NHS
Surrey Downs
Clinical Commissioning Group

Minutes of a Meeting of the Governing Body held on 17th May 2013 at Epsom Downs Racecourse

Record of attendance

Clinical Members
Dr Claire Fuller – Chairman of the Governing Body and Chair of Medlinc Locality
Dr Jill Evans – Chair of East Elmbridge Locality
Dr Simon Williams – Chair of Mid Surrey Locality
Dr Steve Loveless – Chair of Dorking Locality
Dr Aalia Khan
Dr Andrew Sharpe
Dr Hazim Taki
Dr Kate Laws
Dr Suzanne Moore
Dr Robin Gupta

Officer Members
Miles Freeman, Chief Officer
Karen Parsons, Chief Operating Officer
Keith Edmunds, Interim Chief Finance Officer

Lay members
Cliff Bush OBE, lay member for patient and public engagement
Denise Crone, lay member for patient and public engagement
Peter Collis, Vice Chair of the Governing Body and Chair of the Audit, Corporate Governance and Risk Committee
Gavin Cookman, Chair of the Remuneration and Nominations Committee

External Clinical members
Dr Mark Hamilton, Secondary Care Consultant
Maggie Ioannou, Nurse Member

Non-voting members in attendance:
Eileen Clark, Head of Quality
Nick Wilson, Strategic Director Children, Schools and Families, Surrey County Council

Others in attendance

Sarah Mitchell, Strategic Director, Adult Social Care, Surrey County Council

Minutes:

Justin Dix, Head of Corporate Services and Governing Body Secretary

Apologies for absence

There were no apologies for absence GB170513/001

Welcome and introductions

Dr Fuller welcomed everyone to the meeting, and set out the broad geographical coverage of the NHS Surrey Downs Clinical Commissioning Group (CCG), with a population of 290,000 people and 33 GP practices. The CCG is responsible for commissioning the majority of local healthcare. She welcomed the large audience and said the CCG was aware of the huge interest in the Better Services Better Value (BSBV) agenda item. She said the CCG was very keen to work with the public on this issue. However, she reminded all those present that this was a Governing Body meeting in public and not a public meeting. GB170513/002

Dr Fuller then set out the composition of the CCG. There were ten GPs, four lay members (two more than required by law), one nurse and one Secondary Care Consultant (hospital based Doctor), plus three officer members – the Chief Officer, Chief Operating Officer, and Chief Financial Officer. The Head of Quality, who was also a nurse, also attended the Governing Body, as did a representative of Surrey County Council. GB170513/003

The members of the governing body and others in attendance then introduced themselves and stated their name and role with the CCG. GB170513/004

Register of Interests

The Register of Interests was NOTED. GB170513/005

Dr Mark Hamilton said that as he was employed by St George's Hospital as an intensive care consultant he would not take part in any vote on the Better Services Better Value agenda item due to that hospital's position within the options. GB170513/006

Better Services Better Value

Dr Fuller said that given the level of public interest in this item, it would be bought forward on the agenda. The aim was not to take any decisions about the proposals but to allow the Governing Body members to debate the options being proposed and the clinical standards. She noted that this had been a very difficult issue for the CCG and one which had dominated its work since the end of the previous year. Dr Jill Evans and Dr Simon Williams had been leading this for the CCG with the GB170513/007

support of the Governing Body, local GPs and particularly the patient representatives who had been putting forward the views of Surrey Downs patients. She asked Dr Evans and Dr Williams to give a presentation on the proposals that had come out of the BSBV programme and specifically those of local relevance. The presentation today therefore was one which took out key points from the bigger presentation on the CCG web site. There would be opportunities for questions from those present.

Dr Jill Evans spoke first. She said that the CCG needed to make a decision on whether to agree to go out to consultation on the BSBV proposals, subject to a satisfactory Equality Impact Assessment. GB170513/008

She began setting out the reason why services needed to change. A primary reason was the need to meet the required quality standards. GB170513/009

At this point the meeting was interrupted by Dr Hassan Shehata, Clinical lead for Obstetrics and Gynaecology at Epsom Hospital, who challenged the validity of some of the statistics. Dr Fuller asked him to use the opportunity for questions after the presentation for this. GB170513/010

Dr Evans then continued. The rationale behind BSBV was that there were not going to be enough qualified specialists in future to deliver safe and sustainable care. Services would become too thinly spread. Improvements in technology have meant more specialisation in medicine and the NHS needed to adapt to accommodate this. It was important that care was delivered by the most qualified doctors and nurses. Examples were London initiatives on stroke, trauma and cardiac care where people in parts of the CCG area were now taken straight to St George's Hospital because the outcomes would be better. GB170513/011

Dr Evans said that here was some cynicism that this process was just about saving money. However this was a clinically led process and the aim of the doctors and nurses involved in the programme was to get better outcomes for patients. This responsibility was taken very seriously. A key principle was to do more work in the community and in GP surgeries and less in hospital settings. GB170513/012

Dr Evans said that Surrey Downs clinicians had joined the programme the previous year when the proposed merger with Ashford St Peter's Hospital NHS Trust had broken down. Their aim was to represent the interests of patients in this process. Clinicians from different groups had come together to look at what is best for patients and working groups had been established to look at all the affected areas. The focus had been on clinical standards and it had been agreed that all five hospitals should stay open. However there was a need to raise standards and to ensure access to services as there was a danger of Accident and Emergency (A&E) becoming overwhelmed. At the moment we know that people end up in A&E inappropriately, so GPs and community services need to step in to avoid this happening. GB170513/013

The recommendation in the BSBV programme was for three full A&E departments, three maternity units and the possibility of a standalone midwifery led birthing unit. There would be a network of children's services with St George's at the centre, a dedicated A&E for children and an overnight stay unit. It was emphasised that full A&E departments need to be backed up with emergency surgery, and obstetrics 24/7 diagnostics and a standalone A&E is not a possibility. GB170513/014

The proposed options for potential consultations are as follows. There would be one major acute teaching hospital, at St George's, providing stroke, heart attack and major trauma services. It would also have a A&E, obstetric-led maternity unit, specialist children's inpatient unit and a children's ward. There would be two major acute hospitals, at Kingston and either Croydon or St Helier, providing emergency and urgent care and obstetric-led maternity services with an attached midwife-led unit. These hospitals would also have children's inpatient wards. There would be one local hospital with a planned care centre, urgent care centre, diagnostics, outpatients and day surgery at either Epsom or St Helier. Finally there would be one local hospital with an urgent care centre, diagnostics, outpatients and day surgery at either St Helier, Epsom or Croydon. GB170513/015

Dr Evans said that the above options had been arrived at by going through a thorough process of ranking the issues in order of priority and looking at a number of criteria such as the quality of outcomes, travel times and so on. There was then a separate financial evaluation. The team had started with 72 options which they had then narrowed down to a small number of final options. There had then been a specialist financial appraisal before taking the revised proposals to the clinical strategy group and finally on to the BSBV Programme Board which was made up of both clinicians and officers of the CCGs involved. She then passed over the presentation to Dr Simon Williams. GB170513/016

Dr Williams said that there were three options in the consultation proposal. GB170513/017

The first and preferred option was for St George's to be a major acute teaching hospital. Kingston and Croydon would be major acute hospitals. Epsom would be a local hospital with a planned care centre. St Helier would be a local hospital. This option scored the highest both clinically and financially. It played to Epsom's strengths in terms of the existing orthopaedic centre. GB170513/018

The second option would mean that St George's would be a major acute teaching hospital; Kingston and Croydon would be major acute hospitals; St Helier would be a local hospital with a planned care centre; Epsom would be a local hospital. This option had scored lower (and it was noted at his point that the PowerPoint slide was incorrect) but when all the factors were taken into account such as capital and deliverability then this was appropriately the second placed option as it would be much easier to deliver. GB170513/019

The third option would mean that St George's would be a major acute teaching hospital; Kingston and St Helier the major acute hospitals; Epsom would be a local hospital with a planned care centre; and Croydon a local hospital. However this would mean some patient flows to more distant hospitals and require very significant capital outlay. GB170513/020

Dr Williams then talked about the proposal for a midwifery led unit. This was felt to be safe and financially viable provided it had at least a thousand births a year. These would have to be assessed as low risk pregnancies. Part of the consultation process would be to gauge the level of interest in this. GB170513/021

Dr Williams then moved on to talk about the range of services that would remain at Epsom under the preferred option. There was considerable clinical evidence that 50-60% of people who currently attend A&E would still attend an Urgent Care Centre (UCC). He also noted that Epsom does not currently have a full A&E Department as it does not take ambulance cases requiring surgery, which are sent to other hospitals. On this basis the numbers still attending a UCC at Epsom would be a higher proportion of the current total. GB170513/022

Epsom would have a full range of diagnostic facilities including x-ray, and possibly twenty four hour pathology. There were also options for local discussions to look at putting in other services for instance community beds with re-ablement and other support for older people. This was particularly important given the local demographic changes and the likely increase in older people needing care in dedicated centres. In addition there was scope for discussions on stronger links with local community services and virtual wards; extending diagnostics to include facilities such as ultrasound; and closer working with community paediatrics and primary care. GB170513/023

Dr Williams summarised by saying that for local people, this would mean that 80% of the existing services would continue on the Epsom site. Epsom would remain as a local hospital and patients would have access to services on a number of other sites. The UCC could still treat 70% of existing A&E cases. GB170513/024

Dr Williams then talked about the impact on other Surrey Hospitals. They would need to achieve the standards laid down by the Royal Colleges. On behalf of the CCG the BSBV team had written to the Royal Surrey, Ashford St Peter's and Surrey and Sussex Trust and assurances were received that Trusts were working towards raising standards. GB170513/025

Dr Williams then talked about the impact on people in terms of travel times. Between 480,000 and 570,000 people across the BSBV programme area will have a different nearest major acute hospital than currently. The people most affected would be those living in Epsom, Ewell, Banstead, Leatherhead, Carshalton, Croydon, Purley, Wallington and Coulsdon. Dr Williams said that he was aware that this was a very GB170513/026

big issue for the local population, and one which would need to be addressed in the consultation process.

Dr Williams then asked what would happen if we did not make any changes. The main issue was that it would become increasingly difficult to maintain standards. All the hospitals in the BSBV programme were struggling to maintain quality and in some cases were not financially sustainable. Keeping this going would mean there would be no money to invest in community services. GB170513/027

Dr Williams then stressed the desire of the CCG to involve local people in the consultation process. A consultation plan had been agreed with the Health Overview and Scrutiny Committee (HOSC) and this would involve individual consultation events in local areas in an attempt to gather the views of as many people as possible. Members of the Governing Body were happy to attend these meetings. GB170513/028

Dr Williams said that each of the seven CCGs involved in this process had been asked whether they would support going to consultation on the preferred options. If they did there would be a fourteen week consultation period which would seek to involve as many people as possible. Whichever option was approved, there would be no changes until capacity was in place across the different sites, and a 4-5 year period of development. GB170513/029

Dr Fuller then outlined the process that the CCG had adopted for reviewing the BSBV proposals. The Council of Members, which represented all thirty three GP practices that made up the CCG, had discussed the BSBV issue recently on the 1st May. There had been broad support for improving clinical standards and the models of care but not all GPs agreed with all of the proposals. GB170513/030

Dr Fuller then moved on to questions from the public, saying that the CCG had received a number of questions already via its web site and in writing and all of these would be responded to. Today the Governing Body would take three questions in each of a number of different categories as follows, the first four categories being about the clinical model of care: Emergency care; Maternity; Paediatrics; Elective care; Options and Process; Travel; Money; Implications and opportunities for Epsom. She would like a professional or expert opinion in each section. GB170513/031

The following questions were raised by members of the audience in relation to Emergency care: 1) There had been media coverage of issues relating to A&E and Care Quality Commission concerns about this area needing investment, with a suggestion that substantial finding would be made available to improve A&E. Given this why was there a proposal to downgrade Epsom A&E at this time. 2) Studies in Europe and Sheffield had suggested that death rates increased when A&E departments were moved and patients had longer journeys. There had been a specific study in Newark that suggested that death rates increased after an A&E Department had been closed. Would this not be GB170513/032

the case locally if we were asking patients to travel to St George's? 3) What would happen if there was a major accident?

GB170513/033

In response to the second question Miles Freeman said that it was true there had been conflicting studies and statistics relating to what happened when you moved an A&E. The figures for Newark over a period of six years had fluctuated but remained largely level, and there was no sharp increase in deaths.

GB170513/034

With regards to the third question, Dr Williams noted that it was already the case that major accident casualties were taken to St George's and were not taken to Epsom.

GB170513/035

With regards to the first question, Miles Freeman said that it was true that the NHS nationally had been asked to submit emergency proposals for how to manage the pressures on A&E Departments. There were significant issues with breaches of four hour waits and emergency admissions.

GB170513/036

Miles Freeman said that for Surrey Downs CCG, 41% of admissions via A&E were for less than one day, and if we could invest in more effective community services many of these could be avoided. Dr Williams said that 17% of A&E attendances for Epsom were not appropriate and involved no intervention, and a total of 30% could be managed in the community. One of the benefits from this programme would be the opportunity to invest in better community services.

GB170513/037

Dr Fuller then moved on to the issue of maternity care and invited Dr Shehata to speak. Dr Shehata outlined his experience including chair of the relevant Royal College workforce group. He said there had been several reviews over the last ten years but in his view Epsom and St Helier's current maternity arrangements were safe and sustainable. The service locally had modernised to meet rising demand. He had met with senior members of the CCG recently but he challenged the CCG's statistics, particularly saying that they had been corrected for the relative affluence of the local population. He also challenged the clinical model and said that he did not think that the clinical reference group for maternity within the BSBV programme had listened to his views. He said that recently published data showed that Epsom and St Helier met all the required clinical standards laid down by the Royal Colleges and was in the top 15% nationally. The transfer rates were half the national average. In terms of consultant cover, Epsom and St Helier were both compliant with Royal College standards. He felt that the higher standards proposed by London for 24 hour consultant cover were not evidence based had been set to deliberately facilitate the closure of some hospitals.

GB170513/038

The following questions were raised by members of the audience in relation to maternity care: 1) Dr James Houghton, a local GP, said that a standalone maternity unit would mean that services locally would effectively be downgraded 2) Are there any figures regarding how many

low risk births end up needing emergency care?

GB170513/039 Dr Fuller began by saying that she understood Dr Shehata's passion. Dr Evans echoed this. She had also been on the same clinical reference group and had felt that he had the opportunity to make all his points, but the group as a whole had chosen to support the higher standard of 24 hour consultant cover.

GB170513/040 Dr Evans said that with regard to the midwifery led unit, this had been very well researched, and provided that women were assessed against strict criteria it was safe.

GB170513/041 With regards to transfers, these were very few in units of this type but there would be further work with the local community on this. There were also issues about pain relief which would need to be addressed.

GB170513/042 At this point in the meeting Dr Fuller said that if people did not get a chance to ask questions today they were very welcome to write in and that all questions would be answered.

GB170513/043 There was a question from a member of the public about the number of District nurses trained in the previous year. Dr Fuller asked Jo Pritchard, Joint Managing Director of Central Surrey Health for advice on this. Jo Pritchard said she did not have the figures to hand but would supply them.

Action Jo Pritchard

GB170513/044 Dr Fuller then moved on to the issue of paediatrics and invited Dr Janet Nicholls, Consultant Paediatrician at Epsom St Helier to speak. Dr Nicholls said that she had been a member of the children's working group and said that she disagreed with the proposals. She said that they were not evidenced based and did not demonstrate that services were not currently safe or sustainable. Epsom already had an integrated model of care that met Royal College standards and received consistently good feedback. She supported the hub and spoke model but felt that St George's was a weak hub and was attempting to strengthen itself by pulling in services from other hospitals. Dr Nicholls said that going ahead with the proposals would mean the loss of local services and a loss of integrated care and asked the CCG Governing Body not to support them.

GB170513/045 There were then two questions regarding paediatrics. 1) How would this affect patient choice, for instance choosing where to get procedures such a grommets and tonsils done? Did this not remove choice? 2) How would community nurses supporting very sick children in the community be supported in their work.

GB170513/046 Dr Suzanne Moore said she had been on the Clinical Working Group. She was aware that the proposals were contentious and needed to be looked at closely. The BSBV programme was committed to achieving high standards and there had been agreement in the clinical working

group to this. A dialogue had been taking place about how an ambulatory care centre might work and how an elective centre would function. This would bring in expertise from other areas where such models were working well. There had been a meeting the previous week to look at the workforce model that would support this.

Dr Hazim Taki said that his main concern was the possibility in a few years time that there would not be enough specialists to support effective delivery of care. He said that patients should still have choice of specialist units and consultants. Dr Williams said that choice would also exist in relation to out patient care. GB170513/047

Dr Fuller then took the Governing Body on to the issue of elective care, and clarified for the audience that this meant care that was routine and planned and invited questions. GB170513/048

1) A member of the public said that the Elective Orthopaedic Centre (EOC) at Epsom was seen as a leader in quality both locally and nationally and that it had recently been proposed that this should move to St Helier. Why could this not be built up as a local centre of excellence? 2) Dr Houghton asked if the proposed elective care centre would be at Epsom as this was not a given in the consultation proposals. 3) Dr Shehata asked how much work had been done on elective gynaecology. GB170513/049

Dr Jill Evans said that the preferred options is for Epsom to keep the EOC and to expand this to all electives, and this was what had come out of the elective working group. Miles Freeman said that he understood Dr Houghton's concerns but this would be a way of protecting local elective services. With regards to Dr Shehata's question on elective gynaecology, Dr Fuller said the answer to this was not known but the CCG would check this with the BSBV team. GB170513/050

Action Claire Fuller

Dr Fuller then went on to the question of options and processes. GB170513/051

Rosemary Najim said that the main issue was that Epsom was not part of London and was still seen as an add-on to the proposals. She had requested individual data about mortality rates under the Freedom of Information Act about each hospital's current ability to meet required standards although she noted that this had been asked at the recent Sutton CCG meeting and there had been a reluctance to mention individual sites. She asked if the consultant cover figures were available because in her view they would demonstrate that Epsom was a safe site. She also felt that even though the presentation quoted a hundred clinicians agreeing with the proposals, it was clear the Epsom clinicians did not. She also noted that the birthplace survey did not include the fact that 40% of mothers have to be transferred. GB170513/052

A local Councillor expressed the view that South London should not be GB170513/053

deciding what is happening with a Surrey hospital and that Epsom was needed for the residents of Surrey.

A member of the public asked if the presentation used today would be put up on the CCG web site and Dr Fuller confirmed that it would be. GB170513/054

Responding to the above, Miles Freeman confirmed that standardised mortality rates were in the public domain. All of the hospitals were at below average for mortality. GB170513/055

With regards to the inclusion of Epsom in the London programme there had been an attempt to resolve this by partnering Epsom with Ashford St Peter's but this had not been successful because the combined Trust could not reach financial with the current mix of services. However, Epsom would always be seen as a Surrey Hospital and part of the Surrey system, whatever came out of the review. Simon Williams reiterated that there was no question of Epsom closing and that the aim was for a reconfiguration of services. GB170513/056

Dr Fuller then went on to the issue of Travel times. GB170513/057

Bob Gardner, a Surrey County Councillor, asked if the Governing Body had reviewed the 137% increase in blue light journeys to St George's and Kingston and asked if there would be deaths if people could not get there within 12 minutes? GB170513/058

A local radiographer at Epsom Hospital said that patients bought to the hospital are treated with appropriate medication and make a good recovery even with local travel times and local congestion. She did not feel that travelling to more distant sites would be safe. GB170513/059

A Banstead resident said that the statistics suggested 500 preventable deaths but did not say how many deaths might occur as a result of additional travel time. He also asked how the ambulance services might cope with the changes. GB170513/060

Dr Fuller again reiterated that the CCG welcomed questions in writing from people who had not been able to speak today. GB170513/061

Dr Evans spoke to the points that had been raised. She said that the figures on ambulance times had been received from the ambulance service and that blue light ambulance journeys were far outweighed by the amount of local care that people received. The critical issue was not usually the time it took to get the patient to hospital but the time it took the ambulance and the paramedics to get to the patient. Paramedics were now highly trained and urgent care in fact started from the time they reached you. GB170513/062

Dr Fuller then moved on to the issue of finance. GB170513/063

1) A member of the public asked if services would be tendered out to GB170513/064

private companies. 2) Another member of the public said that 14 GPs on the CCGs register of interests had shares in local private health services and asked if they would abstain from voting as this was a conflict of interest? 3) Bess Harding said that costs were higher in London. She also felt there were infection control issues.4) A neurologist working in a local tertiary centre said that they did not feel that the assertion that the NHS has stayed still whilst medical practice has improved was in fact true. He felt that there had been too much reconfiguration in the NHS and did not see how closing two out of five A&E departments would bring benefits. He felt the process was financially driven.

Dr Fuller spoke to the conflict of interest issue. She said that many people had an interest in the NHS, including consultants from Epsom who had spoken today. She did not believe that the GPs present today had any conflict of interest when it came to the decision to go out to consultation but there may be issues in future if services were tendered. GB170513/065

Dr Fuller then moved on to Implications and Opportunities for Epsom. She invited Chris Grayling, MP for Epsom and Ewell, to speak first. GB170513/066

Chris Grayling said that he felt the process was riddled with significant issues and that clinical support for the proposals was ebbing away. Secondary care consultants do not support the proposals and the local community is against them. He said there were two inaccuracies in the statistics in the CCG's presentation, namely the issue of twenty four hour consultant cover and the question of whether other Surrey Hospitals were working towards the same standards. He said that the responses from the other Surrey Trusts did not support the view that they were working towards and could achieve the higher standards set out under the BSBV programme. The Surrey Health Overview and Scrutiny Committee Chair had written out to Surrey Providers and the responses he had received had been contradictory to the statement in the presentation. He said the CCG was not in a safe place to take the decision and should take legal advice before deciding to go any further. He said that if it chose to, the Governing Body of the CCG could put a stop to this process now. GB170513/067

Dr Evans spoke to the issue of quality standards. It was clear that the process had considered both the Royal College standards and the proposed higher standards and it had been agreed that we should aim for the higher standard around obstetrics. Dr Fuller said that this was very clear and although some people did not like it, it represented a difference of opinion. Dr Fuller apologised if there had been any potential misunderstandings in the interpretation of RCOG guidelines due to the earlier interruption of Dr Evans. GB170513/068

Miles Freeman said that the CCG had taken legal advice and that the CCG would not be taking a decision today about whether to proceed to consultation. The reason for this was that the final consultation document needed to be prepared and considered alongside the Equality Impact Assessment before any decision is made. In response to the GB170513/069

concern related to potential inaccuracies in data presented, he felt that the Governing Body had heard conflicting evidence and were capable of independently assessing evidence prior to forming a judgement.

Dr Fuller said she would like to hear whether anyone around the table had any other views. GB170513/070

Dr Andy Sharpe said that from his perspective, having been involved, he felt that the push for higher standards was a positive thing and could save lives. When people were very ill they did not just need good care but very good care. There had been a focus on money but the real issue was standards. He had some concerns about maternity services, but felt that despite the longer journeys and the concerns about inter partum transfers, the proposals made sense. With regards to A&E, he had reviewed the evidence from other parts of the country and felt that it showed that reconfiguration worked well. 60-70% of the work could be safely done in a UCC. He did have concerns about paediatrics, particularly the additional travel times and children who had to stay in hospital overnight. More work was needed on that. Travel times generally were an issue. He was not comfortable with the data on journey times, but he felt that on balance we should have a consultation process for precisely this reason, to give a chance for further discussion. GB170513/071

Sarah Mitchell, from Surrey County Council, said that it was important to have a consultation process which is why today's meeting was so valuable and so important as it gave Surrey a voice and could stop the continuous review of services that had characterised the last ten years. The County Council wanted to support the CCG to work through the issues with the local population. There were significant opportunities for better integrated health and social care and better mental health services. This needed to be done from an evidence based approach and the consultation process would facilitate this. GB170513/072

Dr Aalia Khan said that she also shared the concerns about travel times, particularly from the perspective of her patients in Bookham and Fetcham who already sometimes expressed a preference for using Royal Surrey. As Royal Surrey did not currently meet the required standards, she hoped that the principle of raising standards of care would be extended to other Surrey Hospitals. She cautioned that if there was a BSBV style review for Surrey, there was no guarantee that Epsom would keep its current range of services. GB170513/073

Denise Crone, Patient representative on the Governing Body, said that she felt that the process had been clinically led and she was aware that there were a range of opinions. She was very aware of the travel times issue and felt that was important to have a wider discussion and felt that consultation was important to give the public a voice. She felt that it was very positive to see so many people here today and felt that it was important to widen the consultation out. GB170513/074

At this point a member of the public asked that the public present be GB170513/075

asked to vote on whether the Epsom A&E should be retained. Miles Freeman said that this was a meeting of the CCG's Governing Body in public, not a public meeting and it was not appropriate to do this.

The same member of the public said there was no meaningful financial information on the website. Keith Edmunds, Chief Financial Officer, said that this information was in the pre consultation business case on the CCG web site. GB170513/076

Dr Fuller then asked Miles Freeman to summarise and set out what the CCG needed to do next. GB170513/077

Miles Freeman said that, as highlighted in his response to an earlier question, it was necessary to work with the other CCGs in the BSBV process to consider the Equality Impact Assessment and final Consultation Document before deciding whether to go ahead with the consultation. The decision would be made in a meeting in common with the six other CCGs and that the CCG needed to nominate three members of the Governing Body to do this on its behalf. GB170513/078

The decision would not be taken on the basis of a majority. All seven CCGs would need to agree to go ahead for the consultation to go ahead. Miles Freeman stressed therefore that the decision to be taken now was not one of closing or reconfiguring any services, but whether the governing body wished to delegate going ahead with the consultation to three members of the governing body. The proposal was for one executive member, which would be himself as Chief Officer; a lay member, Gavin Cookman; and Dr Simon Williams as the clinical member. GB170513/079

Clair Fuller noted that there were some non-voting members of the Governing Body around the table. These were Nick Wilson and Sarah Mitchell from Surrey County Council; and Eileen Clark. GB170513/080

Dr Fuller noted that Dr Mark Hamilton would abstain from the vote for the reasons set out at the beginning of the meeting. GB170513/081

Cliff Bush said that he had not been notified of this resolution in advance and could not support it as a patient representative for this reason. Miles Freeman said he was sorry Cliff did not feel able to take part in the vote. Cliff Bush said he had been expecting to vote on whether to go to consultation but not to delegate this to three members of the Governing Body. GB170513/082

At this point Dr Fuller proceeded to the resolution, as follows: to nominate three members of the Governing Body as previously stated to represent the CCG in the joint meeting with other CCGs to agree whether or not to go to consultation. GB170513/083

Dr Fuller asked for a show of hands on this resolution. The resolution was AGREED as follows: 16 in favour; 1 against; 2 abstentions. GB170513/084

There was a short break before proceeding with the rest of the agenda. Cliff Bush left the meeting at this point. GB170513/085

Chief Officer's Report

Miles Freeman reminded the Governing Body of the seven conditions that had been placed on the CCG as part of its authorisation. Five of these related to quality. It was now working towards addressing these. The June seminar of the Governing Body had been set aside to discuss quality issues in order to support this. The remaining two conditions related to financial planning and could not be removed until information on the CCG's first two quarters of operation were available. GB170513/086

Miles Freeman then talked about the CCG's intensive programme of work around out of hospital services. There had been a rapid review of data to see where patient care could be improved, and a series of high impact projects were being put in place to improve care and to stem the flow of activity into acute settings. GB170513/087

Workshops to achieve this had been well attended and had come up with proposals around elective care, urgent care, A&E, and also community support and use of community hospitals. GB170513/088

There was still a lot of work to do on historical issues. Integrated Access to Psychological Therapies (IAPT) remained a problem and work was ongoing with providers to clear the backlog and raise standards. Alternative providers were being considered as part of this process. GB170513/089

On the more positive side, Miles Freeman highlighted the procurement for new X-ray facilities at Dorking Hospital that was underway and the expansion of virtual wards for frail elderly patients. GB170513/090

Gavin Cookman asked when Neuro Rehab would be addressed. Karen Parsons set out the timescales for all developments. The X-ray procurement would be complete by September. Neuro Rehab could be in place by July. GB170513/091

Health and Wellbeing Strategy

Sarah Mitchell, Strategic Director for Adult Social Care, gave a presentation on the Health and Wellbeing Strategy. She noted that the model in Surrey was quite unusual in that there was a joint chairing arrangement with Councillor Michael Gosling, Cabinet Member for Adult Social Care, and Dr Joe McGilligan, Clinical Chair of East Surrey CCG. Michael Gosling was present today. GB170513/092

Sarah Mitchell said that the aim was to get as much benefit from each public pound as possible in relation to health and wellbeing and to avoid duplication. This might involve difficult and honest conversations about the needs identified in the Joint Strategic Needs Assessment (JSNA). GB170513/093

There had been considerable work done, driven by the public health team, about how to get a joined up approach across all partners to deliver improved services.

GB170513/094 The Health and Wellbeing Board had identified 14 potential priorities for discussion with partners and consulted with the public through right meetings attended by three and a half thousand people, including all key stakeholders. An online survey had also been conducted to identify the top three priorities. This had concluded that the three main areas would be children, mental health and physical health (focusing on areas such as obesity and complex needs).

GB170513/095 There was a clear message as part of this engagement that health and social care would be expected to work together to support families and care for people in complex situations.

GB170513/096 The work had also identified some underpinning principles namely that services should be person centred and improve outcomes.

GB170513/097 Sarah Mitchell said that the next step would be to progress these priorities and not put in another layer of planning – existing structures would be used to ensure we are achieving outcomes and have a plan for each priority in the coming year.

GB170513/098 Michael Gosling summarised by saying the approach was not to try and work on areas such as Cancer that were properly the preserve of one agency but to look at areas where there was a significant degree of overlap between the agencies. The Health and Wellbeing Strategy was there to address what we can do better together. Dr Steve Loveless endorsed this. He said this had already been apparent in areas such as psychological therapies where there was now a much greater role for the third sector. Dr Fuller said that Nick Wilson for the County Council was a standing member of the governing body and there would therefore be ongoing input on this agenda.

Financial Plan

GB170513/099 Keith Edmunds spoke to his written report. The context for this report was the ongoing process around transition from the PCT. The CCG had a budget of approximately £1,100 per person of its population for acute services, community services, mental health and continuing care. He said that the CCG had inherited an underlying cost pressure of approximately £11 million so presenting a balanced budget meant achieving a range of efficiency savings. These were achievable but needed focused work, for instance by reducing activity in acute services and concluding acceptable contracts.

GB170513/100 He reminded the Governing Body that the CCG was the lead for Continuing Health Care (CHC) in Surrey and that this carried significant potential liabilities. There were in fact 1,800 of these not 1,400 as stated in the papers.

There was work ongoing with NHS England to define the exact boundaries between specialised services and services commissioned by CCGs. This should be cost neutral but remained an area of risk. On the positive side there had been a £6.5m improvement in the CCG's allocation following a review of budget allocations between the CCGs in Surrey. GB170513/101

Maggie Ioannou asked about retrospective CHC claims. These could take years to complete and asked what the risk pooling arrangements were? She also asked if the collaborative agreement around safeguarding had been done as there were potential cost implications in this portfolio. Keith Edmunds said that a review of CHC retrospective claims was being undertaken but acknowledged the risk and said some provision may have to be made at year end. He confirmed that the safeguarding SLA had been signed. GB170513/102

Gavin Cookman asked four questions on the finances. 1) What was the level of confidence regarding the current run rate? 2) When will the Governing Body see figures about actual expenditure? 3) When will the remaining third of the contracts be signed? 4) What accounted for the difference between the £418m and £313m figures in Appendix 1 of the report? GB170513/103

Keith Edmunds answered these questions in reverse order. Firstly, the difference between the two figures in Appendix 1 was that the higher figure was the allocation before transferring budgets to NHS England, the local authority and other bodies that had responsibility for former PCT functions. With regards to contracts, the remaining local ones should be signed within two weeks. After that there may be a delay associated with the London and other non-local contracts which always took longer to sign off. With regards to expenditure, figures should be available shortly. Finally, current run rate was based on what we believed was happening in the absence of any published figures. Gavin Cookman asked if we were in an acceptable place at the moment, and Keith Edmunds said that we were on the basis of what data we had. GB170513/104

Quality and Patient Safety Report

Dr Fuller said that ensuring quality was one of our most important statutory duties and that the CCG's Clinical Governance, Clinical Quality and Safety Committee was chaired by the independent Nurse on the Governing Body, Maggie Ioannou. This was a committee made up of a variety of clinicians, lay members and executive members. GB170513/105

Eileen Clarke then introduced her report. The CCG now had a monthly meeting of the Clinical Governance, Clinical Quality and Safety Committee. The report shared with the Governing Body today was taken from the full report which would come to the Governing Board bi monthly. Since writing the report two significant issues had emerged. The first was capacity around child safeguarding, which was being GB170513/106

discussed with Guildford and Waverley CCG as the host for this area. Recommendations would be coming to all CCGs as to how to address this as there were risks around lack of supervision of designated professionals and overload on the teams that needed managing. The second was the intervention of the CQC in Mount Alvernia, a private hospital in Guildford. The host CCG had suspended all referrals. A letter to all practices should have been included in the report but would be shared on the CCG's website.

The second issue was the intervention of the CQC in Mount Alvernia, a private hospital in Guildford. The host CCG had suspended all referrals. A letter to all practices has been sent and this should have been included in the report as it set out the actions that were being taken, but this would be shared on the CCG's website. GB170513/107

Eileen Clarke set out how patient safety issues were addressed and the early warning systems. All CQC reports relating to our commissioned services were reviewed as there was a programme of inspections in place including primary care. A Surrey Quality Surveillance Group had also been in place since the 1st April. This was a key means of getting early warning signs around quality. Locally we also have quality meetings with all our main providers and are setting these up with other out of hospital providers such as Epsom Downs Integrated Care Services (EDICS) and Ramsay Health Care. Lastly, serious Incidents Requiring Investigation (SIRIs) were scrutinised collectively with other CCGs to identify trends and shared learning, not only for Surrey providers but also for contracts in London. GB170513/108

The terms of reference for the Surrey wide group that scrutinised Serious Incidents (the Patient Safety Assurance Review Group) were included in the paper, and as this carried out functions on behalf of the CCG Eileen Clarke asked that these be approved the governing body. GB170513/109

The Governing Board AGREED the terms of reference of the Patient Safety Assurance Review Group. GB170513/110

Eileen Clarke then highlighted a number of other areas in her report that were of particular interest. GB170513/111

Health Care Associated Infections (HCAIs). CDiff rates were of concern at Epsom Hospital where the trust exceeded its target in 2012/13 by 19 cases. The trust had put in place special measures and we were working with both Merton and Sutton CCGs to conduct an audit of antibiotic prescribing to look at the causes of this. GB170513/112

NHS 111 – this had had a very difficult operational start and we were working with other CCGs to address the issues. Patient feedback had been invited via GP practices and this had been co-ordinated by Dr Steve Loveless. GB170513/113

The Governing Body seminar for June would focus on developing an GB170513/114

integrated quality plan for the year ahead.

Maggie Ioannou congratulated Eileen on a well presented report. She remained concerned about Safeguarding Adults. There was a plan for training in primary care but it would only take three or four significant cases to swamp existing capacity. She asked if there had been a capacity discussion and Eileen Clarke said there had. Training was delivered by a number of people not just the designated nurse. There had also been a workshop with Chris Maclean from Surrey County Council and Surrey CCGs to develop a joint workplan. Training would be a key area in this. GB170513/115

Nick Wilson welcomed the joint approach around adult safeguarding. He said that working together guidance had just come out which had clarified compliance issues with GPs. He asked how this was being jointly progressed. Eileen Clarke said that she hoped to bring a report back on this issue in July. GB170513/116

Nick Wilson asked about the 111 report and whether this had been delayed. Dr Steve Loveless said that there was a rectification plan; everyone was aware of the issues and a recruitment plan was in place. He was not aware of any formal report. GB170513/117

Dr Robin Gupta asked if there were plans to use soft data from local GPs rather than relying on CQC reports and Eileen Clarke confirmed that this was part of the approach, both patient participation groups and GPs directly. She was working closely with patient representatives on this. GB170513/118

Denise Crone asked about our patients at Mount Alvernia? Eileen Clarke said they had been referred back to their GPs. Denise then asked if there was a timescale for implementing improvements. Karen Parsons said we would be getting the CQC rectification plans via the lead commissioner and we would work with the other CCGs to ensure these were implemented, but in the meantime some areas such as diagnostics were still being used. Denise asked what was happening regarding any of our providers who had been sub-contracting? Eileen Clarke said we were aware of the need to do this and will be able to give timescales shortly. GB170513/119

Denise Crone asked about the clinical audit of discharge processes and whether this will involve patients and carers? She noted there were already recommendations in the carers strategy for this. Eileen Clarke said that the plan is to involve patients and carers and she would welcome assistance with identifying people who can contribute. GB170513/120

Denise Crone asked if we would be doing something jointly with Sutton CCG as she was concerned at the need to focus on the Epsom rather than the St Helier site. Eileen Clarke said there will be a joint approach as some of our patients do go to St Helier for surgery but we need to put the focus back to Epsom Hospital particularly with regard to informal GB170513/121

inspections and “walkabouts”.

Dr Kate Law asked about looking at primary care prescribing of antibiotics as a lot of work had been done in this area in the last two years. Eileen Clarke said that she has had a conversation with Liz Clarke, one of the pharmacy leads, and had been looking at the data as need to assure ourselves that we have improvements where possible. GB170513/122

Gavin Cookman noted that there had been 7 serious incidents in two months and asked if this was normal and what we were we doing about them? Eileen Clarke said we needed a low tolerance about serious incidents but some clinical approaches such as reablement had inherent risks. Similarly with mental health the risk of absconding went with the rehabilitation process. As a CCG we are looking at all serious incidents as they come in and doing Root Cause Analysis and also sharing across CCGs to identify shared learning and trends. Quality leads across Surrey are determined to address this. GB170513/123

Miles Freeman said that we need some trend analysis on this to see whether serious incidents were going up or down. GC asked if we were prepared to set a tolerance level. Maggie Ioannou issued a note of caution about this approach as we want our providers to be transparent and report serious incidents and this was an area where targets sometimes have the opposite to the desired effect. Gavin Cookman agreed but asked what ambitions the Governing Body might have for driving trends down. Maggie Ioannou said that this needed to be seen in context – over the last two years falls and pressure ulcers had become part of serious incident reporting and this had driven the numbers up again. Greater reporting of near misses would be a good indicator.

Dr Mark Hamilton said that we relied heavily on reporting by providers and asked if we had any plans to go in and develop our own sources of information on patient safety and quality. He was concerned about providers who under-reported. Eileen Clarke said that she agreed and that a programme of visits was being organised, and there was also mutual support through the network of quality leads. GB170513/124

Risk Register

Miles Freeman said that the risk register was designed to look at a range of issues that impact on the CCG’s business including patient care, finance, and strategic objectives. The Audit, Corporate Governance and Risk Committee has a key role to monitor and bring back risks at the Executive Committee and the Governing Body. One of the top risks was continuing care as this meant that not only were patients potentially at risk of not being able to get access to the care they need, there could also be financial risk to both them and the CCG. GB170513/125

Maggie Ioannou said that she felt that Safeguarding Adults was the big unmanaged risk in the system and that there should be something on the register for this. Claire Fuller said this would be explored at the next Governing Body seminar. GB170513/126

Peter Collis regarded this as good work in progress and said that the Audit, Corporate Governance and Risk Committee would want to develop a fuller assurance framework that helped it to understand the totality of its responsibilities. There needed to be a process for the Governing Body to understand what was going on behind the scenes so that it had confidence that not only were risks being managed but that other issues were being managed as well. GB170513/127

Gavin Cookman said that in process terms we needed to understand when things would be dealt with and by whom. We also need to know if the residual risk score was considered acceptable. Some risks were never going to be reduced beyond a certain level and it was for the Governing Body to say what it was prepared to accept. Miles Freeman agreed with this and said that there needed to be a fuller strategy behind each risk that demonstrated how it would be dealt with. GB170513/128

Dr Mark Hamilton said that he would like the register to demonstrate how long the risk had been on and the changes particularly were they getting worse or better? Miles Freeman agreed but said this was our first risk register and trends would go forward from here. GB170513/129

Any other business

Dr Fuller thanked all the Governing Body for their support for today's meeting and also thanked the wider staff of the CCG for their huge efforts in preparing for such a big meeting. She also thanked the public for their attendance, particularly those who had stayed for the full agenda and not just the BSBV item. GB170513/130

Date of Next Meeting

Dr Fuller confirmed that the next Governing body meeting in public would be on the 19th July when there would be a focus on the Out of Hospital Strategy. GB170513/131

Summary of actions:

GB170513/043: Jo Pritchard (Central Surrey Health) would supply figures on District Nurse training numbers

GB170513/050: Dr Claire Fuller. The CCG would ask what work had been undertaken on elective gynaecology by the BSBV team.