NHS
Surrey Downs
Clinical Commissioning Group

Minutes of a Meeting of the Governing Body held on 27th September 2013 at Elmbridge Civic Centre

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 Jill Evans – Chair of East Elmbridge Locality
Dr Ibrahim Wali
Dr Hazim Taki
Dr Kate Laws
Dr Suzanne Moore
Dr Robin Gupta
Dr Andrew Sharp

Officer Members
Miles Freeman, Chief Officer
Keith Edmunds, Interim Chief Finance Officer
Eileen Clark, Head of Clinical Quality

Lay members
Denise Crone, lay member for patient and public engagement
Cliff Bush, 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
Alison Pointu, Lead Nurse

Local Authority
Nick Wilson, Surrey County Council

In attendance:
Kate Taylor, Service Redesign Manager; Mable Wu, head of Planning and Performance; Justin Dix, Governing Body Secretary (minutes)

Agenda item 4
Attachment 2

1) Welcome and introductions

Dr Fuller welcomed everyone to the meeting and members introduced themselves to those present. GB270913/001

The Governing Body noted that Dr Ibrahim Wali (Medlinc Locality) has been elected to the Governing Body to replace Dr Aalia Kahn; and that Alison Pointu has been appointed as an external clinical member (Lead Nurse) to replace Maggie Ioannou. GB270913/002

Dr Fuller welcomed Alison Pointu and Dr Wali to their first meeting. She thanked Maggie Ioannou for all her help during the CCG's authorisation period and as interim lead nurse for the first few months of the CCG. GB270913/003

2) Apologies for absence

Apologies had been received from Karen Parsons and Dr Mark Hamilton. GB270913/004

3) Register of members interests

Amendments to the register were noted as follows: GB270913/005

- Removed – Dr Aalia Khan and Maggie Ioannou (no longer on Governing Body)
- Added – Dr Ibrahim Wali and Alison Pointu (new members)
- Amended entries – Dr Jill Evans (interest as a QOFF Assessor removed); Gavin Cookman (additional interests with 360 degree consultancy and Elixir financial services, neither of which undertake any NHS work)

4) Minutes of the Governing Body held on the 19th July 2013

These were agreed as an accurate record. GB270913/006

5) Matters arising not on the agenda

It was NOTED that all actions from the previous meeting had been completed. Dr Fuller said that on investigation, the New Life referrals mentioned had been attributed to EDICS, and these would be honoured by the CCG. GB270913/007

The Assisted Conception Policy would need to be reconsidered by the Governing Body in November as it has not yet been reconsidered by the priorities committee. GB270913/008

Action Justin Dix

Denise Crone asked if South East Coast Ambulance Service could be added to the risk register as mentioned in page 6 of the minutes of the last meeting. This was AGREED. GB270913/009

Action Justin Dix

6) Chief Officers Report

Miles Freeman noted that the expiry of the EDICS contract had raised a number of issues that had dominated the summer's work; these were covered later in this meeting's agenda. GB270913/010

With respect to authorisation, the CCG was waiting to hear about the discharge of the remaining two conditions relating to planning and finance. If the application was not successful the CCG would not seek to discharge these conditions during the remainder of the year. GB270913/011

The move to Cedar Court had been completed with a £0.5m annual saving. This project had been delivered exceptionally well and the project team were thanked for their hard work. GB270913/012

Miles Freeman then invited questions on other aspects of his report. GB270913/013

Gavin Cookman asked when the CCG might hear about the outcome of the final authorisation conditions. Miles Freeman said he hoped this would be concluded fairly quickly, as potentially failure to discharge conditions might mean that these could be turned into directions. GB270913/014

7) Objectives and Delivery Plan

Miles Freeman introduced this. Two of the papers, around clinical appointments, were being reviewed and would not form part of today's meeting. GB270913/015

Miles freeman said that the objectives were described in a way that meant they were structured and could be managed as programmes. It was intended to cascade these down through the organisation and hold everyone to account; in particular it would enable the Governing Body to hold the Executive to account. Organisations needed this kind of structure in order to address all tasks, not just the easier ones; and to look at the range of issues not just the ones that are pressing and immediate. The aim therefore was to have a balanced approach with clear programmes behind the individual objectives. GB270913/016

Miles Freeman acknowledged that the programme was very ambitious. Already in the first six months some big issues had been addressed. The CCG would not achieve everything but it would enable it to review and reprioritise its work and develop a fit for purpose organisation, with the right staff in the right place. The CCG had worked with an interim structure whilst it worked through these objectives. The new programme might require staff to change. GB270913/017

The CCG did now have quite a large provider arm as it had expanded the Continuing Health Care team and taken on Medicines Management which had not been envisaged initially. This made the organisation more robust but bought its own challenges with it. GB270913/018

The aim of the paper was to ensure that the programmes resonated with governing body members. It would be picked up by the Programme Management Office (PMO), the head of which started next week, and substantially developed. GB270913/019

Nick Wilson asked about how this fitted with the integration agenda, and also whether this plan was scheduled for delivery over one, three or five years? GB270913/020

Miles Freeman said this was probably a two year programme but longer term plans would be developed, although in his experience (particularly in relation to five year financial plans) it was difficult to predict future financial and planning assumptions. There was no clear Surrey wide view on the integration work yet but programmes such as the Out of Hospital strategy and its related programmes did fit well with this and could be taken forward through this fund, as well as considering Surrey County Council's priorities. GB270913/021

Peter Collis expressed concern about the size of the agenda and asked if there was a sense of what was achievable once the PMO had got to grips with it and potentially proposed slimming it down. GB270913/022

Miles Freeman said a lot of the work was in the "must do" category. Although the CCG was managerially small it was clinically strong with 33 GP Practices and there was the prospect of bringing in short term support as well. Some of the programmes would overload a small number of key people and this would be a challenge to executive capacity. Overall however he felt it was deliverable. The programmes and projects were not isolated and needed to be seen together, such as amendments to care pathways and enhanced services within the Out Of Hospital strategy. He was encouraged that the organisation's culture had already embraced the required sense of pace and urgency, and said that clinicians were keen to see change after some years of frustration with lack of progress. GB270913/023

Gavin Cookman also expressed concern about the size of the task and asked that the PMO bring it back to the Governing Body with a sense of where the hard and soft targets were, where resources were committed, and more visibility of the detail. The overall direction did however look right. Miles Freeman agreed and said it would be subject to regular review by the Governing Body. GB270913/024

Denise Crone said she understood this was still in draft and would comment in detail outside the meeting but asked generally how she could contribute. Miles Freeman said he would be happy to meet Denise Crone outside the meeting to discuss this further. GB270913/025

Dr Fuller then moved on to the role of clinicians and the clinical leadership framework. She reminded everyone that the CCG was fundamentally a clinical membership organisation based on 33 practices, which was the fundamental level of clinical leadership, along with the four localities through which the practices were represented and who made nominations to the Governing Body. This meant there was clinical representation at every level of the organisation. GB270913/026

Dr Fuller noted that one of the biggest areas was acute care which was being led by Dr Hamilton, but that he was supported in this by the transformation boards – Dr Williams with Epsom, Dr Evans with Kingston, and Dr Loveless for East Surrey. Dr Fuller stressed the need for the listed clinical leads to bring back significant issues to the Governing Body. Below the clinical roles there were managers and other clinicians supporting the lead clinicians. GB270913/027

Dr Evans said that the layout of the document was somewhat confusing and asked that it be reviewed to make it clear where accountability sat, particularly locality as opposed to corporate representation. Dr Fuller agreed. She asked however that clinicians acknowledge the roles they were being asked to lead on and that this was about clinical leadership for the organisation as a whole. GB270913/028

The following clinical roles were therefore noted: GB270913/029

- Dr Steve Loveless – Community
- Dr Kate Laws – End of Life Care
- Peter Collis – Elective Care. Dr Fuller explained that because of the conflicts of interest of clinical members this was one area where a non-clinician was leading in a particular area
- Dr Jill Evans – Mental Health
- Dr Robin Gupta – Dementia
- Dr Phillip Gavin – Learning Disability

- Dr Claire Fuller – Continuing Health Care
- Quality Lead – Suzanne Moor
- Dr Hazim Taki and Dr Suzanne Moor - Children, Maternity and Children's Safeguarding
- Dr Ibrahim Wali – Medicines Management
- Dr Andrew Sharp – Caldicott Guardian and Information Governance
- Dr Jill Evans – Champion of clinical standards
- Dr Andy Sharp - COPD
- Gavin Cookman – Diabetes. Dr Fuller explained that although not a clinician Gavin Cookman does have expertise in this area.
- Dr Steve Loveless – Urgent Care, 111 and Stroke

Dr Fuller noted that there were a number of locality based clinical roles that had been supported by individuals out of historical necessity but without a proper selection process. In the interests of succession planning, the aim was to advertise and interview for these roles which were currently gaps in the relevant columns of the document. GB270913/030

Dr Evans noted that other areas may arise that need attention in future in addition to this list. GB270913/031

7) **Risk Strategy and Governing Body Assurance Framework**

Dr Fuller said that this document had been through several committees as part of its development. It was about high level assurance against the six focused objectives as follows: GB270913/032

1. To ensure that the CCG has medium term strategies in place for its main commissioning functions GB270913/033
2. To ensure that the CCG has sufficient capacity and capability to deliver its business
3. To deliver specific and defined quality improvements
4. To implement specific and defined service pathway/provision changes
5. To establish operational control of services, contracts & budgets
6. To establish effective governance

Dr Gupta asked about the previous scores but it was noted that this was the first formal version of this document. GB270913/034

Gavin Cookman noted there were a number of reds and ambers and asked if this meant the CCG had a lot to do as an organisation. Dr Fuller said that this reflected the reality of where the CCG were, and reflected the programme of work just discussed. Gavin Cookman said that the high number of ambers close to red was a source of concern in terms of overall capacity. He asked to what extent the programme dovetailed with the objectives just discussed. GB270913/035

Miles Freeman said that the Governing Body Assurance Framework and Risk Register were inherently cautious and reflected in many cases the fact that the CCG had no clarity about some of the issues the CCG were dealing with such as the five year plan. This was rated red because the CCG had no confidence about allocations. He added that the Governing Body Assurance Framework did dovetail with the document on objectives and work programmes and was in fact derived from it. One aspect of this was that it meant the CCG had a clear picture of what the impact of not doing something would be. GB270913/036

Nick Wilson expressed some confusion between the delivery plan, the assurance framework and the risk register. He asked if the CCG were acknowledging that high risk areas needed addressing urgently. GB270913/037

Miles Freeman said that the delivery plan was not intended to reflect risk as such. The Governing Body Assurance Framework gave a clearer picture of actual risk. GB270913/038

The Risk Strategy was then discussed. Gavin Cookman said he was happy with the risk strategy but said there were a number of emerging risks which he knew were being addressed but had not had the chance to reflect on. GB270913/039

Nick Wilson said that the draft Risk Management Strategy did not address risk mitigation and risk tolerance. GB270913/040

The risk strategy was AGREED subject to work on the above points. GB270913/041

Miles Freeman said he agreed with the above comments and that this was part of an emerging journey and it was timely for the Governing Body to be more aware of all that it had to do. The strategy and the risks and the CCG's response would mature over the course of the next few meetings. Some of these risks were inherent to being an NHS body and some were difficult to mitigate due to the nature of government policy. If risks do not come down over time the CCG would need to reconsider out position. GB270913/042

Peter Collis agreed with this and said that the value of this framework was that it made us more aware and that the issue was what the CCG were doing about it and what the CCG was prepared to tolerate. BSBV and the financial situation highlighted the level of risk but did not mean the CCG needed to panic. We needed to set out clearly what the CCG could do in response to them. GB270913/043

Nick Wilson said this was a key point; Surrey Downs CCG was a new organisation that had to deal with a lot of risks because of its situation and that the public needed to understand its legacy (which needed to be addressed through integration and out of hospital care) and its tolerance of risk. GB270913/044

8) **Risk register**

Miles Freeman noted the additional risks this month around Health Care Acquired Infection and Surge and Capacity planning around the main hospitals. The latter would be mitigated when clear plans were in place. There was also a risk around the expiry of the EDICS contract. The full descriptions of these risks were provided as annexes to the overall document. GB270913/045

The two main Continuing Health Care risks would not be mitigated until the current external review was completed which would hopefully be in Mid-October. An interim report had been received. GB270913/046

Denise Crone asked whether NHS 111 should be removed from the risk register given the service has improved. Dr Loveless said the service was performing to specification but there was still room for improvement and the national specifications were still under scrutiny. However in his view it could be removed safely. Miles Freeman agreed and said that the need for service improvement was not a reason of itself to put an issue on the risk register. He noted that Integrated Access to Psychological Therapies (IAPT) had been removed from the register due to recent improvements in performance. GB270913/047

Dr Laws, in relation to EDICS, asked how a new risk could be an improving risk. Kate Taylor said that the reason for this was that although this was the first time that this risk had come to the Governing Body, the risk had improved quite quickly since it was first drafted. GB270913/048

CB asked that the Patient Transport risk around SECAMB be added as per Denise Crone's earlier comments but as a separate risk. This was agreed. GB270913/049

Action Justin Dix

Denise Crone asked about SD0053 – quality of estate. She said there were continuing issues with New Epsom and Ewell and Poplars. There had been a contract meeting with Central Surrey Health that morning. She felt there was a significant possibility that the risks would become real based. Eileen Clark said that there were issues around infection control due to the state of the building. GB270913/050

Miles Freeman said the actions relating to this risk needed to be reviewed, as they were currently not correct, although he also noted there had been little response from NHS property services on this matter. GB270913/051

Jill Evans asked if it a lot of the risks were in fact outside of our control? Miles Freeman agreed and said the CCG needed to be clear how it defined these, as some services were not commissioned by us but impacted significantly on the CCG's patients. The point made earlier by Cliff Bush was an example as the service was commissioned by Surrey County Council. GB270913/052

Dr Loveless said that it was important to highlight these risks because the CCG was a part of a bigger system; he said that the CCG must work with the system as a whole to resolve these issues. Jill Evans said that in that case our narrative should reflect this and should pick up on Nick Wilson's point earlier about risk tolerance. GB270913/053

Gavin Cookman said this was not an easy task and the CCG needed to look carefully at it. The risk appetite framework should develop to reflect what the CCG can do to mitigate risks to patients. This would be helpful and would help us to manage the impact down to an acceptable level. GB270913/054

Jill Evans said that she felt that in practice this was our approach and that the CCG did not just accept risk but should try and influence change. Gavin Cookman said that was good but the NEECH and Poplars narrative did not reflect this and the risk appetite column needed to be used differently. GB270913/055

Miles Freeman summarised by saying that that the Governing Body was asking for greater clarity about what risk is tolerated and what is not and whether the actions being taken were adequate. Only when there were no more mitigating actions possible would the CCG be prepared to accept it. GB270913/056

Nick Wilson said the CCG needed to consider risk and public perception. He had looked at the SASH risk and said the CCG needed to understand how the Dorking locality lead could manage the SASH risk given that this was centred on a particular provider over which the CCG had limited control. GB270913/057

9) Cessation of Epsom Downs Integrated Care Services Contract

Keith Edmunds presented the report in the papers to the Governing Body. The contract had expired on the 31st July and the CCG had not been able to offer a new contract for commercial reasons. The expired contract was subject to a formal dispute resolution process which was taking place at the moment. GB270913/058

A small team had been established to manage the handover, working with EDICS to mitigate clinical risk and the handover of patient records. Patients had been transferred to new providers. Short term arrangements to ensure business continuity had been put in place. There would be a structured review of services to ensure that long term arrangements were more robust. GB270913/059

Dr Fuller then asked Kate Taylor to give the Governing Body assurance about what had been done to ensure that patient care had not been compromised and that patient records had been securely transferred. GB270913/060

Kate Taylor set out the detail of how this had been done: GB270913/061

- The CCG and each provider had set up a patient line to receive enquiries from patients
- Arrangements had been made for records to either be transferred or archived
- The CCG had managed an operational and administrative tracking process to ensure patients were all allocated to new providers
- She was personally in touch with new providers on a weekly basis to ensure that they had all the information they needed
- The ongoing communication channels between the CCG and the providers remained open
- the risk register entry would be updated to reflect further actions that had been taken as the situation had moved on against since this last version

Miles Freeman emphasised that EDICS had worked hard and very closely with the CCG despite the contractual dispute to avoid any harm to patients. GB270913/062

Dr Sharp asked if the CCG could firm up the timeline for dispute resolution and the scale of the risk. Keith Edmunds said that this was not in our control and was subject to both mediation and adjudication; the timescales were set by the adjudicator. It would GB270913/063

still probably be some months. The difference between best and worst case was probably in the region of £2.5m.

Dr Wali noted that the CCG needed to have a contingency plan for situations such as this happening in future as it had made for a lot of work for the CCG. The CCG had a lot of providers who might cease to trade for any number of reasons and the CCG needed to be prepared for this. GB270913/064

Kate Taylor said that the Out of Hospital strategy would be a key mitigating factor to prevent this happening again in future. GB270913/065

Alison Pointu asked what process the CCG would put in place to gather the learning from this. She also asked about the process and timelines for the clinical review and the development of the Referral Support Service (RSS). GB270913/066

Miles Freeman said there was an intention to put a Referral Support Service in place and recruitment was underway for the clinical leads for this. There was a need for the CCG's practices to buy in to this. As to learning for commissioners, this would need to take place after the disputes resolution process but he reminded the Governing Body that this whole issue went back to previous organisations, and it would not be easy to go back over several years, a national process for transition, and a number of former managers in relation to this contract. GB270913/067

Cliff Bush said that in addition to learning for the CCG, shareholders of other organisations also needed to learn from this and those organisation's shareholders should manage the issue differently from their perspective. GB270913/068

Gavin Cookman asked if the CCG were satisfied that the three cohorts of patients were all safe and Kate Taylor said she was satisfied that they were. GB270913/069

Dr Fuller thanked all the team involved in this for their hard work, but in particular Kate Taylor and Karen Parsons for prioritising patient care and ensuring services were still available. GB270913/070

10) **Service reviews of out of hospital provision**

Miles Freeman said that these reviews had been prompted partly by the recent events around EDICs but also by other areas of significant expenditure such as Local Enhanced Services where contracts had been rolled over. The CCG acknowledged the need to better understand its contracts. GB270913/071

The portfolio had grown up over a period of years and the CCG now needed to take a step back and review the value of existing contracts and in some cases re-specify and even re-procure them. This would ensure best value for the public. GB270913/072

With regard to local enhanced services, it was necessary to define the standards the CCG expected rather than letting providers define them. GB270913/073

The CCG would be setting a higher or more extensive set of standards in primary care to help it manage demand outside of hospital. This would not be a micro approach, which was onerous and put costs on commissioners and providers, but it would be about setting standards in critical areas such as access as part of a basket of requirements. Patients would have guarantees about what they could expect in these areas from General Practice. Currently patients lacked confidence in accessing appointments and the CCG needed to explicitly commission and change patient behaviour. Too many patients were still going to accident and emergency departments with basic primary care needs. GB270913/074

Miles Freeman said that the CCG did also need to look at how it commissioned across networks of providers in line with the thinking in Jeremy Hunt's recent speech. Contracting for populations might be better than contracting for services. GB270913/075

Dr Fuller said that there was a high standard of General Practice in Surrey Downs. Dr Williams agreed. He said he applauded the approach to these reviews, but felt that the terminology needed to be carefully applied to avoid a suggestion that there was a major problem with current standards. GB270913/076

Dr Evans said that she had visited most practices over the years as a Quality Outcomes Framework (QOF) assessor and felt standards were extremely high but the CCG needed to raise everyone to the standard of the best to ensure equity of access. GB270913/077

Dr Laws said that training for GPs with a Special Interest (GPSIs) needed to be looked at, and in some cases the CCG needed to support individuals to get the necessary qualification as this was now quite difficult. Dr Fuller said the Deanery had indicated they would be taking this on in future and linking it to established appraisal processes for GPs. GB270913/078

Dr Taki asked if these services might be tendered out in future. Miles Freeman said that some services required a registered GP list and these would be part of one offer which could only be delivered by GPs. He added that he understood the issue of standards and wanted to make it clear that he was impressed with the standards of primary care in Surrey Downs. However he wanted to make sure that it was understood that these services were additional to those in the GMS contract, making it explicit that this was on top of the GMS contract rather than instead of. GB270913/079

Cliff Bush said that his business experience was that the CCG needed to push contractors to deliver on the basis of lean management. We needed to treat all providers as providers and hold them to account. Miles Freeman agreed but said the CCG needed to start from where the CCG currently was. We had to express it carefully so that it people understood this was a development of General Practice, with investment, and not a confrontational approach. GB270913/080

Nick Wilson said that from listening to the debate it seemed to be about a different model of primary care around access that reduced the need for inappropriate A&E attendance. Standards need to be constantly monitored but his experience was that a fundamental change was needed. Dr Evans reiterated that this needed to have an impact across the full range of services, not just A&E. GB270913/081

Dr Fuller summarised by saying that there seemed to be widespread support for and agreement with the paper. The standard of general practice in Surrey Downs was good but we needed to ensure that access for patients was equitable. GB270913/082

11) **Quality report**

Eileen Clark noted this was a summary of the bigger report which had been reviewed by the Clinical Quality Committee. She drew particular attention to Health Care Acquired Infection and the CDiff trajectory of 73 cases. The report showed that the CCG had had a big increase in July and August which put the year end position at risk but more importantly impacted significantly on patient experience. Some of the cases were complex but there were particular issues with antibiotic prescribing where more can be done to limit the occurrence of the infection. A lot of work was being done with member practices to try and address this. GB270913/083

Serious Incidents would be shown with trends and learning in future. There would also be more of a focus on never events. There had been a medication related never event at SASH recently. GB270913/084

The friends and family test reporting had started in July but there were some concerns about the data. GB270913/085

Finally she noted that commissioner walkabouts were also being undertaken to give a feel for how services were being delivered and what the situation on the ground was. GB270913/086

Dr Fuller asked about the friends and family test in relation to community reporting and what the figures were. Eileen Clark said that that scores as high as 98% were being reported by Central Surrey Health with the net promoter score being around 85% GB270913/087

Dr Gupta asked about CDiff and whether the numbers had been validated to eliminate laboratory errors. Microbiology testing might ascribe some cases to acute services when they were not. Eileen Clark said this was important and still being progressed and she hoped to have a clearer picture for the next Governing Body, although this was not about a blame culture. GB270913/088

Dr Fuller asked about medicines management's role in CDiff and Eileen Clark said they had been very helpful. They were producing a lot of data about prescribing habits in relation to specific drugs that affect the CDiff rates. GB270913/089

Cliff Bush asked about Mental Health and whether the CCG had records of information about suicides and related serious incidents. He felt that suicides were increasing considerably. He was particularly interested in how these were handled and how they are reported. GB270913/090

Eileen Clark said that the host commissioner was North East Hants and Farnham CCG and that Surrey Downs were working closely with them. Post discharge suicides within six months were treated as Serious Incidents. The host commissioner had done an independent review and she would bring this to the Governing Body in due course. GB270913/091

Cliff Bush asked about the duty team's lack of access as he had needed to call ambulances for people when the team did not respond. Eileen Clark said incidents such as this were always investigated but they did need to be raised by a patient or GP. She felt that Surrey and Borders Trust did investigate these cases. GB270913/092

Dr Evans asked about CDiff and whether the CCG were an outlier compared to national figures. She also asked how the national target was set. GB270913/093

Eileen Clark said this was not just a Surrey Downs problem and many areas were far worse. The target was set by the GB270913/094

Department of Health based on previous year's outturn with a percentage reduction.

Denise Crone asked about the friends and family test and how the percentages worked. She was also unclear what the net promoter score was. Eileen Clark said it was judged on response rates and this was what was in the table. The net promoter rate was the answer to the single question of whether you would recommend the provider to a friend. The number of detractors was offset from the number of supporters to give a score. She would share the description of the methodology. GB270913/095

Miles Freeman said that this was a start-up year and it would become more sophisticated in years to come. At the moment the emphasis was on getting sufficient feedback for comparison in future years. Denise Crone asked if this meant it was not a helpful measure at the moment. Eileen Clark said the net promoter score was important but the numbers were very small at the moment and so not reliable. GB270913/096

Gavin Cookman asked if the CCG could have the full quality report at the Governing Body as he felt the Governing Body should see it. He felt it was a good and very important report and not everyone sat on the Clinical Quality Committee. GB270913/097

Gavin Cookman also asked about the PALS data. 25 people had written in about difficulties getting appointments and his understanding was that 13 of these were relating to EDICS. This was confirmed. GB270913/098

He then noted there was a section which seemed to repeat itself from the performance report. GB270913/099

Miles Freeman said that it would be possible to share the full quality report but he did not want to duplicate the same conversations in two places. GB270913/100

Nick Wilson raised a concern about Tier 4 mental health services for young people. He said that the CAMHS team had said that young people locally had been placed a long way from home such as Manchester and asked if this could be addressed as a systemic failure of commissioning. GB270913/101

Dr Evans agreed with this and said it was already being escalated locally and nationally. Surrey children were being placed a long way away and this was not acceptable. It was a priority for the CCG to resolve this and it was being escalated by the host CCG. GB270913/102

12) Performance Report

Miles Freeman referred to Gavin Cookman's earlier comments about duplication. He said that the CCG was subject to performance monitoring around both outcomes and process measures in the NHS constitution in much the same way as PCTs had been. There was therefore a detailed performance regime which meant some duplication with the quality report. GB270913/103

He noted the issues with infections, mixed sex accommodation and cancer patients treated within 62 days although this last target related to just two patients. These failures meant that the CCG were assessed as red on the balanced scorecard. The mixed sex accommodation issue was largely focused on Epsom and step down from the critical care unit. The overall trend however was downward. GB270913/104

Miles Freeman noted that there was an attempt to look at trends in the Local Health Economy (LHE) to ensure there was no overheating of the system, although the data was not reliable. Some of the non-elective admissions had been artificially inflated. GB270913/105

Denise Crone asked about life threatening calls within 8 minutes to SECAMB. She did not feel that the issue had progressed in the last two months and there was still no additional information. Miles Freeman said that contractual penalties were in place but these had not improved performance. He agreed to bring back a more detailed report back to the next Governing Body. GB270913/106

Action Miles Freeman

Gavin Cookman asked what the CCG could do about continuing poor performance. Miles Freeman said that every effort was being made but that one of the issues was that this was a monopoly provider. GB270913/107

Cliff Bush said that he had raised this with SECAMB and they had responded by saying that they calculated performance differently and felt they were compliant. Miles Freeman said the CCG had a clear problem with under-performance against contractual standards which it continued to pursue. GB270913/108

Denise Crone asked about the outcomes indicator set and why there were lines with no data such as quality of life for people with long term conditions. Miles Freeman said this was where there was no national data. Mable Wu, Head of Performance, said that the calculations needed to be made available by Public Health which did not always happen but they might also lack data due to information governance reasons. It was agreed that where there was no data this should be made clear. GB270913/109

Action Mable WU.

13) **Finance report**

Keith Edmunds said that the performance against budget was favourable but there are some emerging cost pressures in acute and prescribing. GB270913/110

There are a number of financial risks relating to transition that could impact on break even. These were not in the CCG's control, particularly specialist commissioning and NHS Property services. GB270913/111

Gavin Cookman noted the above comments. "Business as usual" appeared to be sound but transition risks remained high. He felt the Governing Body should escalate this to NHS England and that the Governing Body should understand the consequences of this situation. GB270913/112

Keith Edmunds said that there would be a process of negotiation ahead, and NHS England had said they did not want to push CCGs into deficit. CHC claims were more difficult due to validation issues but this was not just a local issue. GB270913/113

Peter Collis said that he and Gavin Cookman had worked through these issues with Keith Edmunds in a pre-meeting to the Governing Body. He hoped that the small surplus forecast could be achieved and would not impact on next year. GB270913/114

Dr Gupta noted the key risks and asked for clarification around the prescribing issues and cash. Keith Edmunds said that this had not been signalled and therefore not planned for. GB270913/115

14) **Quality Committee minutes**

Gavin Cookman said that the 1st August meeting had not been quorate due to other work pressures. The meeting on the 5th July had been quorate and reflected the issues in the quality report. GB270913/116

The minutes were NOTED by the Governing Body.

15) **Remuneration and Nominations Committee**

Gavin Cookman gave a verbal report of today's meeting. GB270913/117

- It had been agreed to extend the committee's remit to wider Human Resource (HR) performance and South Commissioning Support HR performance to give assurance to the Governing Body.

- The appraisal policy had been approved, and had the support of the Exec.
- The car parking policy had also been approved.
- The clause regarding TU representation in the disciplinary policy had been reworded
- VSM pay scales had also been reviewed.

Gavin Cookman said that he had also asked for assurance on compliance with policies. GB270913/118

16) **Policies for approval**

Miles Freeman introduced this item. He said that he would like all Governing Body members to see the policies over the next two weeks and asked that they be circulated. Any that were questioned would then be reviewed and bought back to a subsequent Governing Body meeting. Those that did not present any major issues could be taken as approved by the Governing Body. GB270913/119

The Freedom of Information Policy was reproduced in full in the Governing Body papers and was AGREED. GB270913/120

17) **Any other business**

Dr Wali said that he felt that of the medicines management committee should come to the Governing Body in future. GB270913/121

Alison Pointu said that she would like to understand how the CCG provided assurance about whether the CCG was meeting its equality duty and would pick this up with Justin Dix outside the meeting. GB270913/122

18) **Questions from the public**

A journalist from the Epsom Guardian asked about the potential £2.5m cost of EDICS. Was this the worst case scenario? She also asked how would the CCG satisfy the public that the lessons had been learnt from this given that this money could have been spent on other health services Finally she asked why the CCG had not been happy with the contract it inherited from the CCG? GB270913/123

Miles Freeman said that £2.5m was the amount in dispute. Regarding the dispute itself and the reasons behind the contract not being renewed, that remained commercial in confidence pending the outcome of the dispute process and it would not be appropriate to comment until the process was over. GB270913/124

With regards to legacy issues the contract had not been managed properly under the PCT and this meant that the CCG GB270913/125

had had to implement very tight contractual management to address some of the historical issues.

Dr Fuller then read out two questions from Roger Maine, patient representative for the Dorking locality: GB270913/126

"With the introduction from NHS ENGLAND of the Care.Data [project], can you confirm what action the Board is taking on such an important issue to ensure that GPS inform the patient as per the guidelines, and that the information is permanently displayed and that practice mangers are up to speed on the implementation. And does the board intend a press release as per the guidelines for GP practices? GB270913/127

Dr Fuller replied that Care.data is a national project about how patient data is used. She understood that information has been sent to practices for them to display so patients are aware of this project. Whilst the CCG is not directly involved in this project, clearly it is important local people are aware of it. The CCG would like to reassure you that we will be reminding practices of the need to raise awareness through our usual internal communications channels (practice newsletter, locality meetings and so forth). We will also be working with NHS England to ensure a media release is issued to the local media to raise awareness. Dr Williams said that he was aware of a national media campaign on this issue. GB270913/128

"The CCCG has been up and running now for a few months. What is the Board's Policy on engaging with the patient [at a] one-to –one level (i.e. when was the last time a board member went out and visited a GP surgery/providers to talk and engage with them (excluding practicing GPs on the board) so as they get a real feel on what is happing on the ground? And [also] to get feedback on current policy making? I do not mean open board meetings. If there is no policy then the Board should review one as it is very easy to lose sight of what is going on in an HQ environment." GB270913/129

Dr Fuller replied that the CCG understood that members need to be close to the ground and have a good understanding of local issues. She assured Mr Maine that we do actively get out and about to meet local people and patients. We have 10 GPs on our governing body, as well as other clinical members, so for many of us we are practicing clinicians who engage with patients and GPs on a daily basis. The CCG does have a communications and engagement strategy and our locality model very much ensures engagement at a local level, with GP practices, stakeholders and local communities. We have already started a series of provider 'walk arounds' where members of the CCG's Quality Committee (which include a number of our Board members) visit hospitals. GB270913/130

These are opportunities to meet with staff, talk to patients (which we always do as part of any visit) and see how things are for ourselves. We also rotate where we hold our Executive committees, getting out and about into the community to visit NHS locations and meet with patients where we can. We also have a Patient Advisory Group which some members of the Governing Body attend so they can hear from local patients and patient representatives directly about issues that matter to them. So as a CCG we are already doing a lot to make sure that as a Governing Body we are visible locally and we have opportunities to talk directly with patients and local people to find out about their experiences of local healthcare

Peter Collis added that he was now receiving a lot of feedback from people he knows about their experience of healthcare simply because he is known to be on the CCG Governing Body. GB270913/131

Chris Baxter asked how the information will get to people who don't have access to a computer or use the internet. Dr Fuller said that the CCG needed to work with our community providers but the CCG needed to take this away and think about it. Dr Williams said he understood there was also going to be a national media campaign. GB270913/132

19) **Dates of future meetings:**

The dates of future meetings were noted. The seminar 11th October needs to be reviewed due to the timescales around BSBV. Gavin Cookman asked that the dates be recirculated on email. GB270913/133

Action Justin Dix

Summary of actions:

008	Assisted Conception Policy to next meeting (Justin Dix)
009	SECAMB risks to be added to risk register (Justin Dix)
048	Patient Transport risk to be added to the risk register (Justin Dix)
106	SECAMB contractual Performance arrangements to come to next Governing Body (Miles Freeman)
109	"No data" issues to be made clear in performance report (Mable Wu)
133	Dates of Governing Body Meetings to be recirculated (Justin Dix)