NHS
Surrey Downs
Clinical Commissioning Group

Minutes of a Meeting of the Governing Body held on 19th July 2013 at Dorking Halls

Record of attendance

Clinical Members
Dr Claire Fuller – Chairman of the Governing Body and Chair of Medlinc Locality
Dr Simon Williams – Chair of Mid Surrey Locality
Dr Steve Loveless – Chair of Dorking Locality
Dr Aalia Khan
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
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
Maggie Ioannou, Nurse Member

Minutes:

Jonathan Perrot, Transition Manager

1) Apologies for absence

These had been received from Dr Andrew Sharp; Mr Cliff Bush; Eileen Clark; Dr Jill Evans; Dr Mark Hamilton; Mr Nick Wilson GB190713/001

2) Welcome and introductions

Governing Body members introduced themselves and stated their role on the Governing Body. GB190713/002

3) Register of Interests

The Register of Interests was NOTED. Dr Fuller said that there were some inaccuracies in this that would need correcting and she would discuss these with the Governing Body Secretary on his return from annual leave. GB190713/003

Action Dr Claire Fuller

4) Minutes of the last meeting

GB170513/126 (adult safeguarding): Maggie Ioannou said that she felt the wording of this paragraph was incorrect. Additional nurses were being trained in adult safeguarding and would inevitably identify new cases. It was agreed that the wording of this should be changed to reflect that the risk was that unknown cases were not being managed. GB190713/004

Action Justin Dix

Other than the above, the minutes of the meeting were AGREED as an accurate record. GB190713/005

5) Matters arising

Better Services Better Value - Numbers of District Nurses GB190713/006

Dr Fuller said that she had spoken to Jo Pritchard from Central Surrey Health regarding this. The question had come about because it was stated in the course of discussions about Better Services Better Value (BSBV) that more work was now being done in the community. Jo Pritchard had said that to some extent this was about descriptions of roles and that the real issue was the role of Community Matrons; the numbers of these in service and being trained was increasing.

Better Services Better Value - Elective Gynaecology GB190713/007

Dr Fuller said that it had been queried by Dr Hassan Shehata at the last Governing Body whether any work had been done under the BSBV programme on elective gynaecology. She had investigated this and had been given minutes of the BSBV Obstetrics and Gynaecology Working Group dated the 5th February. Three members of the Epsom Hospital Team had been present at this meeting – the Lead Nurse for Gynaecology, the Head of Midwifery and the Clinical Director for Obstetrics and Gynaecology. These minutes showed that there had been a discussion which stated that elective gynaecology would go to the planned care centre and that workforce planning for specialist nurses for this area would be undertaken.

6) Policies

The Governing Body considered the following four policies: GB190713/008

- Assisted conception
- List of procedures with restrictions and thresholds
- List of procedures that are not routinely funded
- Policy and operating procedures for individual funding requests

GB190713/009

Dr Fuller said that as an interim measure the CCG had adopted the former Surrey PCT's policies. However it was now necessary as a statutory body to approve policies and review them periodically. A Joint Priorities committee had been set up with the other CCGs in Surrey and Hampshire to review clinical policies – these would begin work on assisted conception and varicose veins in September. Dr Fuller said that she was the CCG's representative on this joint committee. This was not a decision making group but would produce recommendations for each CCG to take to their Governing Bodies for approval if they wished.

GB190713/010

Karen Parsons said that the CCG was trying to work collaboratively and follow NICE Guidelines in reviewing these policies and making them consistent wherever possible.

GB190713/011

Dr Kate Laws asked about assisted conception. The former Surrey PCT had contracted with Queen Mary's Roehampton. She asked if this would still be the preferred provider or whether there would be more choice.

GB190713/012

It was clarified that the CCG currently contracted with Queen Mary's, Woking and Croydon but the pathways were complex and were being reviewed. This was not always convenient for patients and the review was seeking to address this.

GB190713/013

Dr Laws said she was aware of patients being referred to a private service called New Life in Epsom and asked where these referrals had come from. Concern was expressed as this was not an organisation the CCG contracted with. It was agreed that this would be picked up with Dr Laws outside the meeting.

Action Dr Claire Fuller

GB190713/014

Dr Gupta acknowledged there would be changes to these policies. He did not feel that the former Surrey PCT had been very good at communicating changes to GP practices and asked that in future this be done clearly to the Council of Members. Dr Fuller said that recommendations in future would come back to the Governing Body and be shared with clinical colleagues.

GB190713/015

Denise Crone said that the cover sheet noted that these policies had been reviewed in the Clinical Governance, Clinical Quality and Safety Committee and asked if this would be the process in future before they came to the Governing Body. Miles Freeman confirmed this would be the case and that the committee would make the final recommendation to the Governing Body.

Dr Fuller also noted that Healthwatch Surrey and Healthwatch Hampshire were represented on the Priorities Committee. GB190713/016

Denise Crone asked about the Individual Funding Requests Policy. She noted the equal opportunities monitoring form and that the CSU would be compiling information based on this to check if individuals were being discriminated against. She asked if the CCG would get feedback on this as monitoring data was often not reported. Miles Freeman said the data should come to the committee on a quarterly basis and any issues reported to the Governing Body. Dr Fuller added that Cliff Bush also sat on the relevant panel for Central Surrey Health. GB190713/017

The Governing Body AGREEED: the policies for Assisted conception; the List of procedures with restrictions and thresholds; the List of procedures that are not routinely funded; the Policy and operating procedures for individual funding requests. GB190713/018

7) Chief Officer's Report

Miles Freeman said that the report focused on the work of the Executive Committee. Other Committees of the Governing Body sent their minutes to the Governing Body meetings but this was not feasible for the Executive as it was having to meet weekly in order to manage the operational workload and would mean that each Governing Body meeting would have to receive eight sets of minutes. The Chief Officer's report was therefore the best vehicle for reporting back on the work of the Executive in particular where the issues were not covered elsewhere on the agenda. Many of the issues were also reflected in the risk register. GB190713/019

Topics discussed at the Executive Committee included: GB190713/020

- Regular review of Better Services Better Value
- Fortnightly reviews of Continuing Health Care
- Taking the Out Of Hospital Strategy through its development

The Executive Committee also considered the implications of the spending review and the decision to set up a transformation fund, which would result in approximately 3% of the CCG's budget being top sliced to develop projects for integration between different NHS bodies and the local authority. The rationale for this is to ensure that agencies are working together to transform the health and social care interface. Miles Freeman said that he thought the CCG was in a good place to meet this challenge due to its approach around out of hospital care. However this might shift costs around the system to the disadvantage of other agencies and the CCG should be prepared to potentially meet some of these costs whilst achieving savings in other areas. GB190713/021

Miles Freeman said that the CCG had already applied, with Surrey County Council, to run two pioneer projects as part of a national initiative. One project being led by Dr Jill Evans was around the Kingston Hospital hub and focused on integration of care around the frail elderly. The other was a joint project with Surrey and Borders, Central Surrey Health and Epsom Hospital to transform care pathways particularly around non elective admissions. These projects did bring a certain level of responsibility and reporting back to the centre and sharing of good practice, but were central to the CCG's strategy. GB190713/022

Moving on to authorisation, Miles Freeman said that the outcome of the work to remove the five quality conditions was not yet known but there was a monitoring meeting with the Area Team shortly which it was hoped would confirm these had been lifted. GB190713/023

Miles Freeman then moved on to the Better Services Better Value process and said that this had been paused whilst further assurance work was undertaken on the process and the finances. Consultation during the summer holiday period was not felt to be best practice and the process was expected to be picked up again in late September or early October. GB190713/024

Miles Freeman said that the CCG would be moving into Cedar Court. This was due to pre-existing liabilities which meant the there was no scope to avoid the lease commitments following the demise of Surrey and Sussex Commissioning Support Unit, who currently occupied the building and picked up the lease costs. If the CCG did not move in it would be liable for approximately £600,000 per year of overheads for the next three years with a total cost of £1.8m, which was not acceptable in terms of the CCG's duty of care to the taxpayer. GB190713/025

Finally Miles Freeman noted that the closure of beds at Dorking Hospital had been discussed at the Executive Committee but this would be picked up in the quality report. GB190713/026

Maggie Ioannou asked if the Continuing Health Care (CHC) team would be moving to Cedar Court and it was confirmed that they would. It was noted that this was a major project due to the amount of records the team had to manage. Miles Freeman said that records management and records archiving would be part of the CHC review that was now underway. GB190713/027

Peter Collis asked about the spending review and said it would be helpful in particular for members of the Audit, Risk and Corporate Governance Committee to see. It was agreed that this would be circulated to all Governing Body members. GB190713/028

Action Miles Freeman

8) Risk Register

Dr Fuller said that there had been a focus on risk management as part of the last Governing Body Seminar on the 28th June. Miles Freeman said that at this seminar Governing Body Members had raised a number of issues and these were being picked up by the Governing Body Secretary on his return from annual leave as part of ongoing work to fundamentally review the risk management process. GB190713/029

Denise Crone asked whether the South East Coast Ambulance Service's (SECAMB's) overall performance should be on the risk register due to their not meeting targets, particularly emergency response times and time taken to close Serious Incidents. She had also had anecdotal feedback about patient transport services. GB190713/030

Dr Steve Loveless felt this should be on the risk register, as it had been referred to in meetings regarding NHS 111. Other CCGs were also concerned. GB190713/031

Miles Freeman said that this had been discussed at the Surrey Collaborative. It had raised the wider issue of how risks were perceived by CCGs that hosted services and how their perception of risk was more acute, when in fact these were also risks for other CCGs as well. It had been agreed to share risks and have a session at a future collaborative meeting about shared risks. GB190713/032

Maggie Ioannou recognised that the Clinical Governance, Clinical Quality and Safety Committee had to have more of a focus on these issues. She felt that the risks around safeguarding needed to be reviewed and that the scoring was not correct, being too low. She would want to look at the criteria for the scoring of risk. GB190713/033

She was also concerned at the Community Equipment risk. Along with a number of other risks, there were no timescales for action. This meant that it was not possible to be assured that the actions were being taken and what the impact of them was. She felt that this was a serious risk and that the score was again underestimated. It was better to score the risk higher and reduce it if necessary. GB190713/034

Miles Freeman said that he felt that the adult safeguarding risk was correct in as much as it referred to training by our providers; He agreed that there should be a separate overall risk around safeguarding adults that might have a higher score. GB190713/035

Action Eileen Clark

9) Draft Out of Hospital Strategy

Dr Steve Loveless spoke to this item using a series of slides. He said this was a complex issue but today he would focus on the headlines. The full set of slides had been published on the CCG's web site. GB190713/036

Dr Loveless said that this was a clinically led strategy but that it was important to listen to the views of all stakeholders. He was particularly conscious of the need for the CCG to act corporately as an advocate for the silent majority that did not always take the opportunity to express their views in public meetings, and to get a consensus on the need to move services out of hospital and into the community in line with work done by The Kings Fund and the Royal Colleges, as well as existing local dialogues with providers. GB190713/037

The strategy had been built on the local priorities set out in the Joint Strategic Needs Assessment (JSNA) and taking account of the Health and Wellbeing Board's strategy. This was a significant undertaking to avoid services becoming unsustainable and not fit for purpose. GB190713/038

Dr Loveless reiterated that this was a draft strategy that needed more work on it, particularly around contentious issues such as GP Out Of Hours, the interface with A&E, and discharge planning. There had already been widespread engagement but more work was needed with stakeholders particularly around the interfaces between services. GB190713/039

The strategy was based on a care closer to home approach that would improve care and make sure it was sustainable. It was comparable to the BSBV work and the principles established in the clinical reference groups were the same, but with the difference that there was a need to take more account of local circumstances and the impact on the wider Surrey health economy. There was a particular need to do more work on paediatrics; although the principles were clear, the local model of care meant that the acute service was more involved with the community than was the case in other parts of Surrey and in London. GB190713/040

Dr loveless said that the aim of the strategy was to: GB190713/041

- Revolutionise health care and improve care for local people
- Ensure that services are affordable, responsive and deliver improved outcomes.
- Make sure services are sustainable – doing more for less through redesigned care pathways

The programme was ambitious but clinically led, and intended to achieve medium term improvements rather than being a short fix. Key aims were to: GB190713/042

- Avoid preventable elective admission and re-admission
- Reduce length of stay in hospital
- Improve the range of community options
- Improve the discharge process
- Reduce emergency admissions through better case management and integration of services
- Working with Central Surrey Health (CSH), the hospices and other agencies to allow people to die in their preferred setting of care.
- Meet the projected growth in continuing health care

- Commission high quality services that meet national standards
- Aim for best practice and challenge current working practices and vested interests

As an organisation Surrey Downs CCG was committed to achieving national standards and wanted to make sure that patients had choice and equitable access to care. There needed to be an absolute commitment to safe services with adequate safeguarding arrangements. Outcomes needed to be of proven clinical effectiveness. GB190713/043

The work to date had included local and national benchmarking, clinical audit, areas of best practice, engagement with 160 clinicians in primary and secondary care (nursing, medical and other professions). There was also engagement with patient representatives. More discussion was needed with the patient advisory group on taking the strategy forward. GB190713/044

The key areas of the strategy were: GB190713/045

- Admission prevention
- Timely discharge arrangements
- Investing in community bed capacity
- Referral support
- Unplanned Care
- End of life care
- Dementia Care

Each of these would need to be planned work streams going forward. Dr Loveless then went on to talk about the key areas in turn. GB190713/046

Admission prevention: 41% of admissions in Surrey are for very short periods. These are costly compared to other CCGs. Audit at three local trusts done by independent clinicians showed similar numbers and that 46% of patients could have been managed in alternative settings. Patients with long term conditions reached a crisis where they received a lot of episodes of care (the “intense year”) before being settled again. Early intervention in this hump of episodes could reduce the need for intervention, improve patient experience and reduce costs. Chronic Obstructive Pulmonary Disease was a good example of this. With better support, education and management, poorly co-ordinated care and frequent hospital admissions could be avoided. Telehealth could be valuable in this example. GB190713/047

Timely discharge: data showed longer length of stay than our peer groups due to lack of proper pathways for rehabilitation. Acute, community and social care needed to collaborate to change this by looking at step-down pathways, introducing community led discharge planning, and working with community hospitals and nursing homes to support this. Pilot work was being done with Epsom on this. The quality and timeliness of discharge information was also key if GPs were to play their part. GB190713/048

Community hospitals: these would be central to care closer to home arrangements involving both step down (rehab to leave hospital and return to normal life) and step up (people in their own homes who need care but not in an acute hospital setting) care. More beds would be needed – 30 step down and 6 step up. The capacity did not exist at the moment and existing units such as Dorking needed remodelling with (potentially) neuro rehab and stroke featuring in this, along with facilities to avoid elective admissions via a Community Assessment Unit. These units needed to be viable, high quality, able to support economies of scale and with dedicated staff. GB190713/049

Referral Support for GPs: Surrey Downs has a higher than average level of first outpatient appointment referrals compared to national benchmarks. The underlying reasons seemed to be a lack of consistency in referral management and an incomplete Directory Of Services. Some patients were not reviewed and had inappropriate hospital visits. It was therefore proposed to set up an independent Referral Support System (RSS) led by a clinician with triage skills. A database would be maintained to support this both operationally and for future planning purposes. The service would help to develop referral pathways and improve care and equity. This would give better patient experience and support training and education. Patient choice would improve and the system would be transparent. GB190713/050

Improving Urgent Care: 16% of A&E attendees had no need for diagnosis or intervention and a further 28% just needed basic diagnostics such as urine analysis. These could be dealt with differently for both the patient's benefit and the system's. GB190713/051

Dr Loveless also noted that 15% of patients could have been seen in primary care and did not go there either because they could not get an appointment or did not know that primary care was appropriate. A feasibility study would be undertaken to see if this could be addressed through an urgent care centre integrated with A&E. A reconfigured Community Assessment Unit (CAU) with step-up beds, possibly transferring to the Epsom site eventually, could be part of the improved system. GB190713/052

Dr Loveless noted that GP Out Of Hours (GPOOH) was also being re-procured and this could support improvements in the overall system as well, possibly co-located with A&E. Pilot schemes for same day access to a GP were also being looked at to improve access and patient flows, incorporating telephone triage. GB190713/053

With the ageing population, End Of Life Care (EOLC) was a major issue with many patients not being able to die at home. This would be a growing issue and was a national priority. The CCG hoped to establish a shared register of such patients to support them more effectively across all agencies. This would educate clinicians on effective care. GB190713/054

Dementia: prevalence rates were underestimates and may patients and carers suffered. Hospital care was often inappropriate and length of stay was inappropriate as well. A pilot screening project in Dorking using risk stratification was in place. This would help services to be planned effectively and support independent living. GB190713/055

Keith Edmunds spoke to the financial aspects of the strategy. This focused on longer term trajectories and patterns of spend. Benchmarks against peer groups showed that Surrey Downs could achieve £24.9m of improvements if it was in the upper quartile. GB190713/056

Two thirds of Surrey Downs expenditure was in acute care and recent growth in the last four years showed this was a continuing trend. If the CCG did not address this in five years' time it would be £16m in deficit, incorporating other growth and demand factors. GB190713/057

The strategy showed low, medium and high scenarios. These ranged from break even to the £25m shown above. The strategy would bring a substantial benefit, although other work would be needed. GB190713/058

Keith Edmunds then showed the component parts of the strategy with an £8m benefit in the first year. GB190713/059

Dr Loveless said that work was needed to engage with stakeholders including providers. Doing nothing was not an option. GB190713/060

Dr Claire Fuller then asked the Governing Body for comments and questions. GB190713/061

Dr Robin Gupta said that we also needed to work with CCGs and providers around the boundaries such as Kingston and SASH. This was agreed. It was not just an Epsom strategy. Miles Freeman agreed and noted the work of the Local Transformation Boards. GB190713/062

Maggie Ioannou welcomed the strategy and asked if the acute trusts would support it or see it as a threat to their business. Miles Freeman said that it did not impact significantly on the areas where acute hospitals made significant income such as non-elective work. It would also reduce costly marginal rate activity. Epsom did not expect growth over the next five years so was consistent with the strategy. Rapid progress might however cause them some issues. GB190713/063

Maggie Ioannou then asked if the workforce assumptions were sound. Dr Claire Fuller said that work was being done on this with the Deanery and the CCG would be a pilot site for this. Miles Freeman said that the skill mix would be adjusted to use more appropriate levels of skills which would address the problem. GB190713/064

Dr Kate Laws asked about existing triage providers such as EDICS who although they tended to refer to their own services did have a lot of knowledge, and asked whether we could draw on their experience. This was acknowledged but Dr Loveless said that a vital element of triage would be independence. GB190713/065

Peter Collis asked about the financial assumptions and whether they were robust when looked at in terms of sensitivity analysis. Keith Edmunds said that we were not starting from scratch and a lot of the changes would be at less than full cost. Miles Freeman said that the analysis was in fact quite conservative. GB190713/066

Dr Khan said that the overview was very helpful. She noted there would be a dementia awareness event in late September to raise the profile of the issue and demystify people's understanding. GB190713/067

Maggie Ioannou asked if the Local Education and Training Board was involved in a joined up workforce strategy with providers. Keith Edmunds said this was being done via the Surrey Collaborative and with Sussex. GB190713/068

Gavin Cookman asked if we had the capacity to do this and balance it with other demands. He also asked about the development of the strategy and when it would come to the Governing Body for agreement? Miles Freeman said that the aim was to finalise this by September although public engagement would continue beyond this. A Programme Management Office was being established and contingency funds were being set aside to bring in extra help. Dr Loveless also noted that this would be a phased strategy, not one with a sudden impact. The strategy would be prioritised with some elements needing to be dealt with first. GB190713/069

Miles Freeman reiterated this and said there would be operational opportunities to make changes. GB190713/070

Dr Simon Williams said that although there was significant focus on money, the real aim was to improve patient care and avoid people sitting in hospital beds inappropriately. He felt that there was a lot of excitement about this in the Local Transformation Boards and providers were engaged. He also felt it was an opportunity to address conflicts of interest. GB190713/071

At this point Dr Fuller thanked Mark Needham and his team for getting the strategy to this stage of development. GB190713/072

Denise Crone asked why people were being admitted to hospital when it was not really necessary and said that if we did not understand this then some of the responses we developed would not be appropriate. Stress on carers was an example; how many admissions were due to this? More respite care might be an answer. Dr Loveless agreed that this was a good example of the need to understand the detail of people's experiences. We needed to find better alternatives for patients that were in their best interests. GB190713/073

Miles Freeman agreed and said that lack of information sharing was a key issue with admissions occurring because long term conditions were not understood by doctors in A&E who were not familiar with patients. There was also a lack of understanding by acute hospital staff as to what GPs and nurses could contribute to the care of the patient. This needed to be addressed to avoid inappropriate admission. GB190713/074

10) Prescribing Commissioning Intentions

Miles Freeman explained that most drugs were included in tariff payments, the major exceptions being high cost (usually new) drugs and expensive devices such as cardiac implants. This document sets out the ground rules for paying for these high cost interventions to strike a balance between early adopters for new technologies and the overall needs of patients. The aim was to use NICE appraisals appropriately and the Prescribing Clinical Network to advise where there was no NICE guidance. The network was advisory not a decision making body, comprised of GPs and other clinicians. He invited questions and comments on the processes around this work in particular, and whether it was consider fair and had adequate public engagement. GB190713/075

Dr Fuller asked if the necessary decisions could be delegated to the Clinical Quality Committee. Miles Freeman said that given that this could be interpreted as rationing of healthcare, it was important for decisions to be taken or ratified at Governing Body level. GB190713/076

Dr Robin Gupta said that in his experience many of the drugs were very specialist although some did relate to community and primary care. His understanding was that clinicians within the CCG would be able to review decisions outside of the Prescribing Committee and answer any questions that clinicians on the committee might have. After this a recommendation would be made to the Governing Body following this “second check”. GB190713/077

Gavin Cookman said that much of the language was difficult for lay members and he supported this approach as it gave assurance that there had been a thorough clinical review. GB190713/078

Dr Fuller said that there was a separate panel for high cost drugs that she sat on which was required to make a decision within 18 working days although there were occasions when a faster decision was required, in which case the Governing Body would have to delegate authority to her.

The above processes were AGREED by the Governing Body. GB190713/079

11) Finance Report

Keith Edmunds spoke to his written report. This was the first set of figures proper that the Governing Body had received and forecasts were in line with budget, however there were more estimates than usual due to problems with data. At this stage there was no reason to change the end of year projection although there were a number or material risks. GB190713/080

The CCG had received a number of functions from the former Surrey PCT and by the end of September the full effect of this will be known, and should be neutral to the balance sheet if the correct accruals had been made, although there was a risk that this was not the case. GB190713/081

Allocations within the health system to date had been beneficial to Surrey Downs but work was ongoing particularly specialist commissioning, continuing health care and NHS Property Services. These were not unique to Surrey Downs. GB190713/082

Acute activity was above forecast levels although this will be clearer once month 3 reports are received. Epsom St Helier and Royal Surrey were the main areas of concern. GB190713/083

Invoicing processes had meant that cash flow was below expectations and adjustments were being made to ensure that expected payments were accounted for. GB190713/084

With regards to specialist commissioning there were discussions regarding a disputed figure of £28m between Surrey as a whole and London. It was not clear what Surrey Downs share of this might be. GB190713/085

CHC retrospective claims were still being settled with 1500 in the system and no clarity on the impact of this. GB190713/086

NHS property Services costs were also unclear and being worked through with other Surrey CCGs. GB190713/087

Denise Crone asked why the specialist forecast was not being adjusted and Keith Edmunds said the level of uncertainty made it unwise to change the forecast at this stage. GB190713/088

Gavin Cookman asked how the £28m would be handled. Keith Edmunds said the deadline for resolving this was already overdue but NHS England had signalled they would keep the issue open. Surrey Downs had some headroom to absorb up to £6m. GB190713/089

It was acknowledged that this would be clear on the balance sheet and would not cause difficulties at year end. GB190713/090

Miles Freeman said that we could also ask to renegotiate our final balance if needs be. GB190713/091

12) Performance Report

Karen Parsons spoke to the written report. It overlapped extensively with the quality report and was important to the Assurance Framework meetings with the Area Team. There were three key risks: Infection Control, Mixed Sex Wards and referral systems. She invited comments on the format of the report. GB190713/092

Maggie Ioannou noted that there were overlaps between quality and performance. She felt that the quality report ought to be at the front of the agenda, before finance and performance. Miles Freeman said that there was a generous allocation of time on the agenda for discussion of quality. Maggie Ioannou acknowledged this. GB190713/093

Denise Crone asked SECAMB eight minute standard which had been raised with the trust. She wanted to know what the outcome of the discussion was. Miles Freeman said that a formal contractual review had been triggered which should lead to remedial action. GB190713/094

Denise Crone then asked about 111. She could not see any targets against which to understand primary care performance. This was also the case with patient experience. Miles Freeman said that there were no targets; Dr Steve Loveless said there were standards rather than targets and Surrey was performing well against these. GB190713/095

13) Quality Report

Maggie Ioannou presented the written report in Eileen Clark's absence and picked out the key points. GB190713/096

Safeguarding children would be a challenge to the CCG as the team's performance had been an issue since PCT days, and the CCG needed to look at the level of service it was getting and whether it met requirements. GB190713/097

The CHC reference group was seeking to move forward with the review that was in place. There was a need to review Personal Health Budgets. GB190713/098

Healthcare Associated Infection performance was improving apart from CDiff on one site which needed continuous challenge. GB190713/099

SECAMB Serious Incident closure was also of concern and there was a need to identify the learning points. GB190713/100

Dr Fuller asked Karen to comment on the Personal Health Budgets. Karen said that this was one of the three short life task and finish groups with the local authority and was being looked at in detail. GB190713/101

Gavin Cookman asked how we achieved an oversight whilst also identifying key points of concern; and then how did we intervene to make sure that things were being addressed. Maggie said that this had been discussed at the last Governing Body Seminar and partly involved the need for the Governing Body to focus on soft intelligence, and to identify thresholds for escalation and intervention. She welcomed lay members' views on getting soft intelligence. GB190713/102

Miles Freeman said we also needed to risk stratify our suppliers by looking at a range of criteria, and also identifying systemic failure across organisations. CCGs did have contractual teeth and could stop services where necessary particularly when working with other commissioners. GB190713/103

Karen Parsons agreed and said we were producing hard and soft intelligence and looking at all our suppliers and their sub-contracting arrangements. Walkabouts were taking place as part of quality work.

Gavin said this was very useful and asked when it would come to the Governing Body. Maggie Ioannou said this should be at the next Quality Committee and come to the September Governing Body. GB190713/104

Keith Edmunds asked that this included reporting on numbers and trends of Serious Incidents. GB190713/105

Maggie Ioannou also said we needed to have benchmarks for performance in the report. GB190713/106

14) Clinical Quality Committee Minutes

These were NOTED by the Governing Body. GB190713/107

15) Audit, Risk and Corporate Governance Committee Minutes GB190713/108

Peter Collis spoke to these minutes and highlighted a number of points. GB190713/109

The CHC potential liability was of concern and it was hoped this would become clearer over time. GB190713/110

The scheme of delegation had been recommended to the Governing Body and this had been approved by the external and internal auditors. GB190713/111

The risk register was in danger of being nodded through and he was pleased that points on the register had been picked up in discussion at today's meeting. However it did need to be looked at comprehensively from time to time, in accordance with the discussions at the last Governing Body Seminar. GB190713/112

Conflict of Interest was being picked up and guidance given to staff although it was difficult to do this in a comprehensive way and give examples of every type of risk of a conflict of interest. The main concern was to ask staff to ask if uncertain within a positive organisational culture. GB190713/113

Peter Collis noted that there were a number of points that the committee had drawn to the attention of the Governing Body. He and other lay members were very encouraged by the attitude of staff but ultimately the responsibility lay with the Governing Body. GB190713/114

Finally he noted that it was important for the committee to meet periodically with the Clinical Quality Committee to ask if the sytem was joined up and functional. GB190713/115

16) Any Other Business

Maggie Ioannou updated on the Liverpool Care Pathway. Guidance was clear that clinical oversight and patient and carer involvement were key; although the pathway was being phased out these principles were key and all providers were being asked for their local end of life care plans. GB190713/116

Dr Kate Laws asked if the Assisted Conception policy could now be shared with GP colleagues and it was confirmed that it would be. GB190713/117

Dr Alia Khan commented on the risk register entry for Improving Access to Psychological Therapies, which she felt needed to be updated. GB190713/118

17) Questions from Members of the Public

Rosemary Najeem had left two written questions regarding Better Services Better Value and Epsom Hospital. GB190713/119

The first concerned caesarean rates and paediatrics and noted that services were safe and integrated. They were also as good as or better than other services when benchmarked. She asked if the CCG would be meeting with clinicians to discuss future arrangements. Dr Fuller confirmed that this would be the case and the CCG also discussed service changes with clinical colleagues. GB190713/120

The second concerned resuscitation and stabilisation of patients and Dr Fuller stated that patient safety was the CCG's top concern and the CCG would not support a service specification that compromised patient care or patient safety. This had been discussed at Urgent Care Boards and would be included in future service specifications. GB190713/121

Roger Main asked about 111 and when timely information would be provided on performance. He was disappointed this was not part of the tender process and asked for the Governing Body to give an update. GB190713/122

Dr Steve Loveless said that the CCG were receiving weekly reports and that the service was improving against national metrics. There was an issue around complaints which was being looked at by the joint Governance Committee and was not yet resolved. GB190713/123

Roger Main asked about processes for monitoring out of hospital suppliers as the figures in excess of £21m were significant. Miles Freeman said there was a monthly process in place now for all providers. Providers were challenged and there was a reconciliation process. Quality assurance requirements were not clear with sub contractual arrangements and this was the focus of the work. GB190713/124

Roger Maine asked what the position was with Dorking Hospital beds and asked if this would be resolved by December. Dr Steve Loveless said that the CCG was working with Central Surrey Health to ensure the beds were re-opened by October and possibly with an increased number of beds. It was an essential part of the CCG's Out Of Hospital Strategy. Dr Fuller added that the CCG was involved in interviews for the new senior nurse post. GB190713/125

Roger Main asked about Continuing Health Care. Miles Freeman said that the CHC team were dealing with the backlog issues, including for people who had died, and the issue was to identify the point at which people were eligible for NHS funding. Surrey CCGs had inherited this problem from Surrey PCT and were in the same position as other CCGs up and down the country. Every effort was being made to avoid the process being difficult for people. Karen Parsons said that every effort was being made to recruit additional staff. Maggie Ioannou said this issue arose from a policy change in central government and was not the same as delays in assessment. Roger Main asked what the timescales for completion were. Miles Freeman said that a review of the service had been commissioned because the current backlog could take years to continue. Dr Fuller said there would be a report to the Governing Body at the point when the review reported. GB190713/126

Dr Fuller closed the meeting by giving thanks to Dr Aalia Khan who was leaving the CCG to got to Oman., She said that Dr Khan had been a great influence on bringing Dementia to the fore and had been very personally supportive to herself in developing the CCG. She wished her well for the future on behalf of the Governing Body. 127

Summary of actions

GB190713/003	Review register of interests with Governing Body Secretary	Dr Fuller
GB190713/004	Amend previous minutes regarding safeguarding	Justin Dix
GB190713/013	Dr Laws and Dr Fuller to discuss referrals to New Life	Dr Fuller / Dr Laws
GB190713/028	Spending review letter to be sent to Governing Body members	Miles Freeman
GB190713/035	New risk on safeguarding	Eileen Clark