NHS
Surrey Downs
Clinical Commissioning Group

Meeting: Governing Body

Date and time: 21st March 2014, 2.30pm, The Wells Centre, Epsom

Voting members present

Dr Claire Fuller, Clinical Chair

Executive members
Miles Freeman, Chief Officer
Keith Edmunds, Interim Chief Finance Officer
Matthew Knight, Chief Finance Officer
Karen Parsons, Chief Operating Officer

Clinical GP Members
Dr Ibrahim Wali
Dr Simon Williams
Dr Jill Evans
Dr Andy Sharp
Dr Suzanne Moor
Dr Kate Laws
Dr Robin Gupta
Dr Hazim Taki

External clinical members
Dr Mark Hamilton

Lay Members
Denise Crone
Gavin Cookman
Peter Collis

Other non-voting members
Nick Wilson, Surrey County Council
Eileen Clark, Head of Clinical Quality

In attendance: Justin Dix, Governing Body Secretary (Minutes)

1. Welcome and introductions

Governing Body members introduced themselves to the public and observers. Matthew Knight was welcomed as the new and substantive Chief Finance Officer. GB210314/001

2. Apologies for absence

There were apologies for absence from Dr Steve Loveless, Alison Pointu, and Cliff Bush. GB210314/002

3. Declaration of interests

There had been no changes to the register other than the addition of Matthew Knight who had no interests to declare. GB210314/003

4. Minutes of the last meeting

These were agreed as an accurate record GB210314/004

5. Matters arising and action logs

Miles Freeman updated regarding the lifts at Cedar Court which had caused difficulties with access. There had been a substantial dialogue with the landlords and works should commence shortly. GB210314/005

6. Chief Officers Report

Miles Freeman specifically highlighted the following points from his written report: GB210314/006

- Work on year-end accounts for 2013/14 and planning for 2014/15, both of which had taken up a lot of staff time. GB210314/007
- Medicines Management, which was noted as a critical area when the CCG tried to achieve QIPP targets. GB210314/008
- The Executive Committee had received a very powerful video presentation on carers and acknowledged the need to do more in this area, particularly publishing services in GP practices. GB210314/009
- The appointments of the new Chief Finance Officer and three service redesign managers was noted although there were other posts notably head of finance that were still open to recruitment. The CCG was in a strong position in terms of staffing for the new financial year. GB210314/010

There were no questions on the Chief Officer's report. GB210314/011

7. Quality Strategy

Eileen Clark presented this as work in progress. GB210314/012

The CCG had key responsibilities in relation to quality for the local population as a commissioner of services and quality of care was the “golden thread” that ran through everything the CCG did. This included securing improved outcomes, and this was reflected in the CCG’s constitution. A key ambition was to improve future patient engagement through focused clinical leadership. GB210314/013

The Darzi report had defined quality in healthcare as being about care that was clinically effective, personal and safe. This was the basis for the CCG’s work. National guidance reiterated this. GB210314/014

The CCG had a wide range of intelligence at its disposal but had not fully utilised this in its first year due to the need to get basic systems in place. There was an integrated quality network that supported work on quality, ranging from regulatory bodies to colleagues in other CCGs and safeguarding boards. GB210314/015

The CCG was now in the position of being very focused on monitoring services and scrutinising them, and was looking primarily at systems and processes. With the advent of initiatives such as the Out of Hospital Strategy there was now a need to take a broader view to see what difference the CCG was making to patients, and to look at stretch targets against explicit standards. “Good enough” was no longer an acceptable level to be at and there was a need to aim for excellence. The CCG needed to channel feedback from patients and encourage an open and transparent approach by suppliers. GB210314/016

Over the next 3 – 5 years the CCG needed to have a programme of objectives across its activities that engaged stakeholders through its localities. Methods such as focus groups would be necessary to share the views of patients, clinicians and others. GB210314/017

The aim was to develop a quality strategy through the quality committee that could then be consulted on and bought to the Governing Body for approval and subsequently implemented. GB210314/018

Miles Freeman said that one of the key aspects of the strategy would be to review the CCGs key programmes such as the Out of Hospital strategy and ensure they realised the benefits for patients. GB210314/019

A number of comments were made as follows: GB210314/020

- Engagement would be key and there were short timescales for engagement. This was more than just about working through localities and existing patient forums. Concern was expressed that the CCG should not hurry this and it was agreed that it was better to have good strategy even if this took longer. GB210314/021
- The strategy must put patients first and be broken down into realisable pieces of work. GB210314/022
- We needed to work closely with providers who were a key part of delivering quality services. GB210314/023

- The CCG needed to support people to participate in the process of developing the strategy GB210314/024
- The outcome should be tangible and implementation should be measurable GB210314/025

The Governing Body NOTED the progress being made on the quality strategy. GB210314/026

8. 2014/15 and longer term planning

Karen Parson and Matthew Knight gave a presentation on the planning process and its associated finances. GB210314/027

It was noted that the plan needed to be submitted on the 2nd April and the Governing Body was asked to delegate sign-off to the Executive to undertake this. GB210314/028

Governing Body members were asked to note the papers supplied and the additional Integrated Commissioning Plan. This had been a very complex undertaking which included five year and two year plans and an Integrated Commissioning Plan. The quality strategy would form part of the work. This was all summed up in the CCG "plan on a page". GB210314/029

There were six clinical priorities in the plan: GB210314/030

- Maximise integration of community and primary care based services with a focus on frail older people and those with long term conditions.
- Provide elective and non-urgent care specifically primary care, closer to home and improve patient choice.
- Ensure access to a wider range of urgent care services.
- Enhance support for those patients who need end of life care.
- Improve access and experience of children's and maternity care
- Improve patient experience, outcomes and parity of esteem for people with mental health and learning disabilities (including dementia)

To accompany the clinical priorities there were four organisational priorities: GB210314/031

- Strategy
- Improving quality and performance
- Developing the organisation
- Financial balance

The plan would be submitted on the 4th April. The 5 year plan could however be refreshed and resubmitted in June. GB210314/032

The work to date had resulted in the completion of the following draft documents: GB210314/033

- The two year plan
- The two and five year financial plans
- The plan on a page
- The integrated commissioning plan, which is the “golden thread” document.

The two year plan was highlighted. It aimed to reduce inappropriate admissions and reduce A&E attendances. This was accompanied by one year organisational objectives. GB210314/034

It was clarified that PYLL stood for Potential Years of Life Lost. This essentially meant the aggregate number of years of life lost through preventable deaths and it was an aim of the CCG to reduce these, although it should be noted that the CCG area was already the best in the UK in this respect. GB210314/035

Karen Parsons highlighted a number of areas form each of the key programmes. GB210314/036

A number of projects were highlighted that the CCG was using to deliver the above: GB210314/037

- Primary Care Clinical Networks
- Urgent care and discharge – returning patients to a suitable environment as soon as possible.
- Improving End of Life Care Pathways
- Redesigning CAMHS
- Dementia and Health Checks

Matthew Knight outlined the financial aspects of the planning work. The CCG’s core budget of £322m had been fully deployed this year and the CCG was forecasting breakeven, although there had been an aim of a £1.6m surplus at the start of the year. GB210314/038

61% of the CCG’s commissioning expenditure went on Acute Care, 13% on primary care, and 26% on community and mental health. GB210314/039

For forecasting purposes the financial planning assumed inflation of between 2 and 2.5% per year and a 4% Year-On-Year efficiency target. GB210314/040

Demographic growth was assumed to be 40% above the national average. GB210314/041

Non demographic change at 1% was about double that of most CCGs. GB210314/042

There was also a big initial funding requirement for the Better Care Fund to be factored in. GB210314/043

For the next two years the growth would be allocated for tariff development, demographic and non-demographic change, ans cost pressures. GB210314/044

The key risks were: GB210314/045

- CHC claims in excess of budget
- Specialist Commissioning exceeding expectations
- Achievement of QIPP targets

Peter Collis congratulated the Executive on the amount of work that had been required to get the planning to this stage and asked whether contingency funding and QIPP savings figures were realistic. It was acknowledged that there were risks in this area and that no money was effectively ring fenced. Delivery would be very challenging. It would be essential to see 2014/15 as the first really stable year of operations and to use the first three months to get a grip. GB210314/046

It was noted that there was still a £3m gap in the QIPP assumptions which was being actively worked on. One option was to extend the targets for medicines management where there was more scope for savings. Ultimately QIPP would be delivered through transformational change via the new clinical networks and the preventive of admissions. Agreement would be needed as to how the Better Care Fund would support this. GB210314/047

Dr Williams noted that the new clinical networks were geared more to housebound patients than to chronic disease management. GB210314/048

The potential impact of Continuing Health Care Retrospectives was noted and collaboration across Surrey was key to managing this. However it was not possible to give assurances about how national policy might change. The CCG should be prepared to go into deficit rather than reduce services in-year if the CHC policy decision worked against it. GB210314/049

Gavin Cookman asked that the CCG properly define its risk management in relation to its plans, and that the documents should be simple enough to be easily followed. GB210314/050

Miles Freeman highlighted some specific areas that needed to be addressed. GB210314/051

- It was noted that a lot of QIPP Plans fail because of incorrect assumptions about how general practice works.
- There was a specific view of where investment should be best targeted.
- The CCG must drive down the unit cost of out of hospital care.
- There needed to be effective risk sharing with suppliers over financial pressures.

It was queried how we could address the PYLL issue if we were already in a high performing area. It was acknowledged that this would be challenging but there was close working with public health to look at areas within a draft prevention strategy. It was queried to what extent PYLL was a useful measure given that it was a national rather than a local approach, but it was felt that in the long term technological development should bring benefits. Dr Fuller noted that the quality of GPs in Surrey Downs was very high and this was a contributing factor to its success. GB210314/052

Finally, it was noted that if there were any major shifts in the assumptions behind the planning, this must be bought to the Governing Body's attention. GB210314/053

The Governing Body NOTED the work on planning for 2014-2018 and AGREED to delegate the Executive to submit in accordance with guidance on the 4th April. GB210314/054

9. Better Care Fund

The Governing Body NOTED progress on the Better Care Fund and that this would be signed off on the 4th April. GB210314/055

10. Continuing Health Care Operational Policy

Karen Parsons reminded the Governing Body that the CHV programme was a major piece of work and would be underpinned going forward by detailed governance arrangements. GB210314/056

It was noted that the aim of the policy was to support all the CCGs in the collaborative arrangement to be compliant with their legal duties and for this to be embedded in the everyday working of the CHC team. It improved accountability by making it clear who was responsible for what and when and would therefore ensure a better quality of service. It would also ensure compliance with legislation and improved quality. This was version five of the policy and it had been widely consulted on including with service users and their families. GB210314/057

This was an NHS policy and it was noted that Surrey County Council were seeking further discussion on the policy as they had concerns about some aspects of it. Other CCGs were being asked to sign off on the document, via the CHC programme board which had agreed the document on the 11th February. Further meetings were planned with Surrey County Council. There were key patient centred principles in the document and a focus on areas such as discharge planning which had been problematic in the past. There was also an important section on termination of funding. GB210314/058

It was noted that this policy did not cover Personal Health Budgets (PHBs) and therefore to some extent limited choice. It was clarified that PHBs were being piloted locally from October. It was agreed that this needed a good communications strategy to deliver it effectively, as opposed to just publishing it on the CCG web site. GB210314/059

The Governing Body AGREED the CHC operational policy, noting that it would be updated in future as the work developed. GB210314/060

11. Quality and Performance Report

Eileen Clark spoke to the report and highlighted a number of specific areas for the Governing Body's attention. GB210314/061

- There had been a mixed sex accommodation breach at Royal Surrey in January. This had been due to a misunderstanding of the guidance during a period of intense pressure and measures were in place to prevent this happening again. GB210314/062
- Health Care Associated Infection – the poor performance against Clostridium difficile targets would impact on the CCG's Quality Premium. Rather than focus on the statistics the team were looking at Root Cause Analysis of individual cases to understand why this was an issue. GB210314/063
- It was noted that there were 133 residential and nursing homes in Surrey Downs and this required increasing amounts of work from a safeguarding perspective. GB210314/064
- Work was ongoing with South East Coast Ambulance (SECAMB) to engage with the new lead commissioners regarding performance against emergency and patient transport services. It was noted that local data was now available as well as county wide data. GB210314/065
- There were positive reports emerging from the new Friends and Family Test particularly around Surrey and Borders and Central Surrey Health. Best practice was being shared amongst providers and there were good examples from Kingston Hospital. GB210314/066

The serious incident process was noted particularly the effective Surrey wide processes; however it was felt important that there was a local process within the CCG's scheme of governance to look at local incidents. The Governing Body was therefore asked to agree to the establishment of a Serious Incident subcommittee of the Quality Committee that would take on this role. Draft terms of reference were included in the report although it should be noted that there would be an amendment to the quorum arrangements. GB210314/067

The Governing Body members asked a number of questions in relation to the report. GB210314/068

- Dr Sharpe asked what the loss of Quality Premium was and it was noted this was £150,000. This could not be recovered from the acute trusts where the target had not been achieved. GB210314/069
- It was clarified that the position with Kingston Hospital diagnostics had been recovered and in performance terms and was in fact now ahead of trajectory having put on between 2,600 and 2,700 booking slots. GB210314/070
- Dr Moore and Dr Taki had been reviewing the admissions and the clinical issues relating to children with a variety of conditions. GB210314/071
- The SECAMB position with regards to data was felt to be disappointing given that some individuals had acquired better data through Freedom of Information than the CCG received through routine reports. It was felt that this was already improving with the new commissioner led approach and Miles Freeman reported that CCG level data was being made available. Contract levers would still be applied at a county level rather than a CCG level. Equity of access was noted as being an important issues; at the moment there were marked local variations. Miles Freeman said that the trust had a significant level of data and this needed to be utilised more strategically. GB210314/072
- It was also clarified that the aim with Health Care Acquired Infections was to improve openness and accountability in order to change the culture around reporting. Working in partnership with providers was important to encourage this, using post infection reviews in a transparent way. There was national guidance which the quality team was working through. Dr Williams said it was important to encourage openness before relying on performance penalties. GB210314/073

The Governing Body NOTED the report and AGREED the terms of reference of the Serious Incident Sub Committee. GB210314/074

12. Progress on Delivery and Key Projects

It was noted that this reflected the position at the end of January. A number of dates of delivery had been put back, including the development of an estates strategy, upgrades at Molesey hospital and the development of the CCG's web site. GB210314/075

The estates strategy was becoming a bigger piece of work than originally anticipated. Another major piece of work was disaggregating QIPP work done to locality level. GB210314/076

The Referral Support Service (RSS) was going from strength to strength and the CHC programme was progressing well. This involved a major realignment of teams to local authority boundaries. GB210314/077

Out Of Hospital reviews were now complete and new contracts were being put in place. There had been good engagement on the GP Out Of Hours project and the development of primary care standards. Over 500 people had responded to the GP survey. Linked to this was the development of primary care standards. GB210314/078

It was noted that although there had been good progress a number of these projects needed to become “business as usual”. Each project had a benefits realisation attached to it. GB210314/079

Dr Gupta clarified that Dorking had been waiting for the RSS to get up to capacity before joining but there was every willingness to participate. GB210314/080

Gavin Cookman stressed the need for benefits realisation to be described in these programmes and this was acknowledged. GB210314/081

It was queried what the full benefits from the RSS would look like if it covered the whole patch and Karen Parsons agreed to review this. GB210314/082

Action Karen Parsons

The relationship with NHS Property Services was noted and was likely to remain an issue until they had concluded the changes they were going through. GB210314/083

Denise Crone noted the need for feedback on the patient engagement work around the GP Out Of Hours project. A lot of people had responded to this and they should have a response. GB210314/084

The Governing Body NOTED the progress report on delivery and operations. GB210314/085

13. Finance Report

It was noted that the focus of the work now was on year end. Currently the CCG was forecasting a £60,000 surplus. Volatile areas included acute spend and prescribing. With regards to acute, £130m of the £167m was covered by year end agreements. Ongoing monitoring of volumes of activity was still being undertaken. There was still scope for late changes in policy to impact on the final figures but overall there was a fairly clear picture of the risks. GB210314/086

Late data relating to prescribing was noted as being a major issue, with delays of up to three months in getting information. It was agreed that there might be some scope for reviewing practice level activity for key drugs and Dr Wali was asked to look into this, specifically whether local practice monitoring could be undertaken. GB210314/087

Action Ibrahim Wali

Dr Gupta felt this could be done if the focus was on the main drugs being prescribed. Local software solutions were felt to be difficult to implement in a cost effective way. GB210314/088

It was queried whether changes in A&E attendances represented a risk given that there had been a large increase in the last year, but the achievement of year-end settlements was felt to mitigate this. In addition it was felt that SUS data would not be accurate for financial forecasting purposes. GB210314/089

The Governing Body NOTED the finance report. GB210314/090

14. Governing Body Assurance Framework and Risk Register.

It was noted that most of the issues on the risk register had been covered in earlier discussions. The Governing Body development programme had been delayed until the appraisals of governing body members had been completed. GB210314/091

CHC risks were queried as they were described as static but seemed to be increasing. It was noted that this related to specific risks but also because the net review was not due until April. GB210314/092

The Major incident plan was not due to be reviewed until May and it was queried if this was a risk. It was noted that the CCG did have both business continuity policies and had put in place an action plan following the winter weather. It had also taken part in simulations run by the Area Team. Miles Freeman said that local workshops would be useful going forward. GB210314/093

15. Policies

Karen Parsons summed these up. GB210314/094

The Governing Body AGREED the following policies: GB210314/095

- Fire Safety
- Appraisals
- Incident reporting for Information Governance
- Expenses for patient and carer representatives

The Governing Body also AGREED that the Assisted Conception policy could be extended until July. GB210314/096

It was noted that the bulk of policies could be signed off at committee level in future unless there were particular reasons why they needed to be approved at Governing Body level. GB210314/097

16. Quality Committee Minutes

The recent dementia event was noted and this had been very positive. GB210314/098

The Governing Body NOTED the Quality Committee Minutes. GB210314/099

17. Remuneration and Nominations Committee

There had been a Remuneration and Nominations Committee prior to the Governing Body. Gavin Cookman highlighted the following issues: GB210314/100

- There were no major issues outstanding from previous meetings
- The CCG was nearly at full capacity other than head of finance
- The workforce KPIs were within normal expectations
- A staff survey was taking place in April
- A reward and retention strategy would be developed and reviewed by the committee after the summer period
- The CFO appointment was ratified.
- Policies and procedures were in progress. Embedding in practice was a key issue.
- There was a brief update on workforce issues and the forward work plan was revised.

Dr Williams noted that Head of Finance interviews were planned for the following week. GB210314/101

18. Any other business

Dr Gupta noted that the GP education day held earlier in the week had been very well received. GB210314/102

It was noted that this was Keith Edmunds last Governing Body meeting. He would be staying on for a short while to support the CCG's end of year accounts closure. Dr Fuller thanked him for his enormous contribution to the CCG's success in its first year and the Governing Body recorded its thanks for his efforts. GB210314/103

19. Questions from the public

SECAMB GB210314/104

The difficulties with SECAMB were reiterated. There was an extensive action plan and there may be a request for additional capacity to be funded. This was felt to be a good example of where it was difficult to lever rapid improvement from a major supplier and getting them to adhere to timescales for action.

GP Out Of Hours GB210314/105

It was clarified that the data from patient engagement had been analysed and would be included in the service specification and listed in an appendix. It was requested that this be presented in a format that gave clarity of response, e.g. “You wanted” followed by “We said”.

Dorking X-Ray GB210314/106

It was noted that NHS Property Services had granted the necessary licence and work should start very soon.

Meeting with Healthwatch at Bourne Hall GB210314/107

Rosemary Najim said this had been a good meeting but would have been better with CCG representation in attendance.

Health Care Associated Infections GB210314/108

It was queried whether the figures were accurate.

Friends and Family Test GB210314/109

Concern was expressed about the low numbers which did not really validate the stated results.

Out of Hospital care GB210314/110

Concern was expressed that databases of people with high needs was being shared commercially. This was a known national concern and meant that some patients could be identified even though the data had been anonymised. Dr Sharpe acknowledged the public’s concerns and said further work had been delayed whilst the confidentiality issues were resolved. Unlike this, the “co-ordinate my care” approach being adopted locally was a simple data set based on the consent of the patient.

Home based care

GB210314/111

Concern was expressed about the specifications and some companies not paying staff travel costs. It was concerned this was being addressed in the revised specification by Surrey County Council.

Board meetings

GB210314/112

The CCG was asked to consider placing recordings of its meetings on the CCG web site.

Surrey Downs CCG

GB210314/113

Anthony Barnes asked if the CCG differed in any way from the old Mid Surrey PCT? Although it was a similar size and shape, it was felt that it was more willing to address difficult issues and there was substantially better clinical leadership and engagement.