NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
26th May 2017

Minutes

Members present:

Peter Collis	Acting Chair/Lay Member for Governance
Dr Claire Fuller	Acting Clinical Chief Officer
Dr Andrew Sharpe	GP Member
Dr Elena Cochrane	GP member
Dr Louise Keene	GP member
Dr Hannah Graham	GP member
Dan Brown	Deputy Chief Finance Officer
Matthew Knight	Chief Finance Officer
Andrew Demetriades*	Interim Director of Commissioning and Transformation
Eileen Clark *	Interim Director of Clinical Performance and Delivery/Chief Nurse
Jonathan Perkins	Lay Member for Governance
Gill Edelman	Lay Member for Patient and Public Engagement
Debbie Stubberfield	Independent Nurse
Ruth Hutchinson*	Public Health Representative

***** Denotes non-voting members

Others in attendance:

Dr Simon Williams
Dr Andre Beattie
Dr Robin Gupta

Chair: Peter Collis

Minute taker: Karen Rodgers

Meeting started: 1.04

Meeting finished: 3.29

1. Meeting Matters

1.1 Welcome and introductions

Peter Collis welcomed everyone to the meeting. GBP1260317/001

1.2 Apologies for absence

Apologies were noted from Dr Tony Kelly, Yvonne Rees and Justin Dix GBP1260317/002

1.3 Quorum

The meeting was declared quorate GBP1260317/003

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. GBP1260317/004

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

1.5 Questions from the public

There were no questions. GBP1260317/005

1.6 Minutes of the last meeting (for accuracy)

Subject to the following amendments the minutes of the meeting held on 31 March 2017 were agreed as an accurate record: GBP1260317/006

- The date of the minutes should be 31 March 2017
- P13 110 budget 2018/18 should read budget 2017/18

1.7 Matters arising and action logs

GBP1270117/105 Assurance Framework. The action was agreed for closure GBP1260317/007

GBP1270117/131 GB Meetings. A meeting is yet to be scheduled at Molesey Hospital but likely to be in 4 months' time when East Elmbridge due to give their locality update. Keep action open GBP1260317/008

GBP1310317/023 SASH – Mr Main. Information has been received from SASH and conversations have taken place with the lead commissioners. The action was agreed for closure GBP1260317/009

GBP1310317/096 Joint Quality Committee Meeting. Conversations have taken place with other Quality leads and a joint Quality Committee focussing on Continuing Healthcare will take place by the end of July. The action was agreed for closure GBP1260317/010

GBP1310317/145 Organisational Development. OD was taken to May seminar and all actions are in hand. The action was agreed for closure

GBP1260317/011

1.8 Epsom Medical – Correction to the January minutes

Dr Fuller reported that at the January meeting of the Governing Body reference was made to a team pursuing Epsom Medical for further information regarding a Never Event. This event actually involved Dorking Healthcare and not Epsom Medical therefore the minutes will be amended.

GBP1260317/012

2. Presentations

2.1 End of Life Care (EOLC) Strategy Update

Dr Simon Williams presented this item and thanked the following who had played a critical part in the work around the EOLC Strategy;

GBP1260317/013

- Christine May, Shooting Star Chase
- Julie Leversedge, SCC
- Lesley Spencer, Princess Alice Hospice
- Karen Rosetti, CSH Surrey
- Polly-March Mather, SD CCG
- Lorna Hart, SD CCG

Dr Williams confirmed that the Governing Body was being asked to endorse the revised EOLC Strategy, the outline mobilisation plan and End of Life film. These would then be taken to the June Clinical Cabinet for discussion and approval.

GBP1260317/014

The essential elements of the EOLC Strategy are:

GBP1260317/015

- Early identification
- Staff training and education
- Care that is co-ordinated
- Services that are accessible and meet local needs
- Embracing new technology to improve communication
- Bereavement support

The need for resourcing was recognised and how both the EOLC strategy and the Dementia strategy would align.

GBP1260317/016

Link to film

GBP1260317/017

Gill Edelman commented that the Strategy was an impressive document with an inspiring vision and asked what the challenges in realising it were.

GBP1260317/018

Dr Williams agreed that it was ambitious and one of the challenging areas was resourcing and also the accessing of shared care records. Discussions had already taken place with Dr Andrew Sharp around how this could be taken forward.

GBP1260317/019

Lorna Hart said that it was a 3 year strategy and gap analysis would be looked at immediately. This was the first time that a project plan/mobilisation plan had been owned collaboratively and that highlighted extra responsibility by all concerned. GBP1260317/020

Lesley Spencer said that she hoped that the technology would be there to enable more efficient and effective working in order to achieve the ambition. It was not always a question of funding and resourcing but using what was available in a different way. GBP1260317/021

Gill Edelman commented that the phrase that stood out throughout the document was the 'unwavering commitment'. GBP1260317/022

Debbie Stubberfield thanked everyone involved for all their hard work and said that the document was very powerful and asked that the gap analysis, once completed, was shared with the Governing Body. GBP1260317/023

Dr Williams said that the development of the EOLC Project Board 5 months ago had been one of the most positive aspects. Representatives from all commissioners and providers meet and the collaborative collusion was driving the Strategy forward. GBP1260317/024

Jonathan Perkins advised that he was an ambassador for Princess Alice Hospice. He said the document was very much more powerful than before but asked when was the patient going to benefit. He also asked what plans there were to include the rest of the STP to bring them on board as a surreywide initiative. The ambition of having a caring community was very much County Council driven and the question was asked if the County Council were going to support Surrey itself being a caring community and sign the manifesto and make the commitments. GBP1260317/025

Lorna Hart advised that it was clear from talking to the clinical membership that the CHiN (Community and Hospice Home Nursing) service was very much valued. As part of the audit it was key to understand what was and was not working well, where the resources are and build on that and listen to primary care partners and patients. GBP1260317/026

Dr Fuller said that currently EOLC was not a workstream within the STP. These conversations would take place in the Out of Hospital workstream which is being revised so there was an opportunity to make EOLC a priority across the footprint. The Health & Wellbeing Board was another effective way to raise awareness as the priorities chosen by them were monitored at a Surreywide level. Shared learning from colleagues across the footprint was also key as G&W and NWS CCGs had done some very good work. GBP1260317/027

Jacky Oliver reinforced how good the document was. She said that earlier in the week she had two conversations around EOLC in care homes; one experience very good and the other very bad. GBP1260317/028

Dr Williams said that another project was the Quality in Care Home project which involved community matrons and care workers going into care homes and supporting the care staff. GBP1260317/029

Part of the project was to look at advanced care planning and EOLC and improvements were being seen in the unscheduled admissions taking place.

Dr Louise Keene asked how far ahead an integrated IT system was. GBP1260317/030

Dr Andrew Sharpe advised that a Surrey wide project roll out of initially sharing the GP record through 'Patient Knows Best' should be online within 6 months. A proactive care record built into EMIS web and other clinical systems used by Oxford CCG should then follow. GBP1260317/031

Dr Williams said an IBIS record has been rolled out and can be seen by the ambulance service as a preliminary record and is prioritised for patients on the EOLC pathway. Discussions have also taken place with the locality Clinical Chairs around the new DWAR form, supported by SECAmb, which encompass wishes at the end of stage for patients. GBP1260317/032

Matthew Knight said that as there were some marked differences for place of death for men and women should the two populations be segmented when approaching changes or projects. GBP1260317/033

Lorna Hart advised that nationally men did not live as long as women. GBP1260317/034

Dr Hannah Graham said that East Elmbridge had an amazing relationship with Princess Alice Hospice and suggested colleagues spending time with them. GBP1260317/035

Jonathan Perkins advised that Dr Jill Evans had a meeting with Lesley Spencer and Nicky Shaw from Princess Alice to discuss how the community integrated teams in East Elmbridge could work together with the Princess Alice teams. GBP1260317/036

Dr Elena Cochrane asked if there had been any thought around working with undertakers as unnecessary distress can be caused to families if the undertaker did not accept the district nurse certifying the death. She also asked what bereavement support would be offered other than CRUSE or Princess Alice. GBP1260317/037

Dr Williams confirmed that discussions were being held around community matrons/senior nurses being able to certify deaths and the intention is to embed the expected death work within the electronic documentation to ease the process. Dr Williams said he was not aware of any other support services other than the two referred to. GBP1260317/038

Lesley Spencer said that it was important for communities to talk about death as it was a normal process and more grief and loss cafes would help. GBP1260317/039

Suzi Stanford from Helpout; a self-funded social enterprise, advised that a meeting was being held with Surrey County Council on 12 July to discuss a solution which would enable the sharing of information across the NHS and social services. GBP1260317/040

Dr Keene asked if St Catherine's hospice were involved in the strategy. Lorna Hart confirmed that they were. GBP1260317/041

Christine May advised that Shooting Star look after youngsters until the age of 21 and offer a full bereavement service for up to 3 years after death. The service is open to surrey and 15 London boroughs. GBP1260317/042

Dr Williams thanked Suzi and Lucy from the SD Comms team for the huge amount of work carried out with the making of the film. GBP1260317/043

The Governing Body AGREED to endorse the EOLC Strategy. GBP1260317/044

2.2 Dorking Locality Update

Dr Andre Beattie was welcomed to the meeting to give an update on Dorking Community Medical Team. GBP1260317/045

Dorking locality are the last of the localities to set up a team and currently have a community hub at Dorking hospital Ranmore ward with a small team visiting patients in their own home. GBP1260317/046

The team will be set up with: GBP1260317/047

- 2 full time community matrons initially working 5 days per week 8am–5pm
- Community medical GP working 5 hours per day
- Medical lead
- Care co-ordinator signposting to various teams
- Clinical navigator to triage once referrals received

The team will liaise with other services i.e. GPs for home visits to patients, acute hospitals for step down treatment from discharge, SECAmb, Mental Health and adult social care team. GBP1260317/048

It was noted that ultimately they wanted to work collaboratively within a multidisciplinary community setting to deliver high quality, patient centred, safe and effective clinical and social care to people in their home. GBP1260317/049

The locality wanted to have: GBP1260317/050

- A fully integrated community team with clinical hub on Ranmore ward, Dorking hospital
- Closer relationships between provider services
- More joined up care
- 'Can do' mentality towards managing patients in their own homes
- First steps towards more integrated specialist nurse care in the community – diabetes, respiratory and cardiac

Eileen Clark asked would community matrons/senior nurses be working 7 days a week, how would they link in with existing community services and how mental health practitioners would be bought into the team. GBP1260317/051

Dr Beattie said that given the limited budget and to ensure the team had enough time to embed, it was only possible to produce a 5 day service. If a 7 day service was created it would only last 9 months and it would not be feasible to employ staff for that period. The hope is to show beneficial results for the 5 day service producing a strong argument for funding to then extend to a 7 day service. Mental health is part and parcel of on-going conversations. There is currently a mental health nurse working alongside the community nurses and the hope is to make the role more robust. GBP1260317/052

Lorna Hart advised that a 7 day service already existed outside of the Dorking Community Medical Team remit through all contracts with community providers and therefore it did not sit in silo. GBP1260317/053

Jonathan Perkins said that this item had been red rated at the Finance and Performance Committee for the past 12 months due to the team not being in place. Although colleagues were very glad that this was moving forward, frustration was noted over the length of time taken and the question was raised over how many hospital admissions could have been avoided if the service had been up and running last year. Jonathan Perkins also asked why Dorking was not focusing on the frail elderly over 65s as both East Elmbridge and Epsom were. GBP1260317/054

Dr Beattie said that he did not see any value in limiting the service to 65 and above as younger patients were then excluded who suffered from early onset Parkinson's, MS or chronic physical or mental disabilities. GBP1260317/055

Jonathan Perkins reiterated the need for moving forward at pace. GBP1260317/056

Gill Edelman said that the other localities have said that the 7 day working, integrated care and sharing of information has delivered the improvements and using a 5 day working model may not prove as beneficial. GBP1260317/057

Dr Graham said that she struggled to understand the difference between Dorking and East Elmbridge as East Elmbridge was working well. She also asked what the referral criteria was given that the population was much larger. GBP1260317/058

Dr Beattie said initially there would be specific criteria for practices to refer into the service to give an idea of workload. Referrals from Adult Social Care and SECAmb were already being dealt with by community matrons therefore the addition of the doctor will manage the increased workload. Starting the service with reduced hours will mean the service is manageable as the staffing is increased. GBP1260317/059

Lorna Hart said that she would work with Dr Gupta and Dr Beattie on the presentation for the next Governing Body update and highlighted that integration was still to be tested in Dorking. GBP1260317/060

ACTION Lorna Hart

Dr Gupta was welcomed to the meeting to give an update on Dorking Locality Commissioning Intentions and advised that a Primary Care Home status was applied for in 2016 which was subsequently won: GBP1260317/061

- Clinical Pharmacists - May 2017 - bid to NHSE for 1WTE senior pharmacist to work across locality. NHSE to fund 60%, 40% and 20% over first 3 years and DHC to fund the rest. Requesting the CCG to support the use of the GP 5YFV £3.00 per registered patient fund to offload workload on primary care to employ another clinical pharmacist.
- Integrated Respiratory care - working with the CCG to support the vision.
- Integrated Cardiology care - working with the CCG to support the vision.
- Physiotherapy - early discussions with the CCG re having physiotherapists in primary care to offer timely, appropriate, assessment and treatment for patients with muscle or joint issues. Could use £3.00 5YFV.
- GP access scheme - initial meeting set up in June to discuss opportunities and approaches available to the locality.
- Pre-diabetes / diabetes care - new PQCS in diabetes started in April and 2 practices are part of the roll out to improve pre-diabetes care. Much more can be done and will look at options available next year to move this program forward.
- IAPT for chronic disease - support the CCG wish to offer IAPT for patients living with chronic disease and are keen for our local practice based IAPT therapists to offer this service.
- End of Life Care - due to present locality data and variances to discuss how to offer best care to our patients within the next 2 months. Working with the CCG on improving current pathways and communication.
- Minor illness clinic - utilising Clinical pharmacists, GP access scheme and the community medical team alongside the wider primary care team. Hope to offer minor illness/injury clinic.
- Complex disease / frailty clinic - looking to work with the CCG to fund dedicated 20-10 minute appointments to provide improved care to patients with multiple conditions or frailty.

Dr Gupta explained the four tier pyramid to deliver improved quality and care in long term respiratory and cardiology conditions: GBP1260317/062

- Tier 1: HCA, practice nurse and GPs
- Tier 2: Specialist nurse to upskill nurses
- Tier 3: Community clinic, consultant, GPSI, specialist nurse
- Tier 4: Secondary care

The only part currently missing for the delivery of the service is the specialist nurses and with appropriate funding this could be done very quickly. One opportunity would be to use primary care quality standards across the CCG and each locality would work up their way of delivering to their population and workforce. GBP1260317/063

The benefits of the pathway are: GBP1260317/064

- A minimum level of care and standardisation that can be measured across the practices GBP1260317/065
- Self-care management plans for patients delivered locally so patients can treat themselves in a timely fashion and contact the relevant healthcare services
- Continuous improvements and support for practice nurses and GP's.
- A reduction in patients needing to be seen in clinic and attend hospital, reduce AE attendance and admissions to hospital.
- All patients with chronic respiratory / cardiology illness receive a dedicated review at least once a year.
- Lead to more proactive care with time to discuss ceiling of care plans and end of life care plans when appropriate.

Dr Russell Hills said he recognised the difficulties in terms of resource due to the size of the locality. He asked that in relation to the tier 2 and 3 services would there be any benefits to working with others outside of the locality within the STP. GBP1260317/066

Dr Gupta said that Dorking had been working as an integrated workforce as a group of five practices for 25 years, and the provider arm was set up 20 years ago to run the outpatient appointments. A lot of the tier 3 service was already available in the area with consultants who integrated into both Epsom and SASH. The integrated primary care workforce have worked together for 15 years. The Care Home bids state populations of 40-45k and Dorking has a population of 43k therefore the belief is that that is the model of the future of primary care. GBP1260317/067

Andrew Demetriades said it was good to see the ambition and variety of things the locality wanted to do going forward. He suggested accelerating the primary care home vision as there was a sizable step from small incremental changes at provider level around service redesign and improvement, to take on more of a population health based budget. This could possibly be done not only with Dorking Healthcare but with SASH and other providers. He also asked where relationships with SASH and different ways of doing things featured in the model. GBP1260317/068

Dr Gupta said that the locality tended to focus on things they had ability to change and improve. Dorking was stretched between SASH, Epsom and Guildford so relationships were more difficult as patients arrive at A&E with more severe illnesses. Closer working was taking place with the acutes around how the model could be delivered but currently the focus was with the community providers. With regard to integration, assurance has been received from CSH Surrey that anyone working in Dorking locality would be moving towards using integrated care records (System 1) that is currently in primary care. GBP1260317/069

3. Chairman and Chief Officer

3.1 Chairman's actions

3.1.1 Treatments Not Routinely Funded (TNRF)

The following three items had been through the Surrey Priorities Committee and subsequently Clinical Cabinet: GBP1260317/070

Varicose Veins. Concern had arisen from vascular surgeons at Frimley and ASPH that the thresholds altered after updated NICE guidance were too low. The previous thresholds were reverted back to and only patients with skin changes were referred. The amendment to the policy was NOTED. GBP1260317/071

Trigger Finger. Extra wording clarification was to be inserted. 'One in five patients with trigger finger will improve on their own and that between injections you should leave three months'. The amendment to the policy was NOTED. GBP1260317/072

Bone Anchored Hearing Aids. This has returned to specialised commissioning rather than CCG commissioning. The amendment was NOTED. GBP1260317/073

3.1.2 IT Procurement

Dr Fuller advised that the IT procurement had taken place and the contract had been awarded to South Central West CSU. The change was NOTED. GBP1260317/074

3.2 Acting Chief Officer's Report

Dr Fuller highlighted the following: GBP1260317/075

- Cyber Attack. In responding to a major incident, formal thanks go to Lorna Hart, Shelley Eugene, Charlotte Clark, Justin Dix and Jonathan Perrott for their team work. Elena Cochrane, Andy Sharpe, Russell Hills and Louise Keene for their responsiveness. GBP1260317/076
- Awards Ceremony. Formal thanks to the Surrey Downs Comms team for organising a great afternoon. GBP1260317/077
- Annual Report. The Annual Report was agreed at the Audit Committee earlier today and formal thanks to the Finance team, the Comms team and to Justin Dix for their hard work. GBP1260317/078
- Matthew Knight. Formal thanks to Matthew for the last three years. GBP1260317/079

The report was taken as READ. GBP1260317/080

4. Quality and Performance

4.1 Quality and Performance Report

Eileen Clark introduced this which had been discussed in detail at the May Quality Committee. GBP1260317/081

Debbie Stubberfield highlighted the following areas:

- PPE Strategy – noted the rapid development and can use that as the monitoring framework going forward GBP1260317/082
- Self Assessments – thoughts around on-going development for committee members GBP1260317/083
- Safeguarding Children Presentation – learnt a lot about looked after children and understanding the pathways and issues for looked after children in Surrey GBP1260317/084
- Workplan – QIPP and quality impact GBP1260317/085
- Risks – CSH and workforce. Issues around CQUINS as social enterprise they are not required to undertake CQUINS. GBP1260317/086

Eileen Clark updated the following area in more detail:

- CSH Surrey CQUINS – after discussions with CSH Surrey local CQUINS will be established. A number of areas will fit with local plans including a national CQUIN around safe discharge from hospital which requires the community provider to work with acutes and other partners. GBP1260317/087

Debbie Stubberfield highlighted other key risks:

- Epsom St Hellier – Infection control. Concerns have been fed back around hand washing not improving as much as expected despite reports and assurance to the contrary. GBP1260317/088
- SECAmb Quality Improvement Plan – focus continues as being monitored across the system. GBP1260317/089
- Datix in primary care – issue around Datix roll out. This is seen as a key plank for quality and safety framework going forward GBP1260317/090

Eileen Clark advised that since the Quality Committee further assurance had been received from Epsom St Hellier and improvement had been noticed around hand hygiene works and work is being done with Sutton CCG around this. GBP1260317/091

Bob Mackinson asked if anything could be done to make Epsom better around hand washing? GBP1260317/092

Eileen Clark said a meeting had taken place with the new Infection Prevention and Control Lead who fed back concerns that she had aired with senior management and since then support has been greater. GBP1260317/093

Bob Mackinson asked why the dementia screening was only 60% for patients in hospital in the first 72 hours rather than 100%. GBP1260317/094

Eileen Clark said it was a management problem but the CCG was pushing to make it a high priority. Some people do refuse to be assessed or they have been assessed previously. GBP1260317/095

Dr Graham said that from a clinical point of view some patients would attend with acute confusion and it would not appropriate to diagnose dementia in that admission. GBP1260317/096

Eileen Clark confirmed that it was imperative to ensure that the figures were being reported correctly and also that they are working in the best interest of patients to make sure they are assessing them appropriately. GBP1260317/097

4.2 Dashboard – constitution measures

Andrew Demetriades introduced this item and advised that in future the following three sub items would be one report: GBP1260317/098

- Outcome indicator set
- Constitution metrics
- Operating plan metrics

Breast feeding data was not recorded at CCG level.

The reports were taken as READ. GBP1260317/099

4.3 Dashboard – outcome indicators

There were no further comments. GBP1260317/100

4.4 Dashboard – operating plan metrics

There were no further comments. GBP1260317/101

5. Finance and Planning

5.1 Five Year Forward View: Next Steps

Dr Fuller asked for the following guidance to be formally noted:

- STPs have become Partnerships not Plans GBP1260317/102
- The four national priorities were: GBP1260317/103
  - Urgent Medicine Care
  - Primary Care Access
  - Cancer
  - Mental Health
- There was a continued emphasis on efficiency and workforce issues and solutions through technology and innovation GBP1260317/104

5.2 Finance Report

Dan Brown said that the Audit committee had taken place and the SD CCG annual report and 16/17 set of accounts were formally blessed. The report written by the external auditors, Grant Thornton on the accounts was described as very clean with no significant changes made or significant control issues identified. It was acknowledged that the CCG had a huge financial challenge in 2017/18 they commented favourably on the processes, the reporting and the degree of transparency around the gap. The annual report and accounts were subject to purdah and would be published thereafter. GBP1260317/105

Dan Brown said that a deficit of £8.7m had been reported which had delivered the second year of the recovery plan and £15.5m of QIPP was achieved. There were some areas of overspend – acute sector being the main one. Reference was made to section 2.2.2 in the report which gave further detail. GBP1260317/106

CHC had an overspend of £2.7m although £1.6m was due to the national increase in FNC rates. In achieving the control total for the year the underlying deficit runrate for the CCG was not fixed. The bridge diagram in report section 8.2.3 was highlighted which showed the total gap to plan of £15.7m of unidentified QIPP plus £9.3m gap. Work is being done to address this and despite new schemes being developed the 17/18 position may not materially change. GBP1260317/107

Dr Sharpe asked what the picture was like for the other STP CCGs.l GBP1260317/108

Dan Brown confirmed that both NWS CCG and G&W CCG have very similar problems but not to the scale of SD CCG GBP1260317/109

Matthew Knight said that 2/3 years ago deficits in CCGs were relatively rare but as they are now common from an assurance perspective performance against plan has become the most important benchmark. GBP1260317/110

Dr Fuller said that moving forward the three CCGs in the STP footprint would be regulated and assured as one rather than three. GBP1260317/111

6. Strategies and Policies for Approval

6.2 Dementia Strategy

Andrew Demetriades introduced this item and advised it was largely for noting. The dementia strategy was a collaborative piece of work with the County Council, East Surrey, Guildford & Waverley and North West Surrey CCGs. This was presented to the Clinical Cabinet in February 2017 to ensure that a local action plan was in place to compliment the strategy. GBP1260317/112

The report was taken as NOTED. GBP1260317/113

Eileen Clark highlighted that the strategy was not only about dementia diagnosis but ensuring plans are in place for people to live well with it. GBP1260317/114

Dr Cochrane commented that a lack of knowledge amongst clinicians was a key issue and having a directory of services at fingertips was so important for signposting. GBP1260317/115

7. Governance and Organisational Development

7.1 Governing Body review 2016/17

Peter Collis said that each committee had looked at its own self-assessment and would be taking any specifics forward. Generic issues would be fed into the ongoing Organisational Development of the Governing Body. This would need to be looked at and aligned with NWS CCG and G&W CCG. Once Matthew Tait joins, the two key pieces of work to be carried out are: GBP1260317/116

- What does the organisational structure look like across the three CCGs
- What does the organisational development look like that runs alongside

GBP1260317/117

Jacky Oliver said that the Governing Body development work had proved justified and valuable and whilst recognising that the Quality committee was very different there may be an advantage in doing some further work.

GBP1260317/118

7.2 Proposed revised objectives and Governing Body Assurance Framework (GBAF)

Dan Brown said the GBAF recorded the CCG objectives and what the risks to achieving the objectives were. The risks were scored in terms of their potential impact on the CCG. It was highlighted that the report should say 2017/18 as opposed to 2016/17. The report was for noting, consideration and observations.

GBP1260317/119

Debbie Stubberfield said that in relation to the gaps around controls a more proactive approach should be taken.

GBP1260317/120

Peter Collis said that this would have to be revisited once the three CCGS started working closer together as it would become increasingly difficult to look at Surrey Downs in isolation and a further assurance framework would have to be developed across the three CCGs.

GBP1260317/121

8. Governing Body and Committee Updates

8.1 Clinical Cabinet Report

The committee highlighted the following:

GBP1260317/122

- The EOLC strategy had been reviewed and feedback given and built in.

GBP1260317/123

- A review of the hubs and how they were working was presented and detailed analysis has been fed back into the work being done for the current year. A cross STP analysis was also being carried out.

GBP1260317/124

- The following specific items were looked at:
  - Falls
  - Eye care assessment issues
  - Dermatology issues
  - Epsom safe haven pilot. Dr Julia Chase led conversations and funding was approved for the remainder of the financial year. A business plan would be produced for next year.

GBP1260317/125

- This had been a workshop led by Andrew Demetriades looking strategically at other planning and the identification of other schemes to fill the gap.

GBP1260317/126

8.2 Audit Committee

The audit committee met on 31 March 2017 and 26 May 2017.

GBP1260317/127

- 31 March GBP1260317/128
  - Planning for the annual report took place to ensure everything was on track and other internal auditor reports were looked at. A review had taken place around CHC and clear guidance was given on improvements.
- 26 May GBP1260317/129
  - The annual report was agreed and was signed off by the Acting Clinical Chief Officer. The report would be filled with NHSE on Wednesday 31 May 2017 for regulatory purposes. Due to purdah it would be published on the CCG website when permitted.
  - Cyber security was discussed. A report was commissioned from the internal auditors last year which took place in the first 3 months of 2017. A number of issues were highlighted and that is being put together with the analysis of the recent incident and any national information for learning. GBP1260317/130
  - KPMG are the new external auditors who are also external auditors for STP partners; NWS CCG and G&W CCG. GBP1260317/131

Peter Collis advised that partner organisations have lined up a different internal audit contractor from end of next year so there is a possibility that Surrey Downs may have to change contractors and dovetail the internal audit plan with NWS CCG and G&W CCG. GBP1260317/132

8.3 Quality Committee

This item was minuted under section 4.1 Quality and Performance Report GBP1260317/133

8.4 Remuneration and Nominations Committee

The committee highlighted the following: GBP1260317/134

- Contributions had been made to Matthews Taits appointment GBP1260317/135
- Interesting report on diversity and women on boards and how Surrey Downs did significantly better than the national average. GBP1260317/136

8.5 Finance and Performance Committee

The committee highlighted the following: GBP1260317/137

- Looked at the figures and plans from last year, how things went and lessons learnt.
- Looked at the risk schedule and updated comments were given.
- An update on Dorking locality was presented by Dr Simon Williams, Clinical Director of Integration

9. Other matters

9.1 Any other urgent business

Ruth Hutchinson flagged that local elections had taken place on 4 May and the number of seats held by parties were slightly different (81: 61 conservative, 9 liberal, 11 others). To reflect the integration agenda the previous HOSC is now the Adult and Social Care and Health Scrutiny Committee with Ken Gulati being the Chair. The cabinet member for health remains the same. GBP1260317/138

9.2 Dates of future meetings

The date of the next public meeting is 28 July 2017. GBP1260317/139