NHS
Surrey Downs
Clinical Commissioning Group

Meeting: Annual General Meeting

Date and time: 10th July 2015, 4.15pm

Present

Leith Hill Practice (& Old Forge) – Dr Louise Keene
Dorking Medical Practice - Dr Steve Loveless
Brockwood Medical and Newdigate / Holmwood) - Dr Robin Gupta
Esher Green Surgery – Dr. Jill Evans
Thorkhill Surgery - Dr Hazim Taki
Integrated Care Partnership – Dr Russell Hills
Derby Medical Centre – Dr Hilary Floyd
The Longcroft Clinic - Dr Claire Fuller
Fairfield Medical Centre - Dr Ibrahim Wali
Ashley Centre Surgery - Dr Andrew Sharpe
Tattenham Health Centre - Dr Suzanne Moore

In attendance

Miles Freeman, Chief Officer
Matthew Knight, Chief Finance Officer
Karen Parsons, Chief Operating Officer
James Blythe, Director of Commissioning and Strategy
Justin Dix, Governing Body Secretary (minutes)

1. Welcome and introductions

AGM100715/001

Dr Fuller welcomed everyone to the meeting, thanking people for remaining after what had been a long afternoon with the preceding Governing Body meeting and in some cases other meetings as well.

2. Registers of interest

AGM100715/002

The registers of interest were available with the papers at the front of the room and also available on the CCG's web site. The CCG took this issue very seriously and maintained these registers on a

regular basis.

3. Apologies for absence

The following practices sent their apologies: Riverbank; Capelfield; Giggs Hill; Lantern; The Vine; Littleton; Glenlyn; St Stephens House; Nork; Molebridge; Shadbolt; Cobham; Auriol. AGM100715/003

4. Confirmation of quorum

It was noted that the meeting was quorate with eleven of the thirty three practices present. AGM100715/004

5. Minutes of the 2014 Annual General Meeting

Dr Fuller noted that these had been received at a council of members meeting in November 2014 and subsequently circulated for review. AGM100715/005

The minutes of the Annual General Meeting held in July 2014 were AGREED as an accurate record. AGM100715/006

6. Governing Body Membership

Dr Fuller referred to the paper on membership which was available with the papers at the front of the hall and also on the CCG website. This gave details of the CCG's membership as of the date of the AGM. She noted that there were two recently appointed lay members, Gill Edelman for Patient and Public Engagement and Jonathan Perkins for Governance. Yvonne Rees had also been nominated by Surrey County Council to replace Nick Wilson, who was thanked for all his support in developing the CCG in his first two years. AGM100715/007

7. 2014/15 Annual Report

Dr Fuller thanked Justin Dix, Governing Body Secretary, the communications and engagement team, and the finance team for again producing a very good annual report. She also thanked John Lowes for co-ordinating the member practice's introduction. AGM100715/008

Dr Fuller then gave a presentation on the CCG's makeup and functions. Key issues were as follows: AGM100715/009

The CCG had a population of 330,000 and covered a wide range of different populations from Elmbridge, Banstead, Dorking and Epsom. Practice sizes varied. AGM100715/010

The CCG commissioned a wide range of hospital and community and mental health services but also hosted a number of Surrey wide functions such as Continuing Health Care. It employed over 160 staff. Dr Fuller noted that as well as working for the organisation the staff undertook regular charity fund raising events every month. AGM100715/011

It had been a busy year which had resulted in a £10.7m deficit due to increased demand for health care, a decrease in available funding and an increase in estates cost. The CCG had made changes to its governance to meet these challenges and had worked hard to agree a viable plan for the year ahead with NHS AGM100715/012

England. The Executive were commended for their enormous efforts in this respect but Dr Fuller specifically highlighted the roles of Dr Mark Hamilton and Peter Collis who been so successful in helping to turn around the CCG's oversight of finance and performance.

AGM100715/013 During challenging periods it was essential not to let quality slip but in Surrey Downs key performance in areas such as A&E waiting times had been maintained.

AGM100715/014 The CCG's stakeholder survey had this year shown a steady improvement and it was clear that despite the financial problems local stakeholders perceived the CCG as good and improving, and the CCG was in fact benchmarked higher than average in its cluster group. But there was much to do in order to sustain improvement.

AGM100715/015 With regards to patients Dr Fuller highlighted the following specific areas:

- AGM100715/016 Continuing Health Care (CHC) had continued to improve and performance levels increased.
- AGM100715/017 A new way of working had been introduced into New Epsom and Ewell Community Hospital (NEECH) using a collocated model with Epsom Hospital; this had dramatically reduced the time spent in both the community hospital and in the acute hospital, which was much better for patients. This involved a better combination of medical, community nursing and social care. Other areas of the country were very interested in this.
- AGM100715/018 Diabetes pathways had been reviewed and changed which put more emphasis on education and self-care and improved pathways between hospital and community.
- AGM100715/019 Psychological Therapies had been greatly improved due to changing the way referrals and choice worked, using the Referral Support Service (RSS) to ensure patients had access to the right provider at a time that suited them. This had significantly reduced waiting times and missed appointments.
- AGM100715/020 Three GP networks had been launched, one of which had been successful in bidding for Prime Minister's Challenge fund.
- AGM100715/021 The CCG had applied for Vanguard status with other partners, principally Epsom St Helier, and although not successful the local health community had received very positive feedback on its application. In order not to lose the good ideas, a local programme had been developed and a programme director was now in place.

- Community Medical Teams had been developed as part of this, putting care around the patient. AGM100715/022
- The CCG's website had seen a huge increase in new users. AGM100715/023
- Dr Sharpe had been nominated in the Living and Ageing Well Surrey Awards for his work on telehealth, and had come runner-up. AGM100715/024
- The CCG's work on dementia had been nominated for a British Medical Journal award and been runner up. AGM100715/025
- The Governing Body had been nominated for Governing Body of the year and again was awarded runner up. AGM100715/026

Dr Fuller said that the pace of the work would undoubtedly continue in future and there were big projects ahead as a result of the community hospitals review, the Epsom estates work, planned care service redesign involving a number of care pathways, the local version of Vanguard, and the five year forward view. The CCG would remain committed to seeking the views of local people and stakeholders in addressing the difficult issues it faced. AGM100715/027

8. 2014/15 Annual Accounts

Matthew Knight introduced the annual accounts. Key points were as follows. AGM100715/028

- The CCG had received an allocation of just over £332m and had spent just under £343m, posting a £10.7m deficit. AGM100715/029
- The largest part of the CCG's money (62%) went on acute services. AGM100715/030
- 13% was spent on the local primary care that the CCG was responsible for although the bulk of primary care funding was with NHS England AGM100715/031
- Other key areas were Mental Health, Continuing Health Care and community AGM100715/032
- The CCG spent £7m on running costs, a reduction of 10% on the previous year AGM100715/033

Acute hospital spending was complex because the CCG had three hospitals, two of them based in London trusts. Epsom St Helier accounted for over 40% of hospital spending but Kingston and Surrey and Sussex Trusts were also major areas. AGM100715/034

Matthew Knight then set out the main reasons why the CCG ended the year in deficit. These had been presented to the member practices at the last membership council meeting and were as follows. AGM100715/035

- There had been a £4.7m adverse movement in specialised commissioning AGM100715/036

- Delayed investment had saved the CCG £4.6m AGM100715/037
- The single biggest factor was a £13.2m overspend on acute hospital care, £9m of which was due unexpected increases in demand for services. AGM100715/038
- NHS property costs had increased by an unexpected £1.4m AGM100715/039
- £3.3m was due to savings that were not realised in year AGM100715/040

In summary the bulk of the deficit was driven by factors that the CCG was not aware of at the beginning of the year, although the risk of a deficit had been highlight from the outset of the financial year. AGM100715/041

Dr Fuller invited questions from the public and those present. There were no questions. AGM100715/042

9. Value in Health Care

Dr Fuller introduced the keynote speaker, Professor Muir Gray. Professor Gray was an influential, nationally renowned clinician and inspirational speaker. AGM100715/043

Professor Gray gave an interactive presentation, the key points of which are set out below (*NB – a full transcript of this is available on request*): AGM100715/044

- The two revolutions in health care were public health advances in the 19th Century, and the revolution bought about by the NHS itself. AGM100715/045
- Now however the advances were flattening out and there was a real challenge in terms of emerging variations in care, despite the influence of evidence based medicine. AGM100715/046
- Health services now face four major issues: AGM100715/047
    - Harm from over-use of healthcare interventions a.
    - Inequity from under use of health care b.
    - Waste c.
    - Failures of prevention d.

The focus now was on moving away from looking at institutions to looking at populations, and the aim was not to address quality in isolation but to see quality and safety as subsets of the wider issue of value in healthcare. AGM100715/048

Audience participation highlighted issues of clinical and population outcomes, the relationship between inputs and outcomes, use of resources, and efficiency. AGM100715/049

Professor Gray then noted that: AGM100715/050

- Value is generally personal and subjective AGM100715/051
- Quality is generally objective and technical AGM100715/052

The role of commissioners, which they had generally not done, was to address allocative value. This meant focusing on AGM100715/053

- Productivity AGM100715/054
- Efficiency AGM100715/055
- Value AGM100715/056

Professor Gray explored these, using a mixture of local and national examples, against a number of challenges: AGM100715/057

- How much money should be spent on healthcare? AGM100715/058
- How much money should be top-sliced for research, education and information technology? (and for specialised services?) AGM100715/059
- Has the money for healthcare been distributed to different parts of the country by a method that recognises variation in need and maximises value for the whole population? AGM100715/060
- Has the money for care been distributed to different patients groups, e.g. people with cancer or people with mental health problems, by a process of decision-making that is not only equitable but also maximises value for the whole population? AGM100715/061
- Are the resources that have been allocated being used on the right interventions? AGM100715/062
- Is there the right balance of resources between different parts of the care pathway? AGM100715/063
- Are we ensuring High Value Innovation by disinvestment from Lower Value Interventions and ensuring that any innovation without strong evidence of high value is only introduced using the IDEAL method to ensure evaluation? AGM100715/064
- Are the right patients being offered the high value interventions? AGM100715/065
- Are there clinical services which have gone past the point of optimality? One of the benefits of evidence-based medicine was that it emphasised the need to ensure that the only interventions being offered were those for which there was strong evidence that they did more good than harm. However, the balance of good to harm changes as the amount of resources invested in a health service increases. AGM100715/066
- Has the money for care been distributed to different patients groups, e.g. people with cancer or people with mental health problems, by a process of decision-making that is not only equitable but also maximises value for the whole population? AGM100715/067
- Are the specialist services seeing the patients who would benefit most? AGM100715/068

- Are we sure that every individual patient is getting what is right for him or her? AGM100715/069

A key issue was to work with the public and with patients to ensure they understood the risks and benefits of healthcare interventions. This was particularly relevant to people with multiple health problems and those in the last year of life for whom cost and harm might be significant, and benefit low. AGM100715/070

There needed to be wider clinical engagement i.e. of specialists and not just GPs in addressing these issues. Clinicians as a whole needed to see themselves as responsible for the long term stewardship of the system, as political factors would always be focused on the short term. AGM100715/071

Professor Gray concluded by saying that the future would be driven by citizens, knowledge and technology (specifically smartphones) and we needed to decide how these interactions would work. AGM100715/072

10. Questions from the public

Dr Fuller thanked Professor Gray for his presentation and invited contributions from the audience. These highlighted the following areas. AGM100715/073

- There was considerable pressure on clinicians to make decisions based not on value but on expectations. AGM100715/074
- How could we get the population focused on, and excited in, the potential for prevention? Ageing was inevitable but prevention, fitness and attitude could be used to combat its effect. AGM100715/075
- Patient education was essential to take forward the preventive agenda. AGM100715/076
- Clinical specialists needed to see themselves as knowledge workers as well as clinicians and demand improvements in the knowledge base, although it was acknowledged this could be costly. AGM100715/077
- There was resistance to change built into the system, particularly from vested clinical interests. AGM100715/078
- Change could only be achieved by going back to basics in some cases and focusing on the conditions patients experienced rather than the complexity of service delivery. AGM100715/079