NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
27th May 2016
Leatherhead Leisure Centre

Minutes

Members present:

Dr Claire Fuller, Clinical Chair

Ralph McCormack, Interim Chief Officer
Matthew Knight, Chief Finance Officer
James Blythe, Director of Strategy and Commissioning*
Steve Hams, Interim Director of Clinical Performance and Delivery*

Dr Russell Hills, GP Member
Dr Hannah Graham, GP Member
Dr Andrew Sharpe, GP Member
Dr Tim Powell, GP Member

Peter Collis, Lay Member for Governance
Jonathan Perkins, Lay Member for Governance
Gill Edelman, Lay Member for Patient and Public Engagement
Jacky Oliver, Lay Member for Patient and Public Engagement

Dr Tony Kelly, Secondary Care Doctor
Debbie Stubberfield, Registered Nurse

* Non voting

Others in attendance:

Antony Collins, Interim Director of Turnaround
Justin Dix, Governing Body Secretary

Chair: Dr Claire Fuller

Minute taker: Justin Dix

Meeting started: 1.30

Meeting finished: 3.30

1. Welcome and introductions

Dr Fuller welcomed everyone to the first public meeting of the Governing Body since the changes made to the constitution at the end of 2015/16. Those present introduced themselves. GBP1270516/001

2. Apologies for absence

Apologies had been received from Eileen Clark, Chief Nurse; Dr Louise Keene, GP member. GBP1270516/002

3. Quorum

The meeting was declared quorate. GBP1270516/003

4. Membership of the Governing Body GBP1270516/004

The new membership of the Governing Body as set out in the papers was noted. GBP1270516/005

5. Co-opting of the Chief Nurse

Ralph McCormack noted that since the changes to Governance had been proposed, there had been a reconsideration of the role of the Chief Nurse and it was felt important for her to continue to be on the Governing Body. He therefore proposed that she be co-opted on to the Governing Body with immediate effect and that this should be regularised in the autumn with a further request to NHS England to update the constitution. GBP1270516/006

The co-opting of the Chief Nurse on to the Governing Body was AGREED. GBP1270516/007

6. Register of interests

The register of members' interests were noted. Dr Tim Powell added "Salaried GP at Esher Green" to his entry. GBP1270516/008

It was noted that the register of interests were being streamlined across the various committees. GBP1270516/009

Dr Fuller and Jackie Oliver noted a minor conflict under the learning disabilities agenda item. GBP1270516/010

7. Questions from the public

It was noted that no questions had been received in advance of the meeting. Dr Fuller asked if any members of the public present had any questions for the Governing Body that could be answered under the appropriate agenda items. GBP1270516/011

There were no questions from the public. Dr Fuller offered to deal with any queries arising at the end of the meeting.

8. Minutes of the last meeting (for accuracy)

These were agreed as a correct record subject to the following amendments: GBP1270516/012

- Dr Hills was not at the meeting.
- Antony Collins was in attendance
- 096 – there was an inconsistency in the spelling of Thirza Sawtell's name.

9. Matters arising and action logs

GBP1180316/138 – SECAmb root cause analysis. Steve Hams confirmed this would be completed as part of the action plan and performance review of SECAmb and may therefore take some time. It was agreed this would be deferred until a meeting in the autumn. GBP1270516/013

Action Steve Hams

GBP1180316/074 – End of Life Care Strategy Update. On today's agenda. Agreed for closure. GBP1270516/014

GBP1180316/060 – Read codes for Integrated Access to Psychological Therapies (IAPT). Dr Sharpe said that there was a new code within EMIS and it was agreed this (code 8Hh4) would be circulated via "start the week". GBP1270516/015

Action Michelle Bailey

GBP1180316/057 – Information to new mothers on sepsis. Steve Hams confirmed that all providers were doing work on the sepsis issue. Dr Kelly said that a new tool for mothers (the SAM tool) was being piloted via the maternity red book for providers within the Academic Health Science Network. Action can be closed. GBP1270516/016

GBP1290116/084 - Feedback on changes to management of CAMHS. It was noted that this had been updated via the clinical cabinet and exceptions only would be reported to the Governing Body. Action can be closed. GBP1270516/017

GBP1290116/101 – Sound evidence base for quality relating to vision and values. This would be fed into the Governing Body development day. Action can be closed. GBP1270516/018

GBP1290116/126 – update on stop smoking service. Dr Hills reported that performance had plateaued in line with national trends but a new provider had gone live in April. A lot of the service would be delivered via primary care. A formal report would be available at the end of Quarter 1 for the finance and performance committee to consider. GBP1270516/019

It was agreed that there needed to be more information in start the week on how to refer into the service, highlighting this as a lead item in the "important" section. Existing action can be closed. GBP1270516/020

Action Ruth Hutchinson

10. Chief Officer's Report

Ralph McCormack spoke to his written report. GBP1270516/021

Governance

The benefits from the amended system of Governance were noted. Ralph McCormack particularly highlighted that the clinical cabinet had strengthened the work of the CCG through improved clinical leadership. GBP1270516/022

Risk Management

Ralph McCormack explained how the CCG was in the middle of reviewing its approach to risk and that in future the Governing Body would be sighted on corporate risks, with the Executive Management Team (EMT) and senior managers dealing with operational risk, reporting on this to the relevant committees. The finance risks had been through a recent EMT and there had been an in-depth review and better focus than had previously been the case. GBP1270516/023

Community Hospitals

Consultation had completed on the 5th May and there had been numerous representations from the public. A recommendation would be received at the 5th July Governing Body. GBP1270516/024

Council of members

Ralph McCormack noted that GPs were attending and supporting the Council of Members despite this being at the end of a busy clinical day and he felt that engagement was much better. GBP1270516/025

Leatherhead X-Ray

Ralph McCormack thanked the league of friends at leatherhead hospital for their donation towards new equipment, which would improve access and patient experience of the X-Ray service. GBP1270516/026

360 Degree feedback

The CCG was subject to a national requirement to conduct a local stakeholder survey (stakeholders including constituent practices). This had been very positive and the survey indicated extensive support to the financial recovery agenda and good scores when benchmarked against other organisations. The CCG did however need to communicate that it was fully committed to meeting quality standards, despite the financial challenges it was facing. A link to the report could be provided on request. GBP1270516/027

Nurses Day

Ralph McCormack said this had been very positive, including the simbulance being on site and demonstrating the clinical issues involved. GBP1270516/028

Clinical Leadership and Heads of Service Development

Ralph McCormack said that the level of interest from clinicians had been overwhelming and an additional cohort had been added. The heads of Service programme also recognises the importance of developing the senior management of the CCG. GBP1270516/029

Health and Wellbeing Board

The feedback report from the Health and Wellbeing Board was noted. GBP1270516/030

Questions

Debbie Stubberfield asked about the 360 Degree and said there needed to be more internal discussion in relation to "what does good look like". Dr Fuller noted that work would be done with localities on this by Steve Hams. GBP1270516/031

Dr Hills asked about the rollout of Datix mentioned under the written report on risk management. Justin Dix said that this was a new system that would enable the CCG to manage risks, incidents, complaints and Freedom of Information requests. He and the implementation manager had recently visited Oxfordshire CCG and had been impressed with how they were using it to get feedback from practices on a wide range of areas where GPs were concerned about supplier quality. This information was fed into formal monthly clinical quality reviews and into contract review meetings. GBP1270516/032

Dr Sharpe said that he had been given an overview of the system that morning. He said the feedback form proposed was very simple and could give the CCG a very powerful tool for getting reports back from member practices. GBP1270516/033

Gill Edelman said that the work on the Governance review had been very positive but she asked about the scheme of delegation as this was in her view a piece of work that needed to be completed. Ralph McCormack said there were some draft proposals in place which would come to the next seminar for discussion and be signed off at the July meeting. GBP1270516/034

Action Ralph McCormack

11. Finance Report

Matthew Knight spoke to the written report. GBP1270516/035

It was noted this was the outturn report for 2015-16 and month 1 figures for 2016/17 were not available yet. The CCG had met its control total as agreed with NHS England. The acute overspends had been offset by savings elsewhere. GBP1270516/036

Epsom, Kingston and SASH had all been over budget, as had some smaller providers. Contingencies had been used to meet some of these pressures. GBP1270516/037

The activity had been held in control and returned to levels of the previous year. QIPP savings had been reduced in-year as part of the overall approach to mitigation. The overall result was positive and gave the CCG a good basis for 2016/17 and the financial recovery plan for that year. GBP1270516/038

The in-year deficit of £18m was expected to be halved in 2016/17 but the QIPP challenge for the year was challenging. Although there was a high level of confidence in achieving most of this, there was a gap of £3.6m which was being actively worked on. GBP1270516/039

The Epsom & St Helier contract for 2016/17 (where we are the main commissioner) had been signed. Other contracts for 2016/17 (where we are an associate commissioner) were in the process of being signed off. GBP1270516/040

The Annual Report had been submitted in line with the deadline without any Value For Money (VFM) qualification. GBP1270516/041

Gill Edelman asked about the assumptions around non-recurrent savings. Matthew Knight said that savings in areas such as IAPT, property, and smaller contracts had all been reviewed. The risk was effectively spread across a range of areas. GBP1270516/042

Dr Hills said that since he had joined the CCG a year ago there had been a developing sense of confidence and this had been evidenced at the “fill the gap” workshop the previous day. GBP1270516/043

Dr Graham asked what had topics been addressed at the workshop. Antony Collins said that specific areas had been identified as follows: GBP1270516/044

- Respiratory
- CVD
- Neurology
- Genitourinary
- Diabetes
- Direct access pathology

Programmes would be in place for these by the end of June as agreed with NHS England (NHSE).

12. Financial Recovery Plan

Antony Collins spoke to the Financial Recovery Plan (FRP) in the Governing Body papers. The plan was for approval and he outlined the governance and scrutiny processes to date. This had been submitted to NHSE by the 20th May as required. GBP1270516/045

Dr Powell said that he had reviewed the plan in detail and whilst it was positive overall he queried whether it was healthy to make assumptions around underspends such as those from the IAPT programme. GBP1270516/046

Dr Hills noted that GPs could easily become overloaded with new pathway developments and changes and we needed to find ways of engagement that helped them. James Blythe agreed and said that new pathways should be tested to ensure they were simpler and could where appropriate be supported by the RSS to take away some of the administrative burden. GBP1270516/047

Jacky Oliver asked about how community hospitals related to this. James Blythe said that the community hospital review was not driven by the FRP and the aim was to get the right models of care in place to support integration rather than saving money. GBP1270516/048

Antony Collins noted that the FRP had been a collective effort and was in his view a high quality plan and was stronger for being developed and owned by the organisation with little outside input. Dr Graham said that the report was readable and accessible from a clinical perspective. GBP1270516/049

James Blythe noted that the Right Care programme, which is a national programme looking at unwarranted variations in health care to maximise the performance of clinical pathways, was part of the local work as the CCG was a Wave 1 participant. The CCG was seeking to take the data from Right Care to support its QIPP aspirations and general commissioning. Musculoskeletal (MSK), Cardio Vascular Disease (CVD) and complex patients were the focus areas. Dr Bruce Pollington from Right Care was the CCG's delivery partner for this work. GBP1270516/050

James Blythe explained how patients in these areas could be better supported by taking a deep dive into the care pathways, using Right Care data packs. The CVD data pack had been issued and was very interesting and would support the local work. Dr Fuller noted that peer benchmarking was an important aspect of this work, and extended down to practice level demographics. GBP1270516/051

Dr Hills noted that multiple out patients appointments was a particular issue for older patients as there were few options for a single point of referral. Dr Fuller agreed and said that there was a need to return to generalists who could co-ordinate care. James Blythe gave an example from eye care where patients were reviewed more frequently at specialist centres than was necessary. Dr Graham noted that to some extent there was a psychological support need for some patients. GBP1270516/052

Dr Kelly said that there needed to be a focus on best practice and not a simple focus on statistical variation. Dr Fuller and Debbie Stubberfield agreed and said that this was a focus of the Surrey Heartlands academy work. GBP1270516/053

Dr Sharpe said that some of the problem was maintaining co-ordination of care once the patient entered the acute system. James Blythe agreed and said that models such as CADU were aimed at appropriate shared care rather than inappropriate hand-offs between services. GBP1270516/054

Dr Kelly noted that some portals such as “patient knows best” enabled professionals to work with patients to co-ordinate care. It was agreed to follow this up in conjunction with other care planning work already being undertaken, although this was complex. GBP1270516/055

Gill Edelman noted that part of care co-ordination might be to reduce complexity of interventions as well as supporting access to appropriate services. This was acknowledged and examples from Brighton were highlighted GBP1270516/056

The Financial Recovery Plan was AGREED. GBP1270516/057

13. Quality and Performance Report

Steve Hams introduced this. GBP1270516/058

The Epsom St Helier CQC report had been published today and the overall outcome was “requires improvement”. There was some good practice noted i.e. diagnostic, end of life care and elective orthopaedics which were rated as “good”. GBP1270516/059

The quality summit to look at the report would be on Wednesday of next week but a lot of work had already been done since the time of the inspection. GBP1270516/060

Surrey and Borders had been subject to a coroners notice following a death on the Epsom and St Helier NHS Trust Epsom site. The Mazars report had also been a focus of work within the trust. GBP1270516/061

Steve Hams said that all providers had been asked to give an account of their response to the Morecambe Bay report on maternity services. The quality committee was seeking additional assurance where appropriate. GBP1270516/062

SECAmb performance had continued to deteriorate and this was clearly a problem. The following points were noted: GBP1270516/063

- The commissioners had received a recovery plan at the beginning of May but this was not felt to be sufficient and a revised plan was due by the end of May. GBP1270516/064
- Efforts were being made to support handover delays at acute trusts. GBP1270516/065
- A CQC inspection took place in early May and a briefing report would be available to commissioners in early June, ahead of the formal publication GBP1270516/066
- The aim was for SECAmb to meet targets over the next 6 to 9 months. Every effort was being made to support the trust to achieve this through concerted commissioner, regulatory and provider collaboration. GBP1270516/067

For the CCG's commissioning (outcome indicators) performance, C.Diff. was slightly over expected levels. IAPT was very close to required targets but still under the agreed performance trajectories. A&E performance and dementia diagnosis were however below expectations. GBP1270516/068

Steve Hams noted that the CCG outcomes indicators for 2015/16 would be reviewed by the clinical cabinet next month and the Quality Committee in July 2016. GBP1270516/069

Debbie Stubberfield said that there were some residual risks around workforce across all providers, and this was a common theme. C.Diff. and infection prevention and control needed a continual focus. GBP1270516/070

Dr Kelly said that information was improving and there was a good basis for the delivery of the quality strategy over the next 12 months. GBP1270516/071

Gill Edelman asked if there was scope for more work with the local public through engagement, for instance in the area of hand hygiene and IAPT self-referral. James Blythe said that with regards to the latter there was work taking place regarding the demographics of IAPT to see which groups were not referring in. Working aged men seemed to be a particular group. It was also noted that General Practice was not the only area that needed better information. GBP1270516/072

Dr Hills noted that there was a concern amongst some GPs about the potential stigma of dementia registers. GBP1270516/073

Jonathan Perkins highlighted Page 10 of the Quality and Performance report and the poor "open and honest reporting" performance at Epsom. Steve Hams said it was expected that this would improve and the CCG was seeking to encourage open behaviour. GBP1270516/074

Dr Graham said that one of the biggest barriers to IAPT access was daytime service provision and asked whether evening provision was available. James Blythe said that he felt this was probably only web based at the moment. It was agreed to have an update on this at the next Governing Body. GBP1270516/075

Action Steve Hams

Dr Sharpe said that IAPT service quality was good and his practice was actively marketing this service. James Blythe said that by 2020 the trajectory was for 25% of the target population to have access which bought a cost pressure although Dr Fuller noted that it also produced financial benefits in other areas. Matthew Knight noted that the CCG had probably picked up some unmet demand in the last year. GBP1270516/076

Dr Kelly asked about the Health Help Now App and suggested this could support self-referral. It was agreed that Help Health Now would be reviewed by the communications team. GBP1270516/077

Action Michelle Bailey

14. Dorking Locality and its Partners

Dr Gupta attended to update the CCG on work in the Dorking Locality. GBP1270516/078

The CMT and Community Hub now had community matrons after an 18 month gap employed by CSH Surrey, and there had been very positive feedback in all areas including care management and prescribing. GBP1270516/079

The Community Medical Team (CMT) had been in touch with the CCG and a business case was in development, with recruitment of doctors in June and Go Live in August. The model was similar to the East Elmbridge one which had shown considerable benefit. GBP1270516/080

Ranmore ward feedback was positive, with consistent medical input. There was agreement to move to Phase 2 with more allocated doctor time to support step-up referrals and the handling of complex cases. Access to IT was an issue and paper records were still being used pending rollout of new IT. There were some issues with compatibility between Dorking and Epsom computer systems given that a number of Epsom patients were supported. GBP1270516/081

Dorking Healthcare had new cardiology and respiratory services which had improved access and GP development in these areas. Practice nurses were being targeted for support with regards to respiratory care, which was consistent with the Right Care approach. There was close working with community matrons and heart failure nurses, and much more integrated care as a result. GBP1270516/082

The locality had had two meetings since April and GPs supported the new local governance structures. It was hoped to develop dashboards that highlighted key quality areas and to integrate closely with the work of the CCG's clinical cabinet. The aim was to ensure that there were local solutions rather than one size fits all approaches. GBP1270516/083

Antony Collins asked about the proportion of Epsom patients using Ranmore beds and it was felt this was about a third of the total. Antony Collins said this did constitute a lost opportunity in terms of the Epsom programme. James Blythe said this had been identified in the Community Hospital Review. There was a mismatch between the size of the localities and the beds they could offer. Inevitably a large proportion of Dorking step-up beds would be occupied by Epsom patients from the East of the Epsom patch. GBP1270516/084

Peter Collis said he was heartened by the feedback but noted that it was a very rural area. He asked Dr Gupta how comfortable he was with developments in access as a result of this. Dr Gupta said this did impact e.g. on home visit times but was manageable if the service was well staffed. The high numbers of complex and chronic patients needed to be looked at from a generalist rather than a specialist perspective. GBP1270516/085

Dr Hills said that there was a need for equity in the system although it would never be possible to keep services in locality given the critical masses involved. GBP1270516/086

Steve Hams noted the Multi-Disciplinary Team approach and commended this. He asked how patients had been involved in designing the approach. Dr Gupta said that patient representatives had been involved initially but there had been delays in implementing the originally designed approach. GBP1270516/087

It was queried whether patient experience was being measured and Dr Gupta said CSH Surrey would be doing this shortly as part of routine service delivery. Dr Fuller said this was being discussed in the wider patch. GBP1270516/088

Dr Fuller said that new models of care needed monitoring for their impact and Steve Hams said they were but this needed to be reviewed to make sure it was robust. GBP1270516/089

Dr Hills noted the value of respiratory nurses sharing their practice. Dr Fuller said that education alongside change was a particular feature of the Dorking work and very positive. GBP1270516/090

15. Quality Strategy

Steve Hams introduced this. The new Quality Strategy had been updated to take into account the CCG improvement assessment framework and five year forward view and associated delivery plans. The strategy did therefore reflect current understanding but would need to be adapted over time. The action plan would be supported by clinical directors. GBP1270516/091

It was noted that the quality committee in seminar and formal session, the clinical cabinet, locality chairs and the EMT had all reviewed the strategy. GBP1270516/092

Debbie Stubberfield thanked Steve Hams and colleagues for their work on this, and noted that a lot of detailed comment had been involved which had needed thoughtful incorporation. The new Governing Body needed to feel comfortable with the strategy and its future development. The measurement of improvement and having assurance – particularly where the CCG was not lead commissioner – were critical. GBP1270516/093

A grammatical error was noted on the top of Page 7 – this would be amended. GBP1270516/094

Jacky Oliver said the Quality Committee was now functioning very well. GBP1270516/095

Jonathan Perkins commended the table at the back of the document and this would help monitoring over time, particularly feedback in six months' time as highlighted. Dr Kelly reminded everyone that this was as much a framework as a strategy and needed to be a live document. He gave the example of how antibiotic improvement could be achieved on the back of this approach. GBP1270516/096

Debbie Stubberfield said there needed to be a clear focus on what difference would result for patients from this. The need to keep the document updated was very important. GBP1270516/097

The Quality Strategy was AGREED. GBP1270516/098

16. End of Life Care Update

James Blythe noted that the Governing Body needed to be clear about how a strategy was translated into tangible actions, particularly around integration of care. In addition objectives needed to be consistent and not conflict. GBP1270516/099

There was a need to continue to communicate about practical solutions and he gave the example of care planning. The use of IT systems was a further consideration and Dr Laws and Dr Sharpe had worked closely on this. The CCG did have the resources to educate clinicians on new approaches to care planning but the work would throw up unmet need and highlight the importance of the third sector. GBP1270516/100

James Blythe said that the focus of this was not in the main about additional resource but about focus and effort. The Governing Body needed to ensure that there was tangible delivery from this work. Dr Fuller concurred and said that patients needed to feel that there was a single approach to meeting their care needs. GBP1270516/101

Dr Sharpe said that there was a pan Surrey shared care record workstream and software enhancements to EMIS based on the Oxford model. He noted that this might require PACE to be slowed whilst this work was taken forward. James Blythe said that the CCG would be guided by clinical guidance but that there needed to be a balance between delivering something now or later in the future. Matthew Knight highlighted the capital funding issues behind the shared care record in September which would be critical. GBP1270516/102

Dr Kelly suggested that there should be a risk assessment of the two different approaches. It was agreed that this would be led by James Blythe's team for feedback in a month's time. GBP1270516/103

Action James Blythe

Debbie Stubberfield said this update was very helpful. She emphasised the need for staff to be released to support this. James Blythe said the work sat with the same service manager who was involved with IAPT and dementia and the key now was moving to implementation. GBP1270516/104

Yvonne Rees commented on care planning and said the key was not having too many approaches running in parallel. It was noted that SCC was involved in the Surrey wide care record work and that there were links to community safety issues. GBP1270516/105

Jonathan Perkins thanked James Blythe's team for the update and said that there now needed to be some reflection on how this (and any delays) might impact on elderly patients. There was a close synergy with the Sustainability and Transformation Plan (STP) work. GBP1270516/106

James Blythe said that the organisation's new structure supported the focus on specific areas but governance of strategies needed to be as robust as that being used for the FRP, with a Programme Management Office (PMO) or similar approach underpinning the actions and their delivery. It was noted that the PMO was heavily committed to the FRP and that the EMT might need to hold the stewardship of strategies and their delivery. Antony Collins concurred with this view. It was therefore agreed to remit this to EMT for further discussion. GBP1270516/107

Action Ralph McCormack

The work on care planning would come back to the Governing Body again following discussion at EMT. GBP1270516/108

Action Ralph McCormack

17. Surrey Heartlands Sustainability and Transformation Plan

James Blythe introduced this. The Committee in Common (CIC) had to be seen in the context of the overall work on the STP. There had been several well attended workshops on this, with rapid engagement on key issues such demography, ageing populations, and capacity constraints around funding and workforce. Variations in models of care were significant and not always easy to explain. The 45-64 year old population increasingly showed a prevalence of long term conditions. GBP1270516/109

A key issue was to consider the scale of the opportunity against the scale of the challenge. GBP1270516/110

In terms of deadlines, the CCG's were now expected to submit a draft document in June but there was not a requirement for a committee in common in line with deadline. The formal approved document underpinned by shared governance such as the CIC would be later in the year. This would also allow more time for patient and public engagement. GBP1270516/111

Dr Fuller asked if this meant the terms of reference did need approving today. James Blythe confirmed they did but might need amendment at a later stage. GBP1270516/112

Factual issues in the TORs were noted as follows: GBP1270516/113

- Page 1 – Epsom not Epsom St Helier
- Page 5 – the convenor is not Peter Collis but Jonathan Perkins
- Membership

Justin Dix would amend the documents. GBP1270516/114

Action Justin Dix

Jonathan Perkins said that the main terms of reference had been approved by the other two CCGs and we should sign these off with the expectation of modifications over time. GBP1270516/115

Gill Edelman asked about how delegated authority would work in practice. Ralph McCormack said that there were a number of individual statutory bodies in the Surrey Heartlands transformation board. Below the organisational level there was engagement with clinicians and patients across the patch. The other bodies would need to take the documents to their individual boards but the CCGs could use this mechanism to reach a shared view. The CIC approach had been used in other areas in the last year. GBP1270516/116

Ralph McCormack advised that the CCG should approve the document with the caveat around Epsom's position. GBP1270516/117

Jacky Oliver asked that the need for Patient and Public Engagement was emphasised in any discussion, in terms of citizen engagement. GBP1270516/118

The Surrey Heartlands Committee In Common Terms of Reference were AGREED. GBP1270516/119

18. Surrey Learning Disability Plan

Dr Fuller commended this strategy to the Governing Body particularly the need to join up with children's planning and address health inequalities. This work was now led by Guildford and Waverley CCG rather than NE Hants and Farnham CCG. GBP1270516/120

The Learning Disability strategy was NOTED GBP1270516/121

19. Organisational Development Strategy

Ralph McCormack introduced this. This was a central part of transforming both the CCG and the system within which it operated. Objectives and priorities needed to be designed around corporate vision and values, which was work that would take place in late June and early July. GBP1270516/122

Transformation was the critical business of the CCG and was not negotiable, and therefore OD was essential. It was aligned to the FRP and significant QIPP expectations over the next two years. It was imperative to maintain the momentum of this work. There needed to be a clear methodology for keeping strategies and plans live. GBP1270516/123

There was an aim of improving the culture in the organisation, encouraging ideas and constructive criticism. A communication plan would support the rollout of this, in a way that was meaningful and accessible. GBP1270516/124

Dr Hills expressed some concern about the lack of commitment to equality and diversity and this was acknowledged and would be incorporated. GBP1270516/125

Action Dr Hills

Dr Kelly recommended the need to improve the capability around quality improvement, and cited NHS improvements work on this which would be published in October. This was welcomed. GBP1270516/126

The associated Action Plan which was an appendix to the main strategy would be circulated to Governing Body members. GBP1270516/127

Action Justin Dix

The Organisational Development strategy was AGREED subject to the above amendments. GBP1270516/128

20. Clinical Policies

Dr Fuller introduced this. The policies were a collaborative effort across all the CCGs and the changes were not largely material in respect of TNRF 1 and 2. These policies were already in use under Chairman's action but now needed Governing Body endorsement. GBP1270516/129

ACA assessments were queried. "Now" should be amended to "Not". The statement "not routinely funded by the NHS" was incorrect and should read "not routinely funded by CCGs". With this caveat the policies were AGREED. GBP1270516/130

The assisted conception policy per se was not included in the papers and would therefore be circulated. The changes were as the cover sheet. The policy would be signed off under chairman's action unless there were critical issues. Governing Body members to respond by 10th June. GBP1270516/131

Action Dr Fuller

21. External Audit procurement arrangements

Matthew Knight introduced this item. GBP1270516/132

It was noted that the CCG was now expected to appoint its own auditors as a result of legislation enacted in 2015. Formerly this was done by the Audit Commission. GBP1270516/133

There was a need to agree an audit panel to undertake this work. It was also proposed to do this work with other CCGs. Originally all Surrey CCGs were included in this but two CCGs have dropped out to go with their STP partners. GBP1270516/134

Matthew Knight said that as Exec lead he was proposing a single decision appointing one audit firm, which he was comfortable with as the range of providers was limited. GBP1270516/135

The Governing Body: GBP1270516/136

- AGREED that the audit committee should act as the audit panel for the CCG
- AGREED that the CCG should work with other CCGs through a committee in common approach with membership compromising Dr Sharpe, Peter Collis and Matthew Knight

22. Meetings and committee reports

Dr Fuller said that the reports from the Governing Body committees and other relevant meetings were being incorporated under a single agenda item to give better insight into the links between them and a stronger approach to integrated governance. GBP1270516/137

<u>Audit Committee</u> GBP1270516/138

Peter Collis updated on the work of the Audit Committee. GBP1270516/139

The key point to note was that there had been a meeting on the 20th May to sign off the Annual Report and accounts. He felt this had been a very good process with a very good outcome, and internal and external audit had given very good feedback. He commended Suzi Shettle, Justin Dix, and Matthew Knight and the Finance Team for all their hard work. GBP1270516/140

The Governing Body NOTED the verbal update and NOTED the final minutes of the meeting of the Audit Committee held on the 26th February. GBP1270516/141

<u>Quality Committee</u> GBP1270516/142

Debbie Stubberfield updated on the work of the Quality Committee as per the paper. GBP1270516/143

Jacky Oliver noted the progress on a committee for a Patient Advisory Network with Surrey County Council. This and the more general issue of patient engagement would be referred to EMT for discussion about the way forward. GBP1270516/144

Action Ralph McCormack

The Governing Body NOTED the verbal update on the work of the Quality Committee and NOTED the final minutes of the meeting held on the 1st March. GBP1270516/145

<u>Finance and Performance Committee</u> GBP1270516/146

Jonathan Perkins updated on the work of the Finance and Performance Committee. GBP1270516/147

Jonathan Perkins noted there had been a very helpful discussion about the work of the STP and the impact that might have on local contracting arrangements. The need to maintain operational momentum locally whilst engaging with the STP at the same time was critical. GBP1270516/148

There had been a strong focus on QIPP and an update on the Epsom integration was expected at the next meeting. GBP1270516/149

SECAmb had been discussed in detail and the new risk approach was also noted. GBP1270516/150

The Governing Body NOTED the verbal update on the work of the Finance and Performance Committee. GBP1270516/151

<u>Remuneration and Nominations committee</u> GBP1270516/152

Jonathan Perkins updated on the work of the Remuneration and Nominations Committee. There had been a further meeting this morning and the following points were noted. GBP1270516/153

- There had been a mistake in the Terms of reference which omitted the GP member and this would need updating. GBP1270516/154
- The Governing Body development work was discussed and would be supported by an external facilitator. GBP1270516/155
- Succession planning had been discussed in detail and was a significant issue for the committee, which would closely monitor it. GBP1270516/156
- HR performance had been reviewed and particular issues included absenteeism related to stress, which was being looked at. GBP1270516/157

Two policies had been agreed: GBP1270516/158

- Learning and Development
- Appraisal

The Governing Body NOTED the verbal update from the Remuneration and Nominations Committee. GBP1270516/159

<u>Clinical Cabinet</u> GBP1270516/160

Dr Fuller updated on the work of the Clinical Cabinet. GBP1270516/161

The GP forward view was a significant issue for GPs and this would relate to the CCG primary care strategy which would be finalised in the autumn. GBP1270516/162

The Governing Body NOTED the verbal update on the work of the Clinical Cabinet. GBP1270516/163

23. Any other urgent business

Bob Mackinson, a member of the public, highlighted the significance of the Epsom St Helier CQC report which had just been published. GBP1270516/164

24. Meeting dates for 2016/17

The meeting dates for the year were NOTED. GBP1270516/165

25. Date of next meeting

The next meeting of the Governing Body in public would be on the 29th July at 1pm, again at Leatherhead Leisure Centre. GBP1270516/166