NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
27th January 2017

Minutes

Members present:

Dr Claire Fuller	Clinical Chair
Dr Andrew Sharpe	GP Member
Dr Tim Powell	GP member
Dr Louise Keene	GP member
Dr Hannah Graham	GP member
Ralph McCormack	Interim Chief Officer
Matthew Knight	Chief Finance Officer
Steve Hams*	Interim director of Clinical Performance 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
Gill Edelman	Lay Member for Patient and Public Engagement
Dr Tony Kelly	Secondary Care Doctor
Debbie Stubberfield	Independent Nurse
Ruth Hutchinson*	Public Health Representative

***** Denotes non-voting members

Others in attendance:

Dr Simon Williams
Dr Hillary Floyd
Thirza Satwell
Justin Dix, Governing Body Secretary

Chair: Dr Claire Fuller

Minute taker: Justin Dix

Meeting started: 1.00

Meeting finished: 3.30

1. Meeting Matters

1.1 Welcome and introductions

Dr Fuller welcomed everyone to the meeting. GBP1270117/001

1.2 Apologies for absence

Apologies were noted from Dr Russell Hills, Yvonne Rees, and Jackie Oliver GBP1270117/002

1.3 Quorum

The meeting was declared quorate GBP1270117/003

1.4 Conflicts of interests

Members of the Governing Body were reminded of their obligation to declare any interest they may have on any issues arising at meetings which might conflict with the business of Surrey Downs Clinical Commissioning Group. GBP1270117/004

Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link:

http://www.surreydownsccg.nhs.uk/media/53186/01-register-of-interests.pdf

In relation to discussions of End of Life Care Jonathan Perkins highlighted that he was an ambassador for Princess Alice Hospital GBP1270117/005

1.5 Questions from the public

There were no questions. GBP1270117/006

1.6 Minutes of the last meeting (for accuracy)

The minutes of the last meeting were agreed as an accurate record subject to the following amendments: GBP1270117/007

- Steve Hams is interim director of clinical performance and delivery
- P6 048 word should be engagement
- 114 Dr H should be Dr Hills

1.7 Matters arising and action logs

James Blythe gave an update on the written question from the last meeting. This had involved an error in booking patient transport for post -operative physiotherapy. The CSH Surrey Chief Executive was following this up to ensure it did not happen again and a written reply had been given to the individual who had raised the issue. GBP1270117/008

Sustainability and Transformation Partnership (STP) – Gill Edelman asked what Citizen Led Engagement was. Dr Fuller said this was terminology that was adopted in common with Surrey County Council and quite literally empowered people to lead a co-designed piece of consultation work. GBP1270117/009

2. Chairman's actions

Procedures of Limited Clinical Effectiveness (POLCE) admissions had been approved under Chairman's action but would come to the Governing Body in March for ratification. GBP1270117/010

3. Chief Officer's Report

Ralph McCormack spoke to this. Key issues were: GBP1270117/011

- The decision regarding delegated primary care commissioning which mean the CCG would not be pursuing delegation this year. NHS England were following this up with the CCG and would be exploring the issues directly with practices. The opportunity to take part in the scheme might be subject to review in future. At the moment there are only 5 out of 20 CCGs in the South East that do not have delegation. This is causing difficulties for NHS England in terms of recruiting and retaining specialist staff. GBP1270117/012

Jonathan Perkins asked if the CCG was undertaking its own diagnostic as the Governing Body did not know the background. Dr Fuller said the main areas of feedback were lack of clarity about how this would fit with STP and Devolution. Dr Graham said that her practice's rejection was based on experiences of delegation elsewhere and concerns that primary care monies might be eroded. GBP1270117/013

- GP out of hours – Ralph McCormack said that locally the schemes to extend practice hours were bucking the national trend around perceived crises of emergency and urgent care. Local people had alternatives to A&E that were rooted in local GP services and extended services. There was also a paediatric pilot in East Elmbridge that was showing positive results. Children were being seen and treated and getting much more appropriate care. Local service design would continue to explore this as part of the GP Forward View. GBP1270117/014
- Surrey Heartlands STP – the workstreams associated with this were being supported and there had been positive feedback on the plan. Resource for delivery was however needed for this to proceed, which was not easy to provide in the current environment. GBP1270117/015

- The Ofsted inspection of children's services had been published in December and had highlighted the need to support ASD, AHD and neuro-disability patients. The service at Epsom might need review as a consequence. There would also be a need to review the evidence of some CAMHS services before deciding on investment. GBP1270117/016
- GP online – this was becoming more widely available and any Surrey Downs resident could apply. It allowed patients to undertake a number of activities such booking appointments and requesting repeat prescriptions online. GBP1270117/017
- Social prescribing had gone to the Clinical Cabinet and was a way of linking patients into a wider range of options. Dr Sharpe noted this was not a new concept but there had been legal impediments. James Blythe said this was not the case now and social prescribing was building on existing advice and guidance services. GBP1270117/018

Dr Powell asked about delegated commissioning and whether the CCG would pursue this again. Ralph McCormack said this depended on the context and whether there was enough confidence e.g. about devolution and localism for GPs to wish to support it. GBP1270117/019

Debbie Stubberfield asked about transformation funding for the STP as this was a concern. It could delay QIPP initiatives if not funded. Ralph McCormack said that there was also a need for local organisations to agree to create budgets in addition to transformation funding. To some extent the release of transformation funds depending on this collaboration being in place. GBP1270117/020

Debbie Stubberfield asked about levels of transformation funding and the risk associated with this. Ralph McCormack said the transformation funding levels were known but would not bridge existing funding gaps. It would be necessary for CCGs (as the supplier of most of the infrastructure) to take the lead on this. The CCGs were asking for their contingency funds to be released to provide the necessary support; without this they could not resource progress in this area. GBP1270117/021

Peter Collis asked about delegated commissioning and whether this could be forced on the remaining 5 CCGs. Was Surrey Downs prepared for this? James Blythe said the CCG was attempting to build its capacity and create an environment locally where practices knew they could get support from within Surrey Downs. Work was also proceeding with the other two CGs on the administration of primary care transformation funding which was hosted locally by NW Surrey CCG. GBP1270117/022

Dr Graham said that there had been a great deal of support to practices from James Blythe and the Primary Care Team in recent months. Shelley Eugene was very responsive to practice needs and relationships had greatly improved. GBP1270117/023

4. Epsom Integration Update

Dr Hilary Floyd and Thirza Satwell attended for this item. GBP1270117/024

Dr Floyd reminded the Governing Body that Epsom Health and Care was an alliance of four providers with a population built around the 20 practices in the Epsom locality. The “at home” service was now up and running and was proving very positive. The values and aims were patient centred and focused on health and social care. GBP1270117/025

The rationale was based on the needs of an ageing population with far more people living into their 90s. This bought a range of complex health conditions and issues such as loneliness. GBP1270117/026

The assisted discharge team were providing a lot of support in the home and there was a lot of focus on re-ablement. The diagnostic unit (CADU) was proving very valuable. GBP1270117/027

The enhanced at home service worked something like a hospital at home team. Examples of recent case studies were given which highlighted the ability for rapid response that prevented admission. There was also an impact on hospital beds during periods of peak demand to facilitate early discharge and to reduce trolley waits / A&E demand. GBP1270117/028

The record sharing work was also proving very positive with the at home team able to see a single record which avoided patients having to repeat their story. GBP1270117/029

Steve Hams commended the team and asked how patients were involved in improving outcomes and what the team was? Dr Floyd said that the team was based around the clinician of the day who would draw in the resources they needed. There was a range of equipment available from a social care perspective. There was also a follow up process in place to ensure that the patient was not deteriorating. Feedback from carers and service users was common. GBP1270117/030

Dr Fuller noted there was an STP wide evaluation of all new care models including this one. This was being done by a public health trainee. GBP1270117/031

Dr Keene asked about workforce. Dr Floyd said this included GPs and there was a team that went into hospitals when required. It did require an extension of the normal GP role into new areas. Dr Fuller said that any Governing Body member who was interested should go and meet the team as they were very enthusiastic. GBP1270117/032

The diversity in the team was a significant issue in its success. There was a physical location (“command centre”) which was an information hub for the team and where daily meetings were convened, with an option to dial in. GBP1270117/033

Dr Sharpe asked about capacity and referral patterns. Thirza Satwell said that the expectation was that the team would support around 6-10 people per day with 72 hour care plans up to 8pm in the evening. This was built into the prioritisation processes. GBP1270117/034

Jonathan Perkins asked about the governance of the organisation and about its ambitions. Dr Floyd said there was a genuinely multidisciplinary approach but the governance was across the allied organisations. There was an independent chair and lay member presence. The vision was to grow the service and extend it to a wider population. GBP1270117/035

Dr Kelly asked about whether the bespoke approach allowed for the real costs and benefits to be measured. It was acknowledged that this needed to form part of the future approach and that the team needed to identify people at risk who could most benefit. It also needed to extend into proactive work and health education. GBP1270117/036

James Blythe said that the business case was built around outcomes and defined expectations around emergency activity and how different elements of the service were supporting improvements in this area. GBP1270117/037

James Blythe highlighted the approach taken around integration and how the accountability was shared between providers. This was a significant issue for the Governing Body to consider as it differed markedly from other approaches. GBP1270117/038

5. Quality and Performance

5.1 Quality and Performance Report GBP1270117/039

Eileen Clark introduced this. It had been discussed in detail at the January Quality Committee. Highlights were:

- SECAmb– potential for a deep dive for stroke patients
- Workforce – significant pressures system wide
- Issues around SABP and a death on the Epsom site

Concerns were expressed about progress on Patient and Public Engagement. Debbie Stubberfield said there was a real need for the strategy and for this to be linked into STP work. Gill Edelman said this was a fundamental concern that impacted on all areas of the CCGs work. As a Governing Body member she would like to see a clearer iteration of the principles and expectations of PPE, alongside themes emerging from the STP.

Action Ralph McCormack

Eileen Clark then highlighted the following areas in more detail:

- CSH Surrey CQC report – initial feedback has been positive, the formal report would be available in March / April.

- SABP – potential changes to estate on the Epsom site. The trust has been clear that it could not retain a presence in the Delius and Elgar wards due to environmental issues impacting on safe clinical care. As this was an urgent safety issue there was no scope for prolonged consultation and the trust were working with the Surrey Health Scrutiny Committee (HSC) to manage this as quickly as possible. The HSC was supportive given the urgency of the issues. These were surrey wide services but on the SDCCG patch and the emphasis was on good support around transport and staying in touch with relatives when admitted to alternative facilities in Chertsey. Work was now starting on long term solutions and seeking alternative sites for a permanent home for the in-patient beds.

Debbie Stubberfield asked about existing patients and their welfare. James Blythe said the moves were taking place on the 2nd Feb and he had met with the relevant director at SABP to ensure risks for individuals were being managed. Eileen Clark confirmed that in her view the moves were essential on safety grounds.

Dr Fuller said there would be a need for Governing Body members to sit on a committee in common to support this work. Governing Body members were asked to reflect on whether they could take part in this (one lay and one clinical member)

Action all

- Eileen Clark highlighted never events with AQP provider sub contractors. This was being explored with Dorking Health Care.
- Princess Alice Hospice was commended and congratulated on being the first hospice to be in receipt of an “outstanding” CQC outcome.
- Similarly the Royal Marsden had receive a “good” overall rating which was a positive development.
- Hydration project – there had been two sessions so far with care homes and these were really positive. 18 homes were engaged and they were enthusiastic about making positive change. There was already a visible drop in Urinary Tract Infections.

5.2 Dashboard – constitution measures GBP1270117/040

Steve Hams noted that SECAMB remained an issue. There was a lag on data.

Peter Collis asked about the work being done by ambulance crews to avoid admissions and whether this positive development was coming through in the statistics. Steve Hams said that it was evident in the response times and handover approaches. This needed to focus on the whole system.

5.3 Dashboard – outcome indicators

GBP1270117/041

Dr Powell asked about the increase in alcohol related emergency admissions. It was noted that there were some frequent fliers responsible for most of the increase. Ruth Hutchinson said that this was being looked at from a public health perspective. It was noted that there was a 2 year CQUIN for alcohol. It was agreed to continue the dashboard approach in these reports.

5.4 Dashboard – operating plan metrics

GBP1270117/042

There were no further comments.

5.5 Commissioning for Value (Right Care)

GBP1270117/043

Steve Hams said there was clear evidence that Right Care was embedded in the CCG's work and it was regularly evidenced on various workstreams. MSK packs were being reviewed and this had been the predominant focus in recent weeks. New packs would be coming out in the next few weeks.

Dr Fuller reflected that the focus on unwarranted variance reflected the CCG's priorities.

6. End of Life Care Strategy

GBP1270117/044

Dr Fuller introduced this and the four main asks in the presentation. James Blythe reminded people that this was in the context of the strategy agreed in November 2015 and was based on the wider learning of implementing projects through the PMO.

GBP1270117/045

Dr Williams introduced himself as the CCG Clinical Lead for End of Life Care and Integration.

GBP1270117/046

The locally adopted vision for End of Life Care was in line with The National Council for Palliative Care and National Voices statement in 2015:

'I can make the last stage of my life a good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me including my carers'.

GBP1270117/047

Dr Williams noted that more than half of deaths occurred in hospital and there was a change in the pattern of where deaths occurred. It was a matter of concern that the CCG compared poorly against its peers in terms of unscheduled admissions and place of death.

GBP1270117/048

Since the last report to the Governing Body the CCG had:

- Reviewed project management structure and clinical leadership.
- Refreshed the EOLC Project Board
- Identified and recruited a project resource
- Compiled a project outline document and project plan.
- Reviewed end of life contracts and grant agreements
- Scoped out other potential dependencies

Dr Williams reiterated the objectives of the strategy which were "to deliver and enable a workforce that is integrated and localized supported by inclusive communities able to have open honest conversations and supportive networks related to dying". GBP1270117/049

There were a number of actions being taken to deliver this: GBP1270117/050

- 24/7 services
- Provider collaboration
- Training
- Support to carers
- Timely bereavement services
- Support for choice of place of death

The strategy was being delivered by a programme management approach and driven by national standards. There was a governance structure around this. GBP1270117/051

Gill Edelman asked about the metrics behind the poor performance. The key issue was emergency admissions and death in the last of these rather than planned care. There were significant links to long term conditions work and the wider integration agenda. This was the key emphasis now and there could be real benefits from rooting it in this approach. Gill Edelman asked if local demographics were unusual. It was acknowledged that more work was needed in this area. GBP1270117/052

James Blythe highlighted the issues of relationships with ambulance services where other CCGs had more sophisticated systems and relationships to ensure that conveyance to hospital was appropriate. This needed to be developed and embedded in local practice. GBP1270117/053

Peter Collis said he was supportive of the approach and asked how it related to the QIPP challenge. GBP1270117/054

Dr Williams said that the main issue was co-ordination of services which did not involve additional costs. The scope for supporting QIPP was limited but there would be significant savings and improvements in quality in avoiding unplanned admission. This could be in the region of £100k. GBP1270117/055

Dr Kelly asked about conveyance and said that there needed to be more visibility of the information to all those involved in a patient's care. GBP1270117/056

Dr Williams said this was being addressed using IBIS (The SECAmb system). There was also learning from the Sutton Vanguard programme which meant patients carried their own information bags. GBP1270117/057

Debbie Stubberfield thanked the team for taking a grip on this issue and asked whether the CCG was meeting Palliative Care standards. GBP1270117/058

Dr Williams said that in terms of the six ambitions in the Palliative Care Standards there was work planned to self assess against these. GBP1270117/059

Hannah Graham asked if the End of Life Care programme was integrated with the dementia work and it was confirmed it was. GBP1270117/060

Dr Sharpe highlighted the role of the shared care record which could be implemented relatively cheaply. GBP1270117/061

Jonathan Perkins thanked the team for their work which was now much more systematic. He asked when there would be clear data about the number of patients that had been supported. It was encouraging that partnership working was improving across all sectors. He did caution on bereavement services that some people needed to be followed up months and even years depending on individual need. GBP1270117/062

Education was very important and he queried whether nursing and care home staff were being adequately supported. There was significant scope for improvement in this area. He also queried how this work fitted with the STP and with EOLC services in neighbouring CCGs. This was not covered in the strategy. GBP1270117/063

James Blythe said that there was a lack of a strong narrative in the STP work and this had been flagged by the Surrey Care Association who felt there were more opportunities for them in this area. It was important to include EOLC in the integration work in order for it to retain local relevance but there was a question about the role of the academy and standardisation of care. He felt the ambitions should be adopted across the STP area. GBP1270117/064

Dr Powell noted there was a significant number of people for whom hospital was their preferred place of death. He asked if there was a palliative care consultant on the board and it was confirmed there was. GBP1270117/065

Jonathan Perkins noted that next time this was discussed we should invite the relevant EOLC strategy stakeholders. This was agreed. To come back in May. GBP1270117/066

7. Annual Equality and Diversity Report

Ralph McCormack reminded the Governing Body that this was a statutory report. It reflected the work of the CCG over the last year and this was summarised in Section 11. GBP1270117/067

Ralph McCormack highlighted the importance of leadership – substantial progress had been made with the appointment of a GP champion and departmental champions. The E&D steering group was meeting regularly, chaired by himself as Chief Officer. The CCG was now getting to grips with its responsibilities as both a commissioner and as an employer. CCG staff are being supported with training in E&D and this was impacting positively on service redesign. GBP1270117/068

There were recommendations in the report and these were built into the action plan. Again leadership was a key consideration. This work was also happening across the STP where transformation was being looked at in terms of the needs of its diverse communities. GBP1270117/069

Ralph McCormack commended the report to the Governing Body and noted this needed to be published by 31st January. GBP1270117/070

Debbie Stubberfield asked about the regulatory position. Justin Dix confirmed that the report did not need to be submitted but NHS England would expect it to be referenced in the CCG annual report. It was also necessary to make it visible on the CCG web site as the Equality and Human Rights Commission did make spot checks, particularly where they had received complaints about organisations. GBP1270117/071

Gill Edelman noted that some areas of disability were specific such as learning disability and as a CCG we should develop the relevance of these locally. GBP1270117/072

The Governing Body AGREED the annual equality and diversity report. GBP1270117/073

8. Finance and Planning

8.1 Finance Report

Matthew Knight introduced this. The CCG was on track for achieving its control total. Section 2.2 highlighted the overspending in acute due to SASH, Critical Care, Generally higher elective activity, and South West London Elective Orthopaedic Centre work. GBP1270117/074

The table on page 4 demonstrated the detail behind this which totalled £5m adverse. Mitigations reduced this to £2.7m. GBP1270117/075

There were issues with CHC where there were significant increases in enquiries and activity, and there were mitigations to attempt to deal with the overall problem. Issues with CHC were expected to continue into next year as demand was outstripping budgets and this was a matter of concern. Operational changes have contained pressures but this capacity was now reaching a plateau. GBP1270117/076

Overall referrals were increasing by just over 5% in the last month although there were signs of this flattening out. GBP1270117/077

The forecast (Section 4) was in line with budgets but this excluded the £4.5m unmitigated risk that had been highlighted for several months. The overspending in acute was across a number of providers but mitigations had reduced this to £3.7m, this remaining sum being recovered through contingencies and other mitigations. Matthew Knight stressed that the overall position was very tight. GBP1270117/078

QIPP reporting was stable and represented a good achievement. The savings areas were set out in the table on page 9 which broke them down into their component parts, planned care and integration being significant components. GBP1270117/079

NHS England were very aware of the unmitigated risk and the reasons for it and how the CCG was dealing with it. GBP1270117/080

The unidentified QIPP for 2017/18 was £17.9m despite comprehensive discussions with main providers on agreeing next year's contracts. A block arrangement had been agreed with Epsom, with other providers being subject to PBR. It would be difficult to take costs out of the acute cost baser but discussions were on-going with providers. NHS England were clearly sighted on this but the £17.9m which was proportionate and similar to the position between commissioners and providers across the south of England as a whole. GBP1270117/081

Steve Hams asked if it was possible to slow down activity in SWLEOC so that patients were treated within constitutional expectations but at appropriate times. James Blythe said that the issues here were very specific and related to addressing a waiting list backlog across Surrey Downs and South West London. It was acknowledged that it was important to meet the 18 week standard without over performing if possible. GBP1270117/082

Steve Hams re-assured the Governing Body that the CCG was doing everything possible to maintain a level playing field for CHC patients being treated at home, which was an issue which had been highlighted in the media recently. NHS England had requested assurance on this. It was agreed that the Governing Body should also have a summary of the issues and what the CCG was doing, and it was agreed that this would be covered in the next Chief Officer's report . GBP1270117/083

Action Ralph McCormack

8.2 Commissioning Intentions

James Blythe introduced this. It was the end of a long term process rooted in engagement with localities and making use of best practice e.g. from Right Care. GBP1270117/084

Debbie Stubberfield queried whether an Equality Impact Assessment was done against the commissioning intentions as a whole. It was noted that individual changes were assessed where relevant but it was difficult to make the groups with protected characteristics to the broad themes in the commissioning intentions. GBP1270117/085

Ruth Hutchinson said that the public health profile provided some signposts at a high level. There was an obvious focus on people with learning disabilities but there was a need to look at the access of this group to services such as Integrated Access to Psychological Therapies (IAPT). It was agreed to feed this work into the public health profile work. GBP1270117/086

Eileen Clark noted there was a need to engage residents more as the numbers involved were small. However there was engagement on specific projects with specific groups of stakeholders. GBP1270117/087

Gill Edelman felt that there needed to be more narrative approaches to the experience of patients pre- and post- service change. GBP1270117/088

Dr Kelly agreed and said that this approach achieved a very different understanding to other forms of consultation. Dr Graham said that there might be scope for using GP surgeries to access stakeholder views more effectively. GBP1270117/089

The Commissioning Intentions were AGREED. GBP1270117/090

9. Governance and Organisational Development

9.1 Risk Report

9.1.1 Governing Body Assurance Framework

Matthew Knight introduced this. The "P2" definition had been amended as discussed at last Governing Body to produce a more specific focus on quality GBP1270117/091

P3 – primary care commissioning – it was queried how to address this given the vote by GPs not to pursue delegated commissioning. It was agreed to keep the objective but reword in a more appropriate way that did not refer to formal delegation and could be carried forward to next year's objectives. GBP1270117/092

Action Justin Dix

It was agreed to introduce a new risk on next year's QIPP. GBP1270117/093

Action Matthew Knight

9.1.2 Corporate risk

The report was based on an output from Datix. Changes were marginal. There was a need to review the definition of corporate risk as assessed by individual risk owners. At the moment it was not being used consistently. GBP1270117/094

The Governing Body NOTED the risk register. GBP1270117/095

9.2 Conflicts of interest update

Matthew Knight noted that there had been some big changes in process and these were not yet mature. This had been highlighted by auditors and their report contained a number of recommendations which were not unexpected and which were being addressed. GBP1270117/096

9.3 Policy Revision – Procedures of Limited Clinical Effectiveness (POLCE) within Treatments Not Routinely Funded (TNRF)

The POLCE update to the TNRF now included spinal stimulation. This had gone through clinical cabinet and SPC. GBP1270117/097

The revised policy was AGREED by the Governing Body. GBP1270117/098

10. Clinical Cabinet Update

December meeting - The 111 and Out of Hours Strategy was considered as the contracts for provision of these services were due to expire in September 2017 and March 2018 respectively. Several options were proposed and it was agreed to investigate two options further with the localities. GBP1270117/099

Social Prescribing was considered and has already been reported in the Chief Officer's Report. GBP1270117/100

January meeting - As part of the GP Forward View, a Primary Care Steering Group was to be established to undertake deconflicted decision making. Membership would include three Accountable Officers and an independent GP. CCG GPs would be in attendance. GBP1270117/101

The report was NOTED. GBP1270117/102

It was noted that the minutes of meetings needed to be added to the Governing Body reading room. GBP1270117/103

Action Justin Dix

11. Governing Body and Committee Updates

11.1 Governing Body Seminars and Development Sessions

In these sessions the Governing Body has: GBP1270117/104

- Undertaken exercises to help the Governing Body members to become individually and collectively more effective.
- Reviewed the detailed financial and contracting risks and issues associated with the remainder of this financial year, and 2017/18.
- Considered issues relating to working with other partners across the STP patch and also the potential impacts of devolution.

The report was NOTED. GBP1270117/105

11.2 Audit Committee

Key issues from the 8th November meeting were: GBP1270117/106

- The critical importance of Cyber Security both for the CCG and GP practices was highlighted.
- The Information Governance Steering group terms of reference were approved, with amendments.
- There was much better progress on signing off audit actions
- Continuing Health Care Audit – limited assurance outcome, but good and rapid progress made on remedial action

The following Policies were agreed: Conflicts of Interest, Gifts and Hospitality and Working with the Pharmaceutical Industry. GBP1270117/107

The report was NOTED. GBP1270117/108

11.3 Quality Committee

December Seminar - key issues to report. GBP1270117/109

- Primary Care - an in depth discussion was led by the Head of Primary Care
- The Deputy Director of Commissioning had led an update on the CCG's integration work
- Terms of Reference - for review in February and sign off by the Governing Body in March
- Hydrate - working with care homes to ensure hydration of residents
- SECAmb - On-going work to recover performance

January Formal session: GBP1270117/110

- Work on outcomes was ongoing
- The committee was keen to see progress on Patient and Public Engagement with the strategy and capacity issues being addressed.
- Significant areas of quality risk - these were identified as SECAmb and Workforce generally
- The legal action against Surrey and Borders by the Health and Safety Executive was noted
- Learning and Candour - update on the outcomes from the Southern Health report

The committee would be reviewing its performance in the spring GBP1270117/111

The report was NOTED. GBP1270117/112

11.4 Remuneration and Nominations Committee

The committee met on the 18th November. GBP1270117/113

- The learning and development policy was approved.
- The significant benefits from the Heads of Service development programme were noted.

The report was NOTED. GBP1270117/114

11.5 Finance and Performance Committee

The committee highlighted the significant financial issues in the Finance Report. GBP1270117/115

- It was noted that CHC costs and activity were escalating.
- The benefits of, but also concerns around administration of health budgets was highlighted.
- The development of the Improvement and Assessment framework was noted.
- The Procurement Policy had been agreed
- NHS Estates issues were highlighted in a comprehensive presentation - there are significant financial risks.

The impact of QIPP had been effectively mitigated by the high level of QIPP achieved - to be revised for next year's assurance framework. GBP1270117/116

The report was NOTED. GBP1270117/117

12. Other matters

12.1 Any other urgent business

It was agreed to hold a Governing Body meeting at Molesey Hospital at some point this year so that Governing Body members could visit the site. This should be combined with an East Elmbridge locality update. GBP1270117/118

Action Justin Dix

12.2 Dates of future meetings

The next public meeting would be on the 31st March 2017. GBP1270117/119