NHS
Surrey Downs
Clinical Commissioning Group

Governing Body Meeting – Part 1
Friday 30th September 2016
Dorking Halls, Dorking RH4 1SG

Minutes

Members present:

Dr Claire Fuller	Clinical Chair
Dr Andrew Sharpe	GP Member
Dr Tim Powell	GP member
Dr Russell Hills	GP Member
Dr Hannah Graham	GP member
Dr Louise Keene	GP Member
Ralph McCormack	Interim Chief Officer
Matthew Knight	Chief Finance Officer
Steve Hams*	Interim Director of Quality and Delivery
James Blythe*	Director of Strategy and Commissioning
Eileen Clark *	Chief Nurse
Peter Collis	Lay Member for Governance
Jonathan Perkins	Lay Member for Governance
Jacky Oliver	Lay Member for Patient and Public Engagement
Gill Edelman	Lay Member for Patient and Public Engagement
Debbie Stubberfield	Independent Nurse
Ruth Hutchinson*	Public Health Representative

***** *Non voting*

Others in attendance:

Justin Dix	Governing Body Secretary

Chair: Dr Claire Fuller

Minute taker: Justin Dix

Meeting started: 1.00 pm

Meeting finished: 3.30 pm

1. Welcome and introductions

Dr Fuller welcomed everyone to the meeting, particularly Dr Natalie Moore, and Dr Jill Evans, Chair of Elmbridge Locality GBP1300916/001

2. Apologies for absence

Apologies had been received from Yvonne Rees and Dr Tony Kelly GBP1300916/002

3. Quorum

The meeting was declared quorate GBP1300916/003

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

The changes to the register as set out in the accompanying paper were noted. There were no known conflicts relating to the agenda for the meeting. GBP1300916/004

5. Questions from the public

There were no pre-submitted questions. GBP1300916/005

Bob Mackison, member of the public, asked whether the action from the last meeting regarding the cost of the community hospitals consultation had been completed. James Blythe said that the cost of the consultation had been £18,000 and the model had been considered very successful and was now being widely copied. GBP1300916/006

6. Minutes of the last meeting, held on 29th July 2016

082 – Gill Edelman noted that she had said that the centre for ageing better was an important resource, not that it should be represented. She would share details with James Blythe. GBP1300916/007

Other than this the minutes were agreed as an accurate record. GBP1300916/008

7. Matters arising and action log

GBP1207516/103 Risk assessment of EMIS vs PACE – completed, agreed for closure. GBP1300916/009

GBP1290716/014 - Confirm the budgeted cost of the Community Hospitals consultation. As above. Agreed for closure. GBP1300916/010

GBP1290716/069 - Update on Leatherhead regeneration to be given at a future meeting of the Governing Body. Scheduled for November. Agreed for closure. GBP1300916/011

GBP1290716/105 - Primary Care Strategy – James Blythe set out a timetable for this. A paper would go to the October clinical cabinet and then go on to localities for discussion. Ralph McCormack noted that NHS England had asked for a submission of interest in Co-Commissioning by the 5th December. Agreed for closure. GBP1300916/012

GBP1290716/131- Finance Report – Matthew Knight updated and said there would be more information in the finance report on this. Agreed for closure. GBP1300916/013

GBP1290716/177 – Committee Reports – Peter Collis said this was in hand and there would be a discussion at the AGM later. Agreed for closure. GBP1300916/014

All actions marked as Recommended for Closure were agreed for closure. GBP1300916/015

8. Chief Officer's Report

Ralph McCormack highlighted the following items from his written report: GBP1300916/016

The timetable for the Sustainability and Transformation Plan (STP) which required an extraordinary Governing Body meeting on the 14th October ahead of submission on the 18th. A lot of work had taken place to ensure that the work streams were supported and that there was proper scrutiny of the proposals. GBP1300916/017

The conflict of interest guidance issued centrally in July was being taken forward at local level. GBP1300916/018

Integrated Access to Psychological Therapies (IAPT) performance had historically been poor in Surrey Downs and a new promotional campaign was starting on Monday. This was aimed at ensuring people were aware of the help available for people with emotional issues such as stress and mild depression. GBP1300916/019

Junior doctor industrial action to date had been suspended. The inherent risks for service delivery had therefore been avoided and this was welcomed. GBP1300916/020

Heads of service development was proving very positive and this tier of managers was now more effective in supporting organisational delivery. This had been evident in the morning's commissioning intentions workshop, which had been a very successful event. GBP1300916/021

Ralph McCormack noted that Board Pad was now being rolled out and it was hoped that the November meeting would be the first where this would be trialled. Paper copies would still be available for the public. GBP1300916/022

Domestic abuse and the IRIS programme were particularly highlighted from the Health and Wellbeing Board report. GBP1300916/023

9. End of Life Care Strategy

James Blythe introduced this. It was an update to the strategy agreed in November 2015. There was a particular focus on personalisation and co-ordination of care. GBP1300916/024

Dr Williams, clinical director for integration and urgent care, joined the meeting to give a clinical update. The main development had been with PACE (Personalised Anticipatory Care Plan) which was being trialled in East Elmbridge and was a positive attempt to create a standardised document that enhanced choice around where to die. GBP1300916/025

The final draft agreed with Epsom St Helier was now being rolled out with local GPs and would be evaluated to see if changes were needed. GBP1300916/026

Education and training was a priority and workshops were taking place starting in Epsom locality in October based on changes to the directory of services for this group of patients. It was expected that this will focus on the shared care record available across health and social care and including ambulance and 111 services. IT systems varied across organisations and integration in this area was being pursued. GBP1300916/027

Hospices were also included in the integration work. GBP1300916/028

Since the last update there had been agreement to fund PleurX, which was a drainage system during episodes common in end of life care. This enabled patients to be discharged home rather than dying in hospital. GBP1300916/029

A number of other projects were coming on stream relating to the quality care homes initiative, with a multi-disciplinary team working with hubs to ensure that the End of Life Care message can be taken out to care homes. GBP1300916/030

Dr Sharpe said that PACE had widespread clinical support and it was hoped to extend this with funding of the Surrey wide solution. A decision was awaited from the Department of Health on this and would probably be tied into responses to the STPs. GBP1300916/031

Debbie Stubberfield welcomed the update and asked that next time there could be some figures on indicators such as the percentage of patients dying in the place of their choice. GBP1300916/032

Dr Keene asked about Dorking. Dr Williams noted that Dorking used different IT systems and were using different documentation which was being rolled out locally. The integration team were working across the patch to try and standardise developmental work. Dr Keene said that it would be helpful to pursue integration with PACE – Dr Williams would pick this up with her after the meeting. GBP1300916/033

Jonathan Perkins said that the aims and objectives of the strategy were laudable but felt there had only been progress in one small area. He agreed with Debbie Stubberfield on the need for a more performance based summary of the strategy's impact. He would particularly welcome a more ambitious approach going forward and challenged the CCG to raise local services to the standards set out nationally in 2015. He would also welcome more public health input into the work on compassionate care. GBP1300916/034

James Blythe said that the strategy was challenged by local system complexity, particularly the local hubs. GBP1300916/035

There was a need for a more broad ranging strategy and he said that the new DH strategy published in July made a number of commitments around 24/7 access and personalisation; a Right Care data pack was also expected in the next two months which would show where the local gaps were. GBP1300916/036

Steve Hams said that the CCG could improve on indicators regarding dying in hospital but noted that there were positive indicators regarding preferred place of death at a local level. From June 2017 there would be a measure of improvement nationally on end of life care. Jonathan Perkins welcomed this but felt that there also needed to be more assessment of the impact on the wider family and carers. GBP1300916/037

Jacky Oliver noted that there was a need for carers and the public to understand the PACE approach and to ensure it was incorporated into local care planning, as it was open to misinterpretation. Dr Williams agreed and said that the aim was to improve not withdraw care as was sometimes the perception. GBP1300916/038

Dr Graham said that from a clinical perspective this was a complex area and that preferred place of death was an important measure. Steve Hams noted that there were also opportunities to make Continuing Health Care (CHC) - particularly fast track care - more effective and give people better experience. GBP1300916/039

It was agreed to bring back a refresh to the strategy and include commitments in the commissioning intentions in January. GBP1300916/040

Action James Blythe

Ralph McCormack noted that proactive care was relevant not just to End of Life Care but also had a wider application. He wondered what the practices' experience of this approach was. Dr Williams agreed and said that evaluation was taking place but it would take time for use of the new forms to bed down in primary care. GBP1300916/041

James Blythe said that the Integration Board would take this work forward. GBP1300916/042

Dr Sharpe noted that PACE was a good tool but not a long term solution. GBP1300916/043

10. East Elmbridge Locality Update

Dr Evans was welcomed to the meeting and gave a presentation. GBP1300916/044

The East Elmbridge locality was small (seven practices) and faced in a number of directions including toward Kingston for hospital services. The GP practices were formed into a network which the CCG commissioned a community medical team from. Developments were organic but were already highlighting opportunities to reach frail elderly patients. GBP1300916/045

Multi-disciplinary working across health and social care was very strong and felt like a “one team” approach. The care co-ordinator approach was essential and these individuals worked closely with patients. There was a particular focus on reducing inappropriate admissions and re-admissions. Early discharge was being supported to get patients home. GBP1300916/046

A key issue was to spot patients at risk of admission e.g. because of infection. GBP1300916/047

The team provided a spectrum of care and the hub could admit patients, using a small number (14) of community hospital beds as an alternative to or to supplement acute care. This was known as “GP intensive care”. Community matrons were key to the process. GBP1300916/048

GPs now appreciated that there were alternatives to urgent care and A&E referral and the team was getting more and more referrals from GPs. The wider system was now more aware of the team and contacted it out of hours by mobile phone. GBP1300916/049

Dr Evans gave a case example of a 77 year old man with COPD and other long term conditions who was at risk of frequent hospital admission. The team had been able to work with him particularly on mobility, breathlessness and feeding. There were also social and environmental factors. The team reviewed medication and care and social factors, and the care co-ordinator contacted housing to request ground floor accommodation which was arranged within a month. He has not had a hospital admission since February which proved the strength of the approach. GBP1300916/050

The approach did feel more streamlined and integrated and achieved more than any one agency could. Timely hospital discharge was being facilitated as the team also worked at weekends. GBP1300916/051

Dr Evans then presented a range of outcomes and noted the need to ensure that the team was providing value for money. Length of stay had reduced and the capacity to deal with complex medical problems was improved. The work had improved the culture of care and the attitudes of staff working with the team. GBP1300916/052

Streamlining medication arrangements was a particular focus; this improved patient care and reduced costs. GBP1300916/053

Dr Evans noted that the bias was towards working with the very elderly, particularly the over nineties. GBP1300916/054

The difference between June 2015 and June 2016 was from 108 to 91 admissions. GBP1300916/055

Future issues include: greater complexity of frail elderly patients; manpower, particularly allied professions and social care; supporting carers to be less risk averse and to cope when a patient deteriorates; identifying at risk patients; and planning for the future. GBP1300916/056

Dr Fuller asked if anything had been done to identify Length of Stay changes at Kingston. This was not known but would be looked at. GBP1300916/057

Action James Blythe

Dr Hills asked if this had helped educate A&E consultants particularly for the need to support discharge. Dr Evans said they had tried to educate them particularly geriatricians but needed to be careful not to swamp the team. GBP1300916/058

Eileen Clark asked what opportunities there were for single assessment. Dr Evans said that this was a developing area. GBP1300916/059

Dr Graham said the team was easy to refer into. GBP1300916/060

Dr Powell noted an experience of a patient who had been referred and whose experience was greatly improved by the team giving him so much support, although it still resulted in a hospital admission. GBP1300916/061

Dr Hills noted that different areas were distinct but key questions applied across them. Dr Fuller said that frailty models across Surrey heartlands STP will be evaluated by public health as part of the Academy work Stream GBP1300916/062

11. Together for Carers

Eileen Clark introduced the Memorandum of Understanding (MOU) for carers. This was a multi-agency piece of work that all partners were committed to for supporting carers and particularly young carers. The statistics were significant. The MOU set out what carers could expect and how agencies would work together. GBP1300916/063

The clinical cabinet had reviewed the quarterly report and it was noted there were still issues with the use of GP breaks and variations in how these were used. A new threshold of £300 had been agreed to give wider access to more carers. The service had won awards for its work. Dr Fuller said that the commitment to young carers was key. GBP1300916/064

The Governing Body AGREED to support the MOU. GBP1300916/065

12. Public Health Annual Report 2016

Ruth Hutchinson introduced this. It was a high level report that this year focused on children and young people and sat alongside the CCG's health profile. The health of Children and Young People in the patch was generally good but there was a lot of disparity. Data was strong and highlighted the financial benefits of early intervention. GBP1300916/066

Examples included: GBP1300916/067

- 8% of children in Surrey Downs lived in poverty which was linked to poor oral health, obesity and substance misuse. GBP1300916/068
- There were a significant number of terminations of pregnancy within the overall figures for teenage pregnancy. GBP1300916/069

- Breast feeding tends to drop off much earlier than the recommended six months GBP1300916/070
- Children on free school meals show lower attainment than the national and south east benchmark. GBP1300916/071
- Robust evidence was needed regarding inappropriate use of A&E by some children GBP1300916/072
- Immunisation rates varied and impacted on herd immunity GBP1300916/073
- Low self-esteem was a significant issue resulting in particular in self harm for young women. GBP1300916/074
- 10% of 11 year olds were obese in Surrey downs and this was a cause for concern. GBP1300916/075
- The call to action was not just for health commissioners but was also important for local authorities and other agencies. GBP1300916/076

Dr Fuller welcomed the report and felt this needed a higher profile within the CCG. GBP1300916/077

James Blythe also welcomed the report and asked how services i.e. maternity could be practically improved to produce better patient experience. Ruth Hutchinson said that this was an area where there were real opportunities to improve mental health but also opportunities to address smoking and weight management at a critical time. GBP1300916/078

Dr Graham said there was a real lack of services around perinatal mental health in Elmbridge. James Blythe said that there were applications in for Surrey for national funding in this area. GBP1300916/079

Debbie Stubberfield noted variations in early years provision and James Blythe said that this was being looked at through the System Resilience Group (SRG) to support under-fives attending A&E in winter. It would show whether there were links to under-doctored areas and other service deficiencies. GBP1300916/080

Peter Collis welcomed the report but would welcome more outcomes information in future reports for this and other patient groups. GBP1300916/081

Dr Sharpe highlighted the availability of online counselling and would share this information. GBP1300916/082

Action Dr Sharpe

Dr Fuller summarised and said that the Governing Body needed to do more in this area and to check that the call for action fed into the commissioning intentions. GBP1300916/083

The Governing Body NOTED the report. GBP1300916/084

13. Chairman's Actions

Surrey Heartlands Sustainability and Transformation Plan: Revised Committees in Common Terms of Reference. Dr Fuller highlighted the minor changes as set out in the paper and noyed she had approved these under Chairman's action. GBP1300916/085

The Governing Body NOTED the actions. GBP1300916/086

14. Finance Report

Matthew Knight highlighted key areas in the report. GBP1300916/087

There were some individual movements from the plan. The underlying acute contract position was an overspend of just over £2m across four providers. The year to date position had deteriorated quite significantly for two reasons: costs associated with critical care patients in London, the reasons for which were unclear, but also increases in elective care. GBP1300916/088

- SASH had seen increases in elective activity that did not match referral changes. An independent audit might be needed. GBP1300916/089
- Guys and St Thomas's – one patient in critical care had cost £250k which could not have been anticipated. GBP1300916/090
- South West London Orthopaedic Centre – costs are higher and discussion were taking place with the trust to review this. GBP1300916/091
- Epsom – this was on a block contract but there was some additional activity and this could impact on the following year's costs. GBP1300916/092
- Overall overspend was mitigated by underspends elsewhere. Savings had also been identified resulting in an on-plan position for the year to date. GBP1300916/093

Matthew Knight noted that the full year forecast left a predicted overspend of £4m. Once mitigations were in place acute overspend was reduced to £2m. There was a lot of residual risk. GBP1300916/094

- The non-acute forecast mitigations offset the overspend and the net result was achievement of the £9m overspend for this year. GBP1300916/095
- QIPP savings were approximately £1m behind plan. The forecast for the full year was being held but there were risks to this. GBP1300916/096

Matthew Knight highlighted the risks and mitigations table which gave a net position of £4.48m overspend. A key issue was a court ruling regarding funded nursing care which meant additional costs backdated to April. This was a national problem for CCGs. The CCG had a risk reserve of £3.5m but this could not be used without NHSE permission and the CCG did not have control over its release. GBP1300916/097

Matthew Knight highlighted the timetable for STP and local planning submissions through to December. GBP1300916/098

James Blythe highlighted POLCE (Procedures Of Limited Clinical Effectiveness) and how thresholds were in place to check referrals. GBP1300916/099

Jonathan Perkins, speaking as chair of the Finance and Performance Committee (FPC), said that Matthew Knight had given a good summary and this had been thoroughly discussed at the last meeting the previous week. The figures had been closely challenged but it was felt that it was very difficult, without one or two more months' figures, to assess whether risks were likely to materialise. It was noted that NHS England receives the papers for this meeting and Matthew Knight had discussed the risks and mitigations with them. They are able to attend if they wish. GBP1300916/100

Ralph McCormack noted that an update on the financial position was being submitted to NHS England today. However, there was a lot of risk involved and the committee was right to scrutinise the position closely. Peter Collis agreed and said that the context of the STP would radically shift the focus and we needed to watch this development closely. GBP1300916/101

The Governing Body NOTED the report. GBP1300916/102

15. Commissioning for Value (RightCare)

Steve Hams gave an update. New data on MSK was imminent and would continue to help the CCG to reduce unwarranted variation in care. There were three key areas of focus with deep dives on two. GBP1300916/103

There was an evaluation process on the Right Care programme but there was a lot of discussion by clinicians at local level about the data to inform decision making. GBP1300916/104

Dr Fuller noted that the local right care representative, Dr Bruce Pollington, had been involved in the Commissioning Intentions workshop that morning. GBP1300916/105

The Governing Body NOTED the report. GBP1300916/106

16. Quarter 1 Improvement and Assessment Framework and Six Clinical Priority Areas Performance

Steve Hams noted that this had been scrutinised by the FPC. The key domains matched the quality improvement strategy. There were two areas for improvement but one of these (staff engagement) was marked as in need of improvement due to incorrect data presentation. Personal Health Budgets would need improvement and was being focused on. GBP1300916/107

- Steve Hams highlighted the variations between the CCG and its peers. GBP1300916/108
- Primary Care standards should improve diabetes care. GBP1300916/109

- Recent data showed improvements in mental health performance. GBP1300916/110
- The maternity triangle was red and should be green. GBP1300916/111
- In terms of next steps, data was being used by clinical directors to seek improvements in performance locally. GBP1300916/112

Dr Powell said that the statistics were very useful and said that there were areas where the CCG was doing very well. He also highlighted the links to the public health report discussed earlier in relation to obesity. GBP1300916/113

The Governing Body NOTED the report. GBP1300916/114

17. Quality and Performance Report

Eileen Clark introduced this and said the focus was on key issues and actions. The quality committee discussed the more detailed report at its meeting in September. GBP1300916/115

- Recruitment was a risk to service delivery. GBP1300916/116
- More assurance was needed in specific areas and deep dives were being proposed for these. GBP1300916/117

Steve Hams noted that SECAmb were placed in special measures this week and the CCG was working with the host commissioner on this. GBP1300916/118

Dr Powell said that the committee was identifying recurring themes and had agreed that more information needed to be reviewed in these key areas. There will also be a focus on a smaller number of critical areas. GBP1300916/119

Dr Keene said that SECAmb had been discussed in detail at the last Quality Committee. GBP1300916/120

18. Risk Report

Matthew Knight introduced this. Risks remained reasonably consistent and were built around the four key priorities agreed at the July meeting. Datix had been introduced for risk management and had gone live, with this being the first report to use Datix outputs. GBP1300916/121

The main aim was to delegate risk management down to the appropriate level. A key issue was how the STP footprint would manage risk and how this would connect with the work of individual organisations. GBP1300916/122

Peter Collis said that the risks were much clearer. He queried whether there needed to be a review of non QIPP risks as the pressures had shifted since the last review. Matthew Knight agreed this needed some thought but the perceptions of regulators also needed to be taken into account. It was agreed to link this into the reset following the next submission. GBP1300916/123

Gill Edelman noted that quality was not key to the objectives and queried what the mechanisms were for keeping an eye on the balance between finance and quality. GBP1300916/124

Ralph McCormack noted that discussions at Governing Body development sessions in the past had been for the need for a quality objective to be specific and that this discussion had been remitted to the quality committee. Steve Hams acknowledged this but also said that most of the discussions today had been quality focused. The fact that quality was not a principal objective did not mean that quality was not embedded in the CCGs work. It was agreed to ask the Quality Committee to review this at its next meeting, with input from other Governing Body members. GBP1300916/125

Action Debbie Stubberfield / Tony Kelly

19. Risk Management Strategy

Matthew Knight noted this had been extensively reviewed to reflect the recent changes linking risk to CCG functions and objectives. Section 4 set out the three tiers of risk and where these would be managed, making clear the responsibilities of the Governing Body, Executive and broader management and leadership. GBP1300916/126

The focus was on whether the risk management system was supporting the controls and in particular incidents that have happened and risks that have yet to materialise. GBP1300916/127

Debbie Stubberfield noted that on page 10 (5.5.1) the quality committee was expected to review quality issues relating to financial changes. She also noted that there was reference to a primary care committee on 5.2 – it was confirmed that this committee was going to be reformed. GBP1300916/128

Gill Edelman said the strategy was very helpful and she welcomed it but would like to understand more about how risk was escalated. GBP1300916/129

James Blythe said that the programme boards were already using the strategy to drive discussions about scoring and escalation, highlighting what could be managed and what needed more senior input. GBP1300916/130

Jonathan Perkins commended the clarity of Appendix 7. GBP1300916/131

The risk management strategy was AGREED. GBP1300916/132

20. Policy Update

Matthew Knight presented this and noted that some policies were behind review. Policies that were technically of date were still in use but these were being being risk assessed by the relevant committees to ensure this did not give rise to any issues. GBP1300916/133

The report was NOTED by the Governing Body. GBP1300916/134

21. Annual Emergency Planning, Resilience and Response (EPRR) Report

GBP1300916/135

Matthew Knight noted that there had been some significant changes to CCG responsibilities particularly around incident management where there was a need for CCGs to take a more leading role. CCGs were working collectively on on-call arrangements and resilience plans for the future. He thanked Dan Dumbarton and Jonathan Perrott for their work on this.

GBP1300916/136

The report was NOTED by the Governing Body.

22. Meetings and Committee Reports

GBP1300916/137

The Governing Body received the following reports and minutes of meetings.

GBP1300916/138

- Governing Body Seminar Report

GBP1300916/139

- Clinical Cabinet Report

GBP1300916/140

- Audit Committee Report

GBP1300916/141

- Finance and Performance Committee Report

GBP1300916/142

- Quality Committee Report

GBP1300916/143

- Remuneration and Nominations Committee Report

GBP1300916/144

It was highlighted that there had been detailed discussion of integration at the clinical cabinet.

GBP1300916/145

Jonathan Perkins highlighted the issues with CCG capital and how these might impact on the STP. Matthew Knight noted the process for this and how there was a gap between small and major bids which might affect availability of capital.

GBP1300916/146

Jonathan Perkins also highlighted the resource implications of workload particularly for finance between now and the end of the year.

GBP1300916/147

The reports were NOTED by the Governing Body.

23. Any other urgent business

GBP1300916/148

There was no other business.

24. Date of next meeting

GBP1300916/149

The next full meeting of the Governing Body in Public would be on 25th November 2016 at 1.00 pm at Leatherhead Leisure Centre