NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
25th November 2016

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
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
Dr Tony Kelly	Secondary Care Doctor
Debbie Stubberfield	Independent Nurse
Yvonne Rees	Surrey County Council
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: 1.05

Meeting finished: 3.45

1 Meeting Matters

1.1 Welcome and introductions

GBP1251116/001

Dr Fuller welcomed everyone to the meeting and noted this was the first Governing Body to be held using BoardPad, which was a paperless system for managing the organisation's business. There was technical support available if required during the meeting.

1.2 Apologies for absence

GBP1251116/002

Apologies had been received from Dr Louise Keene, whose surgery was short staffed.

1.3 Quorum

GBP1251116/003

The meeting was declared quorate

1.4 Register of interests

GBP1251116/004

Hannah Graham and Jonathan Perkins gave updates to their register entries as follows:

GBP1251116/005

Hannah Graham

GBP1251116/006

Jonathan Perkins

1.5 Questions from the public

GBP1251116/007 written

Dr Fuller read out a question received in advance of the meeting from a member of the public who had used local services.

GBP1251116/008

"I am very concerned about care in the community as I feel many patients will fall between the gateposts unless the system is improved and could become seriously ill as a result. I have experienced being handed over to the community and thought I knew where to go for help when things went wrong."

GBP1251116/009

"I recently underwent major surgery in SWLEOC, where the treatment was first class, being handed over to the community for physio. All was well for two weeks until my carer had an unplanned accident and the roles needed to be reversed as he could not look after me. First problem was getting the TEDS on and off – thankfully I did not have to resort to standing outside my gate and asking a passer-by for help."

GBP1251116/010

"Second problem was getting to West Park for Physio; have any of you tried to get there by public transport? I rang and explained the situation and my appointment was cancelled as I thought it unlikely that friends could help out. The appointment was made for a week later where I would probably have the same problem. I could ask to be discharged I was told and apply to go to EGH which I had originally asked for – 14 week wait."

GBP1251116/011

"I rang SWLEOC's advice line where a wonderful lady, Angie, sorted it out. Community Physio were not available nor was IRIS but I was given the number for Hospital Transport which worked a treat. When I explained my predicament to the Poplars, why did they not say, we can arrange transport for you? I thought they must have some system when these problems occur. My question is what checks will be in place to ensure this does not happen be it physio or some other medical problem where the patient is missed or does not turn up for an appointment especially if they live alone?"

GBP1251116/012

The individual in question was now understood to be receiving good and safe care. Eileen Clark noted that Poplars was a unit delivering physio and other therapy, for those who were not aware of its range of services.

GBP1251116/013

It was agreed that James Blythe would provide an answer by the end of the year.

Action James Blythe

GBP1251116/014

A member of the public asked why Ralph McCormack was still interim. Peter Collis, as chair of the Remuneration and Nominations Committee, explained that Ralph McCormack was here to complete the work on lifting the CCG's directions and this would be completed in the final quarter. It was queried whether the STP would take over the CCG's role and Dr Fuller clarified that this was not a statutory body.

GBP1251116/015

A member of the public asked about the vote around delegated commissioning and questioned why there had been no public engagement on this issue. Ralph McCormack said this was an operational matter for the CCG and NHS England relating to contractual matters – it did not impact on the public and was therefore not a matter for public consultation as it would not bring any change in the services provided.

1.6 Minutes of the last meeting

GBP1251116/016

Apart from Steve Hams' title, which was incorrect, these were agreed as an accurate record.

1.7 Matters arising and action logs

GBP1251116/017

Paragraph 040 from the September meeting – End of Life Care report to come back to the Governing Body in January – it was agreed to keep this action open until completed.

GBP1251116/018

Paragraph 057 from the September meeting – Length of Stay (LOS) at Kingston Hospital. James Blythe shared a graph showing trend data since April 2015. LOS was variable and the data was inconclusive although useful. It was agreed this action could be closed.

GBP1251116/019

Paragraph 082 from the July meeting – Debbie Stubberfield gave an update and proposed that the STP objective would be amended to include quality. The proposed wording was read out as follows:

GBP1251116/020

"Take responsibility, with other partners in the footprint, for the Surrey Heartlands STP and ensure that this contributes significantly to the creation of a sustainable health economy with improved outcomes and quality."

GBP1251116/021

This amendment was AGREED.

2 Chairman's Actions

2.1 GBP1251116/022

Children's Committee in Common – this involved a technical change of membership only. The addendum was NOTED

2.2 GBP1251116/023

STP Committee in Common – this involved a technical change of membership only. The addendum was NOTED.

2.3 GBP1251116/024

Procedures of Limited Clinical Effectiveness – Gallstones . Dr Fuller said that there would be regular updates to this policy. This particular one involved only treating Galstones when they were symptomatic and not when they were not causing the patient problems. The amendment to the policy was NOTED.

3 Presentations

3.1 Transform Leatherhead

GBP1251116/025

Nick Gray, Deputy Chief Executive at Mole Valley District Council and Colin Mills, Transform Leatherhead Officer gave a presentation on Transforming Leatherhead. The idea had been in development for the last two years and acknowledged that the town had very good connections and potential, and a skilled local workforce and employers. As a town however there was a need to improve facilities for residents and businesses.

GBP1251116/026

The project took a holistic view of the area but would need funding. A number of partners including the private sector were being looked at. A consultation process with significant engagement had resulted in the current proposals, which involved 15 elements for developing the town.

GBP1251116/027

The role of public sector partners would be particularly important.

GBP1251116/028

The three big themes were:

GBP1251116/029

- A new urban quarter with a large element of housing – up to 500 new dwellings.
- Riverside Park – increased recreational opportunities
- Revitalised High Street and Swan Centre

GBP1251116/030

Dr Fuller thanked Nick and Colin for an excellent presentation.

GBP1251116/031

Eileen Clark said she thought it was a very good plan but asked about flood risk. It was clarified that this was being planned for and should take Leatherhead out of the flood zone.

GBP1251116/032

Dr Powell asked about the impact of housing on local schools and how much would be social housing. This was not known yet but was under discussion. The latter was for a 40% affordable element.

GBP1251116/033

Ruth Hutchinson asked about how health had been factored in such as active travel, cycleways etc. Also not increasing the proliferation of fast food outlets. It was clarified that the former was included in the detailed planning. The latter was not dealt with at the planning stage and the end user could not be dictated. However as a landlord Mole Valley did have some influence.

GBP1251116/034

James Blythe said the CCG had already had meetings with the team and was trying to influence the planning, and asked if there was a sense of timescales. It was felt that this would probably take place over a ten year period as it was a substantial programme, starting with the river frontage. The Bull Hill area was the logistically most complex.

GBP1251116/035

Jacky Oliver asked about disability access and whether existing inaccessible areas would be addressed. It was agreed that all areas would be taken into consideration. Disability Groups had been involved in these discussions.

GBP1251116/036

Dr Graham noted the potential significant impact on general practice.

GBP1251116/037

Matthew Knight asked if there could be consequential development around the town as a result of this. It was noted that this was a possibility.

GBP1251116/038

In concluding the agenda item Dr Fuller highlighted the importance of the public health aspects of the scheme.

3.2 Dorking locality update

GBP1251116/039

James Blythe spoke on behalf of the locality and its aspirations for integrated primary, social and community care. The locality had achieved aspirant second wave care home locality status and was doing development work with the national team. The Community Medical Team model was being finalised and recruited to.

4 Chief Officer's report

GBP1251116/040

Ralph McCormack highlighted the following:

GBP1251116/041

- STP deadlines had been met and the headline feedback was that the plan was a strong one and could now be more widely engaged on. It had been launched on the CCG website for comment. There was a citizen led engagement programme.

GBP1251116/042

- Delegated primary care commissioning was currently with GP practices for agreement – this would require a 75% level of support from the member practices.

GBP1251116/043

- The planning and contracting round had been bought forward significantly and contract signature was now expected by the 23rd December. This was usually completed in March. It was a significant challenge and there was work to be done on reconciling commissioner and provider positions. It was not clear whether this could be assured by the 5th December which could lead to mediation and subsequently formal arbitration. This was something the CCG wanted to avoid and it was seeking collaborative solutions, but it was a matter of concern due to the real funding obstacles to achieving a resolution.

GBP1251116/044

- The CCG constitution had been updated for STP requirements.

GBP1251116/045

- The CCG had appointed new external auditors through a competitive process in conjunction with Guildford and Waverley, Surrey Heath and North West Surrey CCGs.

GBP1251116/046

- The CCG had been shortlisted for a national award for its work on governance and the outcome would be known on the 29th November.

GBP1251116/047

There was a brief update on the Health and Wellbeing board in the report.

GBP1251116/048

Gill Edelman asked about when the Patient and Public Engagenebt (PPE) strategy would be refreshed particularly given the requirement to undertake engagement with the STP proposals. Ralph McCormack confirmed this was being done with the other CCGs in the STP and was at the heart of the work. James Blythe stressed this and said the work was complex. Gill Edelman said it was important that Governing Body and lay members were involved in this.

5 Quality and Performance

5.1 Quality and Performance Report

GBP1251116/049

Eileen Clark highlighted the following concerns:

GBP1251116/050

- Recruitment – CSH Surrey are still struggling in some areas and further assurance was being sought. This was challenging for all providers. Surrey and Borders were also struggling with recruitment and were looking at new approaches and innovative solutions.

GBP1251116/051

- Environment – this was also an issue for providers and site visits were taking place to look at this. There were particular issues with storage on some sites, and this had been acknowledged in the community hospital review.

GBP1251116/052

- It was noted that St George's had been put into special measures, with estate being a major issue. The CCG was the lead for Surrey CCGs and was working with the trust and the host commissioner (Wandsworth). An action plan was expected next month and HealthWatch was undertaking a programme of visits.

GBP1251116/053

- Deprivation of Liberty Standards – there was a significant backlog of assessments waiting to be dealt with, some 5,000. This was not unique to Surrey and would be on the CCG's risk register. Yvonne Rees said this was the case but there had been an amendment to the legislation and if this was passed it might reduce the pressure around inquests.

GBP1251116/054

Dr Graham said that as a GP with a number of care homes she was aware that there were a number of issues with unnecessary re-assessments and frequent re-assessments every three months. Yvonne Rees agreed and said this was being closely scrutinised within the council and representations were being made to government. Matthew Knight noted this was not a practical piece of legislation and was tying up a lot of resource.

GBP1251116/055

- CHC had seen a significant issue with backlogs of assessment and this was being addressed; the number had been reduced to under 400.

GBP1251116/056

Debbie Stubberfield asked if backlog maintenance was addressed with providers in contract meetings and it was acknowledged that it was. Ralph McCormack said that availability of capital for backlog maintenance and capital projects had been a significant issue for several years in the NHS.

GBP1251116/057

Dr Fuller asked about the workforce gaps in CSH Surrey and it was noted these were in District Nursing and Health visiting in some but not all geographical areas.

GBP1251116/058

Jonathan Perkins asked what a "safer staffing huddle" was. It was confirmed this was a meeting to review patient safety, sometimes as often as every shift depending on need, and used evidence based tools. They were action based approaches and were highly patient centred.

GBP1251116/059

Jacky Oliver noted that staffing issues seemed to be intractable and that risks in the community were emerging. This was noted and Eileen Clark said that a recent national event showed this was not just a Surrey problem and was dependent on national initiatives such as increasing the number of training places to some extent.

GBP1251116/060

Ruth Hutchinson said that as commissioners of the 0-5 years' service they had shared concerns with the workforce in Surrey County Council which they were looking to address.

GBP1251116/061

The Governing Body acknowledged the hard work in the report. Jonathan Perkins said that good news reports would also be welcome.

GBP1251116/062

Dr Powell said that there was some positive news in Elmbridge with new paediatric clinics being led by GPs to reduce paediatric A&E admissions.

GBP1251116/063

Dr Graham highlighted Princess Alice Hospice's outstanding CQC report, achieving top marks in all 5 areas.

5.2 Performance Dashboards

5.2.i Constitution measures

GBP1251116/064

The following areas were highlighted:

GBP1251116/065

- A&E performance was variable. The CCG was trying to reduce numbers of attendances.

GBP1251116/066

- Diagnostic tests –breach rates were low but work was going on to support providers to improve further.

GBP1251116/067

- SECAmb Red One – performance in October had improved to 66.8% which is the best this year. This hopefully showed the impact of the remedial action plans.

5.2.ii Outcome measures

GBP1251116/068

Ruth Hutchinson highlighted the Surrey wide alcohol strategy and said that his would be progressed through the STP. It aimed to help people see how their drinking habits impacted on their health. Dr Graham highlighted the self-perceptions of some people with alcohol problems. Steve Hams said the quality committee would do a deep dive on this with Public Health but the number of patients – 60 to 90 per month – was significant. This could link across to domestic abuse work.

GBP1251116/069

Ruth Hutchinson also highlighted Baby friendly and children centres and the consequent positive impact on breast feeding rates.

5.2.iii Operating plan metrics

GBP1251116/070

The following areas were highlighted:

GBP1251116/071

- Integrated Access to Psychological Therapies – commissioners were hoping to see improvement in take-up with the new awareness campaign.

GBP1251116/072

- Dementia register – highest in the last twelve months with 2,634 patients on the register. Thanks to Dr Julia Chase for leading this work. Dr Fuller said that she felt the role of the clinical directors was proving very successful in this and similar areas.

GBP1251116/073

Dr Kelly went back to the SECAmb performance issue and highlighted the importance of the Governing Body being aware. He was concerned that Red 2 (delays in transfers into A&Es) was having a knock on effect on wider performance. He was also concerned that the organisation needed more positive support.

GBP1251116/074

Dr Kelly also said that he felt the Quality Committee was performing very well thanks to the high quality data it was receiving in this and other areas and thanked Eileen Clark and Steve Hams for their hard work.

GBP1251116/075

James Blythe said that he acknowledged the Red 2 issue but local performance had improved at Epsom and SASH, the latter having a very strong focus on handovers.

GBP1251116/076

Jacky Oliver expressed concern that A&E data was being distorted by some of the practices being used in recording information. James Blythe clarified the standards for the four hour standard. Sometimes there were perverse incentives to admit and clinical practice around ambulatory care units had been audited to see if they were being used appropriately. Generally it was concluded they had.

GBP1251116/077

Dr Graham said that her experience of ambulance crews under pressure had been very positive and it was agreed to feed this back to the trust.

GBP1251116/078

Dr Sharpe said that the trust did need support but he had had a very poor experience in the last week of a patient who had collapsed in the surgery and had experienced a long wait for an ambulance. This was not acceptable.

5.3 Annual Safeguarding Report

GBP1251116/079

Eileen Clark said this had been discussed in the quality committee. It was not easy to draw the key risks out of the report as it was very large but she felt there were some good safeguarding processes in the county. Recruitment was again a major theme and impacted on training compliance. There would be integrated safeguarding reports going forward.

GBP1251116/080

Dr Fuller said the purpose of the report was to provide assurance that the CCG was discharging its responsibilities and Eileen Clark felt it was doing this, although there was always scope for improvement.

GBP1251116/081

Gill Edelman welcomed the report but said that the risks should be described in terms of their impact on children and not just reputational issues for the organisations. It was noted that the quality team had already fed these concerns back to the report authors.

6 Finance and Planning

6.1 Finance Report

GBP1251116/082

Matthew Knight highlighted the cumulative deficit of £22m and said the CCG was on track for the year. There had been an overspend on acute which had been offset by savings elsewhere. Acute was £3m overspent in total across all contracts. This was not supported by increasing referrals and this was being investigated. Other key points were:

GBP1251116/083

- Critical Care costs were an issue with a small number of high cost patients in London. This was not part of a wider problem.

GBP1251116/084

- There was a bridge diagram on Page 4 that illustrated the variations and in particular the mitigations in graphic form.

GBP1251116/085

- The full year forecast was that the CCG would achieve outturn in line with budget, once contingencies and offsets were used.

GBP1251116/086

- The QIPP forecast was high risk although £7m out of £9m had been achieved.

GBP1251116/087

- Of the unmitigated risk of £4.8m, £1.6m was due to FNC and out of the CCGs hands. The real risk following mitigation was around £2.5m.

GBP1251116/088

- The planning timetable was ambitious and the risks in next year's process were considerable. There was a significant gap between commissioner and provider and this was being discussed with NHS England.

GBP1251116/089

Dr Kelly asked about the background to the acute over-performance. Matthew Knight said this was a mixture of charging and demand and was being addressed on a trust by trust basis. Charging variation year on year weighted for complexity of patient was being looked at through a specialist audit.

GBP1251116/090

Jonathan Perkins said that as chair of the FPC he could assure the Governing Body this had been thoroughly discussed and the figures scrutinised in detail. They were very concerned at the unmitigated risk but also noted that the position was stable and marginally better in fact compared to the previous period. QIPP plans were also thoroughly scrutinised, focusing on the more problematic ones.

GBP1251116/091

Peter Collis agreed with this and said that the committee could not add much to Matthew Knight's comprehensive account. There was a lot of discussion on the implications for next year's budget.

6.2 Commissioning Intentions

GBP1251116/092

James Blythe introduced this and noted the accelerated planning timetable. This document showed the areas where there had been discussion and reiteration of key areas. The document was open for comment and would need to come back in January for sign off.

GBP1251116/093

Eileen Clark said that there would need to be more of a thread running through the document around carers and learning disabilities in the final document and this was agreed.

GBP1251116/094

Peter Collis asked that the very rural nature of the south of the patch be taken into account, particularly the isolation of the elderly. James Blythe acknowledged this particularly the need for housing and social care support which impacted on health status.

GBP1251116/095

Jonathan Perkins noted that the document was comprehensive but asked about prioritisation. James Blythe said that this was what the CCG had chosen to focus on after wider discussions and was in that sense the prioritised areas.

6.3 Right Care

GBP1251116/096

Steve Hams noted that the CCG was focusing on Cardiovascular Disease, respiratory conditions and complex patients. The right care concepts were increasingly embedded in the CCG's work such as its commissioning intentions. He noted that complex patients were increasingly younger. The commissioning for value packages would continue to be used in the service redesign work of the CCG.

6.4 Local Digital Road Map

GBP1251116/097

Matthew Knight noted that these were key to STPs although not always coterminous, in the local case including Surrey Heath. The Governance meant that Julia Ross was the SRO for this work along with the STP. Over time the misalignment would need to be addressed.

GBP1251116/098

There were some key issues and themes which highlighted the need for

GBP1251116/099

- A Surrey Wide Shared Care record
- Improved network infrastructure
- Other discrete strategic improvements

GBP1251116/100

Dr Sharpe said that there was strong push for the shared care record as it was a key enabler for so many other improvements. The CCG was trying to access different funding sources to support this. The timescales for implementation were not yet clear which was a matter of some concern.

7. Equality and Diversity

GBP1251116/101

Dr Hills thanked all the people involved in the work to date. He felt this was a significant issue for the CCG in both its commissioner and employer roles.

GBP1251116/102

Key issues to note were:

GBP1251116/103

- The CCG needs to comply with its Public Sector Duty under the Equality Act 2010

GBP1251116/104

- A strong E&D strategy would help improve the health of people living in Surrey Downs

GBP1251116/105

- This was not a tick the box exercise – we need to embed the principles of inclusivity in everything we do

GBP1251116/106

- The CCG was well placed to lead broader cultural change across the health sector – showing as a commissioner how it could manage, value and understand equality and diversity

GBP1251116/107

- This could only be achieved by working with partners in all sectors

GBP1251116/108

- It would have to be embedded in all our processes (for instance doing an equality impact analysis on our commissioning proposals)

GBP1251116/109

- There would be targeted engagement of Gypsy, Roma, Traveller (GRT) communities and carers.

GBP1251116/110

Equality impact assessment would be in two stages

GBP1251116/111

- Stage one - Will assess all six areas of risk/ impact in relation to quality, the nine protected characteristics and carers in relation to equality.

GBP1251116/112

- Stage two - Will provide evidence on if the impact has been positive, neutral or negative and how this conclusion has been reached.

GBP1251116/113

Dr Fuller thanked Dr Hills for the presentation.

GBP1251116/114

Gill Edelman said that our communication with disadvantaged groups tended to assume high levels of literacy and understanding and whether this was a piece of work that needed doing. Dr h said that he acknowledged this and that it was often a case of reaching out to patients and signposting services to them. There was a need for a variety of formats for key messages. It was a big cultural change and a big piece of work that needed to be undertaken. There were difficulties with deciding where to put your efforts. Dr Powell said that it would be helpful to collaborate with the local authority on outreach to groups with low literacy levels.

GBP1251116/115

Peter Collis noted that the access to healthcare was a big issue in the CCG's commissioning intentions and this was a helpful discussion. He asked if we were scrutinising our providers and how they were pursuing this. James Blythe said this was pursued through our contractual arrangements.

GBP1251116/116

Jacky Oliver said that the patient participation network members did not feel they were representatives and we needed to acknowledge that they were acting as a voice not a representative.

GBP1251116/117

Steve Hams asked what the timescales for the strategy were and it was noted there were dates towards the end of the paper with a rolling plan going forward. Steve Hams also noted that we were choosing to highlight a particular group. Dr Hills said that it was acknowledged that we also had a responsibility to wider group but Gypsy, Romany and Traveller communities did have very high needs.

GBP1251116/118

It was noted that monitoring progress of the strategy would be through the quality committee for commissioning issues, and the staff side through the Remuneration and Nominations Committee.

7.1 Equality Strategy and Action Plan

GBP1251116/119

The Governing Body APPROVED the strategy and action plan.

7.2 Quality and Equality Integrated Impact Assessment Policy

GBP1251116/120

The Governing Body APPROVED the policy

7.3 Equality and Quality Impact Toolkit

GBP1251116/121

The Governing Body NOTED the toolkit

8 Governance and Organisational Development

8.1 Risk Report

8.1.i Governing Body Assurance Framework (GBAF)

GBP1251116/122

Matthew Knight noted that the GBAF had been reviewed in committees and the position was broadly unchanged. There should be a review of the position in January for changes around financial risk. Peter Collis said there did need to be a Governing Body review of risk in the new year as well.

8.1.ii Corporate Risk

GBP1251116/123

Matthew Knight highlighted the migration of risks to Datix and that this was now in a much better shape in terms of the number and presentation of risks. Datix will be fully implemented in January with a further project about incident reporting in primary care.

GBP1251116/124

Matthew Knight talked briefly to the individual risks. Jonathan Perkins asked about the failure to achieve quality premiums. James Blythe said that there had been new information received just this morning and there were some areas that had been achieved and some had not. He agreed that it might be too high and would need reviewing.

GBP1251116/125

Dr Hills asked about Datix in primary care. Dr Sharpe said that this was important for primary care and the Information Governance issues were not difficult to overcome. It had been agreed at Audit Committee that this would be pursued.

8.2 Conflict of Interest Update

GBP1251116/126

Matthew Knight noted that three new policies had been approved at Audit Committee and data collection on interests was at an advanced stage. There may however be more guidance in 2017. Peter Collis said that the policies were good but did need proper comms support before going out to localities in January.

8.3 Clinical Policies

8.3.i TNRF2 (Procedures of Limited Clinical Effectiveness)

GBP1251116/127

TNRF2 and Assisted Conception were agreed. It was noted that each change to TNRF 2 would be notified.

8.3.ii CHC Operational Policy

GBP1251116/128

Chairman's action on this policy was APPROVED.

8.3.iii Assisted conception

GBP1251116/129

The revision involved clarification of age ranges and freezing of eggs. The revised policy was APPROVED by the Governing Body.

9 Clinical Committee and Committee Update

9.1 Clinical Cabinet Report

GBP1251116/130

It was noted that the diabetes update would go live in January

GBP1251116/131

It was agreed that Clinical Cabinet minutes could be shared via Boardpad.

9.2 Audit Committee

GBP1251116/132

Peter Collis gave an update on the meeting held that morning.

GBP1251116/133

- Cyber Security – a very good presentation had been received from the Cyber Security specialist from internal audit. This was a serious threat and would impact on the NHS. It would have to feature in the risk register. A review of the key risks was being commissioned from the auditors.

GBP1251116/134

- The Terms of Reference of the Information Governance Steering Group had been agreed.

GBP1251116/135

- Audit recommendations – there had been significant improvements in this area and staff were thanked for dealing with audit recommendations in a timely manner.

GBP1251116/136

- Continuing Health Care – there had been a limited assurance report but again there had been significant improvements and the CHC team had done a very good job to get on top of the issues.

GBP1251116/137

- Three policies had been approved – conflicts of interest, standards of business conduct and hospitality and gifts.

GBP1251116/138

Dr Sharpe said that the CCG audit would also look at primary care issues in relation to Cyber Security.

9.3 Quality Committee

GBP1251116/139

Most of the issues had already been discussed. It was noted that there was a Seminar next week.

9.4 Remuneration and Nominations Committee

GBP1251116/140

The election of the clinical chair process was noted. A paper was being prepared on this. This would be shared at the Governing Body seminar in December.

9.5 Finance and Performance Committee

GBP1251116/141

Most issues had already been discussed. It was noted that the budget process for next year was significant and this was a lot of work for the organisation. The committee was also very positive about quality of reporting.

10 Other matters

10.1 Any other urgent business

GBP1251116/142

There was no other business

10.2 Meeting Dates for 2016/17 and 2017/18

GBP1251116/143

These were noted.

10.3 Date of next meeting

GBP1251116/144

The next meeting in Public would be on the 27th January at 1pm at Dorking Halls.