addressed in-year to see if the positive case for change in year two needed to be reviewed. Matthew Knight said that the contractual position was only for a one year commitment. Antony Collins said this would require very high visibility of progress and James Blythe said this would be through the QIPP tracking arrangements. It was agreed this would also be monitored via the Finance and Performance Committee. GBP1180316/108

The Integrated Business Case was AGREED as set out above and with the caveats described by James Blythe. GBP1180316/109

13. Quality and Performance Report

Eileen Clark highlighted the following issues: GBP1180316/110

- Health Care Associated Infections (HCAIS) – still a high profile issue, with the CDfiff target being exceeded. There is more work to do on this in 2016/17. New guidance had just been published and there would be a rollover of targets. GBP1180316/111
- Cancer 62 day waits. There had been a dip in performance in January but there were signs this was picking up, and a national Care Quality Initiative (CQUIN) would be used to drive up performance. GBP1180316/112
- Providers – Eileen Clark highlighted the workforce issues in the hubs and the planned reviews of referrals. This was particularly significant in CSteve Hams Surrey. GBP1180316/113
- Epsom St Helier – still awaiting CQC reports. Two Never Events had been notified since the report was written including a dental case of wrong tooth extraction. GBP1180316/114
- The Mazars report issued following the Southern Health concerns would impact on Surrey and Borders Partnership Trust. The Clinical Quality Review Group would receive a full assessment against this next week. GBP1180316/115
- Training in primary care on the mental capacity act – 328 people had been trained and this had been well received, including the Continuing Health Care team of the CCG. An end of year report would come to the governing body. GBP1180316/116

Dr Sharpe asked about HCAIs and whether trusts would be fined for poor performance. Eileen Clark said that the main focus needed to be on community as this is where the majority of the concerns originated. GBP1180316/117

Cliff Bush highlighted Integrated Access to Psychological Therapies (IAPT) and asked what was happening with access. His feedback was that there were still issues. He did not believe patient experience was improving. Steve Hams said this had been discussed at Quality Committee and that he was satisfied that services were broadly good, but there would be a more detailed look at the range of providers and whether there was consistency in their approach. GBP1180316/118

Cliff Bush asked about Child and Adolescent Mental Health Services (CAMHS) and how the CCG was ensuring that the new contract was being delivered via Guildford and Waverley. Dr Moore said that there had been additional investment in key areas such as eating disorder and learning disability. She would be closely involved with the mobilisation board and would help to monitor improved outcomes. Cliff Bush asked that particular attention be given to young carers attending CAMHS Services. GBP1180316/119

Debbie Stubberfield asked the Governing Body to note that Sepsis was included as a CQUIN for 2016/17. GBP1180316/120

Ralph McCormack commended the emphasis on actions and tracking these in the report. GBP1180316/121

14. Risk Profile

Matthew Knight introduced this and highlighted the following key issues: GBP1180316/122

- There were 36 risks, 8 red, 22 amber and 6 green. GBP1180316/123
- The amber rating for SECAmb may need to be reviewed in light of recent events. GBP1180316/124
- He also noted the close focus on quality risks but that the Sustainability and Transformation Partnership (STP) would need more work to identify strategic risk. GBP1180316/125
- The new risk on IT migration was highlighted. GBP1180316/126
- Risk appetite needed to be considered as over half the risks were outside appetite. GBP1180316/127

Gill Edelman noted the workforce issues and dependence on key individuals. Jonathan Perkins said this had been discussed at the Remuneration and Nominations Committee that morning and there would be a focus on this at the May meeting with a review of succession planning. GBP1180316/128

Steve Hams asked that the use of the word “good” be reviewed in terms of its reference to controls. GBP1180316/129

15. SECAmb Performance Update

The update report was noted. Steve Hams highlighted Red 1 and 2 performance which was below national targets. GBP1180316/130

Commissioners across Kent Surrey and Sussex were withholding 2% of contract values for possibly three successive months. SECAmb had been asked to produce revised trajectories based on action plans. GBP1180316/131

Steve Hams said that the lead commissioner's role was now more significant and contract performance notices had been issued in a number of areas. On the 4th March commissioners had collectively written to express their concerns. GBP1180316/132

The recently published Deloitte report has resulted in the resignation of the Chair and the CEO going on long term leave. An interim was in place. Further reports were expected on the Red 3 case and the way use of defibrillators had been used to justify performance statistics. GBP1180316/133

The Deloitte report had highlighted some significant lapses in governance and leadership and the board's ability to provide robust challenge. GBP1180316/134

Cliff Bush thanked the CCG for sorting out patient transport during 2015. He had not had any complaints relating to Surrey Downs since the changes. He expressed concern about the length of time it had taken for the issues to emerge. He did not have confidence in the interim CEO of SECAmb and expressed concern about the suffering of patients. He was disappointed that the CCG had not addressed the issues despite him raising it in several previous meetings. He was still receiving anecdotal reports of significant lapses. GBP1180316/135

Ralph McCormack said he accepted the criticism. There were issues with the collaborative nature of the commissioning arrangements which meant that the CCG had tried to push on the issues within these when it should possibly have pushed harder. There was now a very different situation but SECAmb would not turn around quickly and it would take time and strong leadership to change the way it was working. Change would take place over months rather than weeks as whole scale change was needed. GBP1180316/136

Cliff Bush thanked Ralph McCormack for his response and said that he felt the CCG should exercise control as it had done with patient transport. Dr Fuller said that hosting and collaborative arrangements were under review and this made the work all the more important. Gill Edelman agreed and said the CCG needed more control over the levers of change where it was not lead commissioner GBP1180316/137

Debbie Stubberfield concurred and said the learning from this needed to be taken into the assurance framework but there also needed to be stronger confidence between the organisations. It was agreed that there should be a Root Cause Analysis into this, possibly conducted with other CCGs. GBP1180316/138

Action Steve Hams

It was agreed that Cliff Bush would be kept in touch on progress. GBP1180316/139

16. Sustainability and Transformation Plans

James Blythe introduced this. The planning guidance required all CCGs and providers to be part of an STP and Surrey Downs was aligned with Guildford and Waverley and North West Surrey to address sustainability issues across larger patches. Although Surrey Downs had more alignment to London it did have much in common with its partners. GBP1180316/140

The STP needed to address the following seven areas:: GBP1180316/141

- to articulate in comprehensive terms the current position of NHS-funded services in terms of quality, health outcomes and effectiveness GBP1180316/142
- to articulate the changing requirements for NHS-funded services over the coming five years GBP1180316/143
- to articulate the current aggregate financial position of NHS commissioners and providers within the system and the potential pressures arising over the coming five years in terms of affordability (for commissioners and the overall system) and sustainability (for providers) GBP1180316/144
- for a number of service areas, to articulate in a common framework, the current plans of the CCGs to address the identified quality, health outcomes and effectiveness gaps, describing a system-wide response which is strategically coherent but locally responsive and flexible GBP1180316/145
- for service areas at the appropriate level of planning, to describe options for addressing identified quality, health outcomes and effectiveness gaps GBP1180316/146
- to demonstrate the contribution of local organisation and STP-wide plans to ensuring that NHS-funded delivery remains viable within the projected financial envelope GBP1180316/147
- to articulate how enabling drivers can support delivery of the outlined plans GBP1180316/148

CCGs need to work with other partners to address gaps across larger patches. The focus would be on integration to address the needs of an elderly population, achieving higher standards for acute services, and delivering the 5YFV. There were particular issues for standards around cancers and the critical mass of services on individual hospital sites. GBP1180316/149

"Surrey Hearltands" hospitals were small and would struggle to meet these standards, particularly as it was a net exporter of patients to London for specialist care. It was also chacterised by pressure on primary care and the primary care workforce. GBP1180316/150

"At scale" planning arrangements needed the STP to deliver in larger areas. GBP1180316/151

James Blythe then highlighted the timescales involved: GBP1180316/152

Phase 1 – to 15th April: GBP1180316/153

- Establish key strategic challenges
- Establish governance, leadership and key timescales
- Establish workstreams and areas to be covered in STP
- Identify the current quality, outcomes and effectiveness of services in the STP footprint
- Demographic and finance modelling

Phase 2 – to May 2016: GBP1180316/154

- Synthesise information from existing plans including content, timescales, expected outcomes
- Facilitated workshops for workstreams
- Capture outputs of workstreams and assess impact on strategic challenges

Phase 3 to end June 2016: GBP1180316/155

- Outputs of the workstreams will be aggregated
- The final narrative will be prepared and finalised

James Blythe acknowledged that this was a very demanding timescale and that the process would realistically identify gaps and set out plans for the future. In terms of governance there would be a transformation board with David McNulty (Surrey County Council) as chair and Julia Ross as Senior responsible Officer. James Blythe would be spending significant time on the operational aspects of this. GBP1180316/156

Dr Evans highlighted that Kingston sat outside the footprint and asked how this would be managed. James Blythe said that all the modelling would capture surrounding areas and that there would be liaison across STPs. GBP1180316/157

Peter Collis asked about the governance of decision making. James Blythe said that this was difficult as individual boards would not have the time to sign this off. The CCGs would have a committee in common but the provider position was more complex as the transformation board could not be given delegated responsibility. Peter Collis then asked about how the different plans would knit together, e.g. FRP, STP and Operating Plan. Matthew Knight said he would be the Executive lead for STP finance and would work to ensure consistent common financial data sets to provide for five year planning. The CCG was also familiar with the SW London work. GBP1180316/158

Antony Collins noted that the diversion of senior resource was going to be challenging given that the CCG needed to find £5m of additional QIPP, although James Blythe would still be active within Surrey Downs. GBP1180316/159

Dr Williams said that he welcomed the brief of the STPs and said that despite the boundary complexities everyone should be working to the same end and not impact negatively on each other. James Blythe said that all STP leaders were committed to keep engaging with clinicians and not lose momentum. GBP1180316/160

Jacky Oliver said that this would be confusing for the public and it was essential to try and convey these issues effectively. James Blythe acknowledged this but felt the STP needed to do more work before engaging. GBP1180316/161

Dr Sharpe asked about the South West London work and Ralph McCormack said there was defined engagement with South West London, predominantly about the Epsom site. Surrey Downs was clearly in Surrey Heartlands for STP work. GBP1180316/162

Gill Edelman asked about relationships with London teaching hospitals and what the thinking was. There were clinical networks and Surrey Downs was the Royal Marsden's largest commissioner. This would need to be reviewed for the future to see if there were other options for the footprint. GBP1180316/163

Cliff Bush felt there was an opportunity to reduce patient flows out of the area but the patient did need appropriate transport arrangements. GBP1180316/164

17. Operating Plan 2016/17

James Blythe introduced this and reminded Governing Body members of the process to date. There had been feedback from NHSE on this but there was a great deal of detail behind the main document and governance around the programmes. GBP1180316/165

18. Delegation of authority to the Audit Committee to approve the Annual Report and Accounts

Matthew Knight introduced this and summarised the proposals. The delegation to the Audit Committee was normal practice and this was the approach used over the last two years, GBP1180316/166

Delegation to the Audit Committee for final sign off of the annual report and accounts was AGREED. GBP1180316/167

19. Annual Health and Safety Statement

Matthew Knight noted that there had been regular staff forums and more training on mandatory training and induction. The statement was NOTED. GBP1180316/168

20. Governing Body Seminar Report

Dr Fuller noted the main issues that were discussed: Organisational Development, Operating Plan, and Right Care GBP1180316/169

21. Audit Committee Report

Peter Collis highlighted that the CCG had moved from regional to local assurance and was suggesting this should be included in the annual report as a very clear sign of progress. GBP1180316/170

22. Finance and Performance Committee Report

The March meeting was next week. Jonathan Perkins noted the key issues were in the Finance Report and the Quality and Performance Report. He would be speaking to Debbie Stubberfield about overlaps with the Quality Committee. GBP1180316/171

23. Quality Committee Report GBP1180316/172

Debbie Stubberfield highlighted the issues discussed at the last meeting and specifically the need to address engagement GBP1180316/173

24. Remuneration and Nominations Committee Report GBP1180316/174

Jonathan Perkins reported that today's meeting had signed off on new structures and covered induction. There had been a significant discussion about risk in relation to the workforce and succession planning. The work on values was seen as a key initiative and Governing Body members were encouraged to do the survey monkey as requested. GBP1180316/175

25. Committees in Common – Framework Approach GBP1180316/176

Dr Fuller said that this was required as part of the Committee In Common work pending constitutional approval. GBP1180316/177

The CIC Framework approach was AGREED. GBP1180316/178

26. Any other urgent business GBP1180316/179

There was no other business GBP1180316/180

27. Date of next meeting GBP1180316/181

The next full meeting of the Governing Body in Public is on 27th May 2016 at 1.00 pm at Leatherhead Leisure Centre GBP1180316/182