NHS
Surrey Downs
Clinical Commissioning Group

Title of paper:	**Chief Officer's Report**
Meeting:	Governing Body, 29th November 2013
Author:	Miles Freeman, Chief Officer
email:	miles.freeman@surreydownsccg.nhs.uk
Exec Lead:	Miles Freeman, Chief Officer

Purpose	To Agree	
	To Advise	✓
	To Note	

Development: The Chief Officer's report reflects in particular the work of the Executive Committee and other issues that are of note and not reported elsewhere.

Executive Summary and Key Issues

1: The Executive Committee

There was only one meeting of the Executive Committee during October as we have moved to a new meeting structure to balance managing: the review of our Out Of Hospital services; the local health economy transformation work focused on Epsom, Kingston and Surrey and Sussex Hospital; and the regular business of delivering high quality, sustainable health services.

The new arrangement is to have a four week pattern as follows:

Week 1 – Business Meeting
Week 2 – Out of Hospital Review Programme
Week 3 – Business meeting
Week 4 – Whole Systems Transformation

2: Estates (Assurance Framework 1.5)

One issue that has been discussed is the position of NHS estate locally, where we continue to work with our suppliers and with NHS Property Services to try and get the best value out of our existing buildings. Members will be aware that the main driver for utilising Cedar Court as the CCG's Headquarters was that this substantially reduced our overheads in this area.

There are however many other opportunities both in utilisation of space and in related areas such as facilities maintenance contracts. Over time we will be developing an estates strategy that sets out how we will plan to address these issues.

3: GP IT

One area that the CCG is working hard on is that of the information technology available to the 33 member practices in Surrey Downs. This is the responsibility of the NHS England Surrey and Sussex Area Team so we have limited control over it but we have submitted bids to replace all equipment over five years old and any unsupported operating systems.

GP's use of IT is not only fundamental to their success as practices but will increasingly be key to the success of our local strategies for improving care.

4: Amendments to the constitution (Assurance Framework 6.1)

Governing Body members will be aware that we have again applied to NHS England to have amendments to the constitution agreed. This time however we have asked for two options to be agreed. The first, which is not preferred, involves a number of changes of a tidying up nature. The second and preferred option is to remove a large number of appendices from the constitution, relating to localities and the committees of the Governing Body, so that these can in future be amended without having to go back to the centre for approval. We feel that this is appropriate for a fully authorised CCG that needs to be able to shape some areas of its governance in response to its own rapid development.

In both versions, we have (in consultation with member practices) produced a Disputes Resolution Procedure that will enable disputes within the group to be discussed, managed and hopefully resolved in a positive way.

We hope to hear about the outcome of these applications before the end of the year.

5: Senior roles – CFO, Head of Finance and Director of Contracting (Assurance Framework 2.1)

As you know we have taken an uncompromising approach to recruitment throughout the organisational structure, in the belief that the CCG must recruit the best talent to deliver effective change and service improvement in Surrey Downs. This has meant delays in some areas, and in particular the permanent recruitment of the Chief Finance Officer and head of Finance. I believe that now the CCG is developing a track record of delivery, the roles have become more attractive.

I am also planning to reconfigure the existing structure to create a new executive appointment, namely a Director of Contracting, as I feel this is an essential appointment if we are to approach the future positively.

We must remember that everything we do – improving quality of care, reconfiguring services, going out to procurement, and making best use of our resources – is ultimately reflected in some form of contracting. This is our core business and I believe will be an essential leadership role going forward.

6: Procurement

The Executive Committee had a very useful presentation on procurement law and responsibilities, which will be a significant area of work going forward as the CCG seeks to change the way services are delivered. This covered a number of areas including:

- Law and Policy
- Patient choice and competition
- Procurement processes
- The role of Monitor
- Tailored procurements as opposed to a “one size fits all” approach

7: Social media strategy

The Executive Committee has agreed with the Communications team that the CCG should seek to maximise opportunities for communication and engagement using modern technology whilst seeking to take a balanced approach that encouraged constructive dialogue rather than information overload. The CCG will therefore be establishing a managed presence on Facebook and Twitter in order to work more closely with patients, the public and other stakeholders to support what we are trying to deliver with them in terms of transformed health services.

It has also been agreed to build an extranet to enable the 33 member practices and the staff to access files from any location and also to substantially improve the CCG’s web site to make it of more value to all stakeholders.

We are currently reviewing our communication and engagement functions. I believe that the function was scoped before there was a full understanding of the likely requirements and we may need to increase capacity in this area.

8: Meeting the demands of winter

We have been working closely with our suppliers, other CCGs and the Area Team to ensure that we can sustain health services through the coming winter. We have submitted our surge and escalation plans to the Area Team and are also working hard to improve our ability to respond with other agencies in the case of a major incident. Our readiness has been tested twice in recent weeks, firstly with the storm conditions on the 27th and 28th October and then the following week when there was a gas leak in the Dorking Area that could have required the evacuation of vulnerable patients in specific streets, although this was not in the end required.

I am pleased to report that in both cases our on-call systems worked perfectly and that on call managers were able to liaise effectively with other agencies and with each other, taking part in teleconferences and contacting suppliers as required.

9: Integrated Transformation Fund (Assurance Framework 4.1, 4.2, 4.3, 4.4 and 4.5)

Governing body members will recall the requirement for CCGs to work with local authority partners to create a transformation fund, which in the case of Surrey Downs will amount to some £11m by 2015-16. We anticipate that this fund will support the workstreams already identified through transformation boards.

10: Referral Support Service (RSS) (Assurance Framework 4.2)

The RSS went live in Nov with the recruitment of 12 GP Triagers and two admin staff based in a self-contained office in Cedar Court. At the time of writing they had received in excess of 300 referrals and repatriated a number back to primary care for more appropriate care options to be developed.

11. Continuing Health Care review

The review has concluded and recommendations are being made to the Surrey Collaborative. I hope to be able to outline any agreements at the Governing Body meeting.

12: Government response to the Francis Report

The government published its final response to the Francis on the 20th November, accepting all but nine of the original 290 recommendations. The majority of these do not require new legislation and many health care providers have been implementing many of them since the report's first publication in February of this year. The Government response is entitled "Hard Truths – The Journey to Putting Patients First". Key points are:

- A new criminal offence of wilful neglect is created. The government intends to legislate at the earliest available opportunity to introduce this offence so that those responsible for the worst failures in care are held to account. Under this law any staff, including managers, who are found guilty could face imprisonment. This does not criminalise unintended error but instead is focused on instances of wilful neglect or deliberate harm.

- NHS Trusts will have to publish nurse staffing levels. Some clinical areas will have defined staff to patient ratios. The government has asked the National Institute for Health and Care Excellence to advise on how safe staffing should be measured.

- The introduction of a statutory duty of candour on organisations. The government will consult on proposals whereby a Trust should reimburse a proportion or all of the NHS Litigation Authority compensation costs where the Trust has not been open with a patient. The professional duty of candour on individuals, will be strengthened through changes to professional codes. As expected a statutory duty of candour on individuals is rejected in favour of a statutory duty on organisations at a corporate level for generating misleading information or withholding required information. Don Berwick had argued that a statutory duty with criminal sanctions enforceable against individuals would undermine the development of a learning culture. Nurses and doctors will have a professional duty to report "near misses" - when patients have been put at risk. At present they only have a duty to report failures and mistakes.

- Introduction of a “fit and proper person's test" under which managers who have failed in the past will be barred from taking up posts. The Care Quality Commission will have new powers to investigate whether an individual is fit to hold a director level position. NHS England will be exploring the development of a parallel set of arrangements for clinical commissioning groups.

- The emphasis in this response for CCGs is about how they empower patients to participate in their own care and in some cases hold personal care budgets. There is also an emphasis on integrated care. The response states that “the main aim of commissioning is to improve outcomes for patients. In doing this, commissioners (NHS England and clinical commissioning groups alike) must consider how the quality and efficiency of services might be improved by a range of means, including through services being provided in a more integrated way, and through the adoption of evidence-based innovative approaches….NHS England will continue to hold clinical commissioning groups to account for quality and outcomes as well as for financial performance, through the clinical commission group assurance framework. NHS England also has powers to intervene where there is evidence that clinical commissioning groups are failing or are likely to fail.”

- Complaints: All hospitals will have to be clearer as to how patients and their families can raise concerns or complaints, with independent support available from NHS complaints advocacy services, Healthwatch or other bodies.

Recommendation(s): This report is advisory and I am happy to take questions from Governing Body members on any aspect of it.
Attachments: None

Implications for wider governance

Quality and patient safety: Items 8 (winter), 9 (Transformation fund) and 10 (referral support service) all highlight potential ability to improve patient experience.
Patient and Public Engagement: Item 7 (Social Media Strategy) is directly aimed at improving patient and public engagement
Equality Duty: Item 7 (Social Media Strategy) will enable the CCG to meet its equality duty by publicising its arrangements and seeking the views of the public.
Finance and resources: Item 9 (transformation fund) and 10 (referral support) will lead to better use of resources.
Communications Plan: This paper is available on the CCG website.
Legal or compliance issues: Item 4 (amendments to the constitution) concerns the CCG's legal compliance.
Risk and Assurance: 5 of the 10 items in my report relate directly to principal risks in the Governing Body Assurance Framework, these are referenced in the report.