Agenda Item 4
Attachment 2

NHS
Surrey Downs
Clinical Commissioning Group

Meeting: Governing Body
Date and time: 29th November 2013, 2.30pm, Leatherhead Leisure Centre

Voting members present

Dr Claire Fuller, Clinical Chair

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

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

External clinical members
Alison Pointu

Lay Members
Denise Crone
Cliff Bush
Gavin Cookman
Peter Collis

Other non-voting members
Nick Wilson, Surrey County Council

1) Welcome and introductions

Dr Fuller welcomed everyone to the meeting particularly members of the public. Governing Body members introduced themselves. GB291113/001

2) Apologies for absence

Dr Mark Hamilton, Secondary Care Doctor
Eileen Clark, lead nurse for quality

GB291113/002

3) Register of interests

Amendments to the entries for Miles Freeman, Dr Hazim Taki and Gavin Cookman were noted.

GB291113/003

4) Minutes of the previous meeting on 27th September 2013

These were AGREED as an accurate record.

GB291113/004

5) Matters arising

The Governing Body received updates on actions and issues from the meeting on the 27th September.

GB291113/005

- Recommendations from the priorities committee on assisted conception and varicose veins would come to the next Governing Body in January.

GB291113/006

- Risks had been added to the risk register in respect of SECAMB emergency ambulance performance and patient transport services.

GB291113/007

- SECAMB Contractual Performance was being addressed through a disaggregation of the existing South East Coast contract into separate contracts for Kent, Surrey and Sussex.

GB291113/008

- It was now being made clear in the performance report as to when there was no data to support a Key Performance Indicator.

GB291113/009

- Governing Body dates had been recirculated and new dates were being set for 2014/15.

6) Chief Officer's Report

Miles Freeman highlighted a number of issues in his report as follows.

GB291113/010

<u>GP IT</u>

GB291113/011

The CCG had received all the funding that it had requested to replace outdated equipment in GP surgeries although the work would be staged over this and the early part of the next financial year.

Recruitment GB291113/012

The CCG was recruiting for a permanent Chie Finance Officer, Head of Finance and Director of Contracting. These adverts were out now. The Director of Contracting role was necessary to provide leadership within the CCG to complement the support from the Commissioning Support Unit (CSU).

Winter GB291113/013

The CCG was now reporting weekly on winter performance as this was a key issue for the centre. With the exception of Surrey and Sussex, local hospitals had traditionally managed well at this time of year. However Surrey and Sussex was now the most improved trust in the country and was currently one of the strongest in the country on A&E performance. There may be additional funding for A&E and patient transport to facilitate early discharge.

Continuing Health Care GB291113/014

The Continuing Healthcare Review has been completed. The CCG hosts this service for Surrey CCGs and under the PCT there had been a Serious Incident which had led to a number of issues emerging. The review had confirmed that there were areas that needed to be addressed if the service was to meet its statutory duties, principally a more responsive localised service with less bureaucracy and more support to discharging people from hospital. This would have implications for the team's processes and workforce.

Karen Parsons confirmed this and said that there were five areas that would need to be addressed: consultation and communication with patients and carers; organisation; governance and compliance; contracting and procurement; and partnerships with otter agencies. Change would be delivered through a programme board and the team was in the process of being briefed about the changes. GB291113/015

It was also noted that the current system did not properly include patients and their families in decision making, which tended to escalate disputes. GB291113/016

Francis Report GB291113/017

The Government had responded to the Francis Report and had accepted nearly all the recommendations. These included a new criminal offence of wilful neglect, the publication of staffing levels, a statutory duty of candour, and a fit and proper persons test for managers.

Alison Pointu said that the main means of embedding this will be through quality standards and improving quality by working with providers. Nursing staffing levels would be critical and there will be ways of calculating this for different clinical areas and reporting this. GB291113/018

Dr Fuller invited questions and comments on the Chief Officer's report. GB291113/019

Dr Williams said that it was noticeable how different CCGs were compared to PCTs, specifically in that clinicians were being contacted for their views on senior appointments and the shape of the workforce. GB291113/020

Cliff Bush noted that a key issue in relation to Francis was the need to rebuild confidence and avoid a blame culture developing. GB291113/021

He also felt that the report did not address the need for high standards on a 24/7 basis. Miles Freeman said this was expected to be addressed through this year's operating framework and reporting on mortality rates. GB291113/022

Miles Freeman said that he did agree with the comments about rebuilding confidence and placed the emphasis on organisational responsibility. GB291113/023

Denise Crone asked when the CHC report would be more widely available, and whether the feedback would be shared the patients and families that had contributed. Miles Freeman said the report was very detailed with 94 recommendations. Some of the information was patient identifiable. A summary document however could be shared with all contributors and stakeholders. GB291113/024

Denise Crone asked about the Integrated Transformation Fund and the carers monies and whether the latter would be ring fenced. Miles Freeman said that all CCGs had discussed the finding and agreed carers funding was a high priority. GB291113/025

7) Governing Body Assurance Framework and Risk Register

Justin Dix spoke to this item. The paper showed updates since the September Governing Body, in particular making the distinction between the Assurance Framework and Risk Register clearer. There were specific registers for projects such as Continuing Health Care. GB291113/026

The risks identified at the last Governing Body had been included in the latest version of the risk register. GB291113/027

A meeting had also been held with the lay members for Governance to discuss how to further develop risk tolerance and risk appetite. GB291113/028

With regard to specific risks, the principal concern was maintaining financial balance. GB291113/029

Miles Freeman noted that the apparent deterioration in adult and children's safeguarding was somewhat misleading as these areas were showing improvement; however the transitional risk had not been correctly assessed at the outset and adjustments had had to be made for this. GB291113/030

Peter Collis said that the risk register and assurance framework were still developing and it was important not to lose sight of the main issues. It would be necessary to undertake a self-assessment using an established diagnostic tool and this would be shared more widely with the Governing Body.. GB291113/031

Cliff Bush said that he was very concerned about winter risks and particularly access to equipment to support discharge from hospital. Miles Freeman said that existing budgets in this area were overspending but this would be funded from slippage in other budgets and there were no plans to cut back in this area. GB291113/032

It was noted that as part of surge and capacity planning there were weekly operational teleconference calls. However it was acknowledged that the equipment issue might not be included in this and Karen Parsons would check this. GB291113/033

Action Karen Parsons

8) Better Service Better Value

Miles Freeman formally noted that the Governing Body had done extensive work to review the evidence base and as a result of this had recommended to local GPs not to continue with the BSBV programme. GP clinical support had been established by NHS England as a prerequisite for continuing. GPs supported this view by a majority of three to one when balloted. GB291113/034

The programme had been very useful in establishing a picture of clinical standards and variation in care. However the strategic risk of uncertainty this would create for services at Epsom, and the impact on the frail elderly population if not admitted to local services, were felt to be the significant factors in not continuing with the programme. GB291113/035

Withdrawal from BSBV did not mean "no change" to NHS Services locally, and CCGs in SW London would continue in the programme and develop proposals based on the forthcoming operating framework and its associated financial allocations. This would impact on Epsom St Helier and the CCG would need to respond to this. GB291113/036

The CCG was now working closely with Epsom St Helier to see how quickly it could meet the standards established under the BSBV programme. For maternity services this was not viable but for most other services this could be achieved within three years. A formal implementation plan would lead to contractual changes being put in place. GB291113/037

Dr Evans said that the paper was misleading in saying that the vast majority of GPs did not agree with the BSBV plans as one in four did and this was a sizeable number and said that this should be amended. It was agreed that this needed correcting. She then asked about the future of Maternity Services and how the continuing BSBV programme would impact on Epsom hospital in future. GB291113/038

Dr Fuller said that the CCG had asked for the Kent Surrey and Sussex clinical reference group to review Maternity at Epsom and the view had been that it was clinically safe service but they were concerned for its long term sustainability. GB291113/039

Miles Freeman said that the picture was very complex and it was not clear yet what proposals would come back. If a future consultation did require change to Epsom Helier Trust the CCG would have to re-engage and understand the impact on Epsom's viability. GB291113/040

Peter Collis asked for re-assurance that all hospitals that Surrey Downs patients were referred to would be asked to achieve higher standards. Miles Freeman said this was the case but we had to bear in mind that we were not the host commissioner in many cases but there was a generally increasing expectation that all trusts would meet higher standards around the clock, every day of the year, and this would impact on how services were delivered. Over the next three to four years there would be national developments in specialist and core standards relating to the seven day agenda and this could lead to service rationalisation. GB291113/041

Dr Fuller said that one of the real benefits of the BSBV programme was that it had led to improved understanding of clinical standards and a pan Surrey discussion at the Surrey Transformation Board. Karen Parsons noted that this was replicated at each local transformation board. GB291113/042

Gavin Cookman asked how we would have assurance that the program was genuinely improving standards and Claire Fuller said this would be monitored through the Transformation Board and through the clinical engagement of the CCG at all levels. GPs would also have direct contact with patients and would be able to monitor the quality of care directly. GB291113/043

Miles Freeman said that there would be an agreed development plan and this would be written into successive years contracts with the Trust. He felt that Epsom St Helier had been very focused on standards as a result of the BSBV work and was committed to achieving these. GB291113/044

Dr Loveless said that there was unanimous agreement amongst GPs that standards needed to be improved although there was a debate about individual clinical areas. He felt that this process had also meant that the Trust was more engaged with the CCG's Out Of Hospital Programme. GB291113/045

Cliff Bush expressed concern about people with complex kidney problems and their access to services which could deteriorate. There was a lack of a dedicated centre in Surrey and a long lead time for service developments. He asked for assurance that this would be addressed. GB291113/046

Dr Fuller said that poor renal provision had been a feature of Surrey historically and the Surrey wide Transformation Board did have this on its list of things that needed to be addressed although stroke care was currently the first priority. GB291113/047

Dr Gupta asked about the reaction from other stakeholders as he had personal experience of other CCGs perceiving our approach as negative. Miles Freeman said this was inevitable due to the long delays in agreeing reconfiguration in South West London but that London CCGs would find a way forward. Dr Fuller said that she had had feedback that our clinically led decision was made. Jill Evans said she was aware of the disappointment amongst clinicians in other CCGs but she felt that there had been a lot of learning for Surrey Downs regarding clinical standards, and it had been some of the practical issues raised by the public that had led to the decision that was finally made. GB291113/048

Miles Freeman said that the decision was consistent with some of the emerging messages from the Keogh report particularly different types of A&E and access to services for the frail elderly. GB291113/049

Dr Taki asked about St Helier and joint rotas with Epsom and what would happen if St Helier was reconfigured. Dr Fuller said that this was a possibility and we would need to find a new partner for Epsom if this was the case. GB291113/050

Denise Crone said that whilst there had been a focus on standards and changes to contracts she was concerned not to lose the patient focus. Miles Freeman said that the patient experience would be monitored regularly through the Clinical Quality Committee and that the Epsom plan would come to the Governing Body. GB291113/051

The Governing Body AGREED to withdraw from the Better Services Better Value Programme as recommended in the paper and based on the outcome of the vote of local GPs. GB291113/052

9. Out of Hospital Strategy

Dr Loveless introduced this item. The Governing Body had already reviewed the Strategy and was now being asked to approve the document after extensive consultation including with the Council of Members. This had generated a number of new ideas and developed some existing ones. There were three main areas of work. GB291113/053

- Elective care which was being reviewed for best fit. GB291113/054
- Urgent and unscheduled care work was focusing on the interface with acute services and social care, in line with the Keogh report. GB291113/055
- Community based care including long term conditions and end of life care. GB291113/056

The strategy hinged on a number of key principles, namely better care closer to home, right service right place right time, integration to reduce duplication, sustainability in the medium term (financial and workforce), and high quality outcomes. GB291113/057

The document paid particular attention to disadvantaged groups such as the frail elderly, travellers and children. GB291113/058

Dr Loveless said that the strategy would be challenging and is bold in vision. The need now was to both approve and start work on implementation, investing where necessary. GB291113/059

Denise Crone expressed concern that the strategy was health focused without sufficient integration of social care. She also wondered if it was ambitious enough and took on good practice from elsewhere, where there was more voluntary sector engagement and wider access, and more integration with social care and respite care. GB291113/060

Dr Fuller said that there was a sub group of the Epsom Transformation Board looking at this particularly in relation to discharge planning where social care was critical. GB291113/061

Miles Freeman said that this was a health focused strategy and that the Integrated Transformation Fund programme would be where the joined up approach would be described. The two documents should be read alongside each other. This would be available in January 2014. GB291113/062

Dr Loveless said that the CCG did sit on the Health and Wellbeing Board and was trying to progress these issues but he accepted the need for integration. GB291113/063

Peter Collis said this was an exciting strategy and the devil was in the detail. The CCG needed to show some early progress that could be demonstrated. The investment issue was key if the benefits were to be realised. This might mean some short term financial issues. GB291113/064

Miles Freeman said that the areas that were lacking were the ability to describe the relationship between inputs (money) and outputs (activity) and how we could work with partners to create an affordable system that was less dependent on beds and more supportive in terms of rehabilitation and home based services. The risk in the system at the moment was passed around rather than appropriately shared and this needed to be addressed with partners by introducing different contracting models that bought real benefits for patients. There would be an increase in activity for social care which needed to be addressed if the whole system were to work. GB291113/065

Keith Edmunds said that there was a need to drive better value out of existing contracts and a lot of work had been done on this this year. GB291113/066

Dr Gupta said that there were a number of disadvantaged groups such as those with dementia and the frail elderly that could potentially benefit from this strategy. He expected national work on dementia to promote integrated working in the area of dementia. GB291113/067

Cliff Bush fully supported the strategy and said that existing services, such as advocacy, could provide real benefits. These advocates provided real continuity of care to patients. Miles Freeman welcomed this and said that the CCG already funded advocacy services through partnership funding. GB291113/068

Gavin Cookman also welcomed the strategy. He felt the Governing Body should see the implementation plan and progress reports. He asked if there were any unexpected risks that might emerge. GB291113/069

Dr Loveless said that there was a historical trend of declining investment in primary care and flat growth in community services as most of the investment had gone into acute care; we needed the support of acute trusts to resolve this but we also needed a significant change in workforce provision in relation to seven day a week working. GB291113/070

Miles Freeman emphasised that this could not be delivered by the CCG alone but needed social care, providers and patients themselves to get behind this work. The total resource in the system needed to be used more effectively to deliver a more efficient system. Unit costs of care needed to be driven down. He agreed with Dr Loveless about the historical trends of investment which were biased towards the acute providers. GB291113/071

Dr Suzanne Moor said that discharge planning was a current example of where patients were not empowered and we needed to do something about better information to patients. Denise Crone said that procedures were good but discharge planning in practice was not good enough. Dr Gupta said this area was being looked at as part of CQUINs. GB291113/072

The Governing Body AGREED the Out of Hospital Strategy. GB291113/073

10. Annual Planning Framework

Miles Freeman spoke to this item. The major change this year was for CCG's to have to describe improvements in outcomes for patients in seven key areas: GB291113/074

- Reducing the number of years of life lost from treatable conditions
- Improving the health related quality of life of the people with long-term conditions and more integrated care in the community
- Reducing the amount of time people spend avoidably in hospital
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Improving the experience of inpatient care
- Improving people's experience of primary care
- Making significant progress on avoidable deaths in hospitals as part of seven day working

One of the major changes for the CCG would be the Integrated Transformation Fund which would reach £11million and be subject to agreement by Health and Wellbeing Boards. This was not new money but money from the CCG baseline which meant that the NHS had to engage fully around the development of the fund and the benefits for patients arising from it. The timescales for developing this were very tight and had to meet the criteria agreed with partners in a transformational way. The paper provided for the Governing Body gave clear timescales and deadlines GB291113/075

Nick Wilson said that there was a significant opportunity here for the CCG and the local authority to integrate health and social care, and local people expected this to happen. At the moment it was difficult to see how a plan could be developed in the timescales available. His concern was not cost shunting but the impact on people using services. There would be further pressure on public sector funding and this process was key to transformation. GB291113/076

Miles Freeman agreed that the timescales were difficult and said that we needed to make time to do the job properly and this was the CCG's intention. GB291113/077

11. Equality Duty Action Plan

Justin Dix introduced this item. The CCG had a legal duty to meet the requirements of the 2010 Equality Act and this action plan was intended to show how it could develop a strategy that would enable it to both challenge discrimination and promote equality as an employer and as a commissioner of services. GB291113/078

Justin Dix said that the CCG did take equality duty seriously as today's discussion and the CCG's constitution showed. This did need to be systematically evidenced and based on public health information. Dr Hazim Taki had agreed to be the clinical lead and it was important to work with the local community as the CCG had to show that it had engaged with stakeholders. GB291113/079

He emphasised that this was not about compliance but about fully embracing the duties under the act and putting the structures in place that would support this. The new NHS equality Delivery System was a much more practical tool since it had been revised and would support implementation. GB291113/080

Denise Crone asked about training for staff and said this should be specific and targeted rather than general. The CCG needed to move beyond tick box reporting and get everyone to think about equality as part of their everyday role, whether it was service redesign or a particular project, and think about the impact. This needed to be clear in cover sheets for papers that came to meetings. GB291113/081

Justin Dix agreed and said there was an example today with the out of hospital strategy but people did need support to do this properly. GB291113/082

Alison Pointu welcomed this work particularly the use of systematic tools such as EDS2 and said it should not be overlooked. She asked that the strategy be based on looking back and taking stock of the work that was being done. Justin Dix agreed and said that the Audit Committee was tasked with monitoring compliance in this area. GB291113/083

Peter Collis said that in both the Remuneration Committee and the Audit Committee there had been discussions about how to not only be compliant but to embed the thinking in the work of the organisation. GB291113/084

The Governing Body AGREED: GB291113/085

- The Equality Duty Action Plan
- That Dr Hazim Taki should be the clinical lead for equality
- That EDS2 should be used to assess the CCG's ongoing work in this area.

12. Locality Reports

Dr Williams updated the Governing Body. GB291113/086

Dorking Hospital had re-opened on the 14th October following investment in an additional six beds from 12 to 18. GB291113/087

The Referral Support Service had been launched and went live on the 21st October with the Medlinc locality practices the first to be included. Other localities were coming on stream as training was rolled out. This would really enhance the CCG's ability to improve the quality of referrals and improve outcomes for patients. A number of clinical triagers and administrators had been employed with around 50 referrals a day being reviewed. GB291113/088

"Co-ordinate My Care" was being rolled out. This was a workplace register that collected data to better co-ordinate patient care across different agencies, allowing access to improve care. Training was being provided to primary care staff. GB291113/089

A Diabetes education programme was being rolled out with Epsom Hospital to which all member practices were able to refer. GB291113/090

The CCG was engaged with NHS England work on primary care relating to elective, urgent, unplanned and end of life care. The aim was to simplify and automate data collection. GB291113/091

Primary Care Review of Standards – this related to the work on what was usually known as Local Enhanced Services and the aim was to use a clinical reference group to develop new standards of commissioning from general practice. This would support integration of care and improvements to care pathways. GB291113/092

Better Services Better Value has as the Governing Body knew been concluded, but one of the potentially exciting areas that had come out of it was better integration and use of joint budgets to improve care. GB291113/093

Safeguarding Adults training was being rolled out and remained an important area. GB291113/094

Out of Hospital Service reviews – these were ongoing and should be complete by the end of January. GB291113/095

13. Performance Against Delivery Plan

Karen Parsons spoke to this item. She noted that the Governing Body had signed off objectives in September and said that the paper before the Governing Body was a high level document below which sat a lot of detailed work through the Programme Management Office. The number of green milestones had increased from 26% to 38% in the last two months. Key highlights included: GB291113/096

- The CCG achieved full authorisation in October. GB291113/097
- The RSS had been established three months ahead of plan. GB291113/098
- The CHC review had been completed and would now move towards implementation. GB291113/099
- Hosted services had been reviewed and medicines management and individual funding requests had now transferred to Surrey Downs. GB291113/100
- There was now a project initiation document for the urgent care work. GB291113/101
- An Out of Hours draft specification had been developed and was out for consultation and there had been a provider engagement event the previous week to inform this. GB291113/102
- The Dementia Screening project was performing above expectations and referring a number of people on to memory clinics. GB291113/103
- Diabetes education events had been commissioned for the 33 member practices. GB291113/104
- Clinical leadership roles were being reviewed and advertised GB291113/105

A number of other areas such as Out of Hospital reviews and Primary Care Standards had already been discussed earlier in the agenda. GB291113/106

Karen Parsons noted that there had been significant improvement across all the main themes in the delivery plan. GB291113/107

Dr Andrew Sharpe noted that the Telehealth Project had also gone live. GB291113/108

Miles Freeman said that it had been noted at the previous Governing Body that this was a very ambitious set of programmes and for this reason it would be reported at each Governing Body meeting. Slippage in some areas was inevitable and priorities would need to be revisited. GB291113/109

Dr Fuller highlighted the success in achieving authorisation without conditions and congratulated the Governing Body on this achievement but specifically thanked Karen Parsons for all the work on submitting the required evidence. GB291113/110

Dr Gupta noted that the figures relating to the Dementia Screening project were not correct. Non responders were being followed up and the figures for people being referred to memory clinics and subsequently diagnosed with dementia was fluctuating. However the figure for people expecting to being diagnosed in the report was significantly wrong as it suggested 20% of the screened population would be expected to have dementia which was not correct. GB291113/111

Dr Kate Laws asked if the memory clinics could cope with the additional referrals and Dr Gupta confirmed that they had taken on extra staff to deal with these. GB291113/112

Cliff Bush said that as Chairman of the implementation board he had received a telehealth report which suggested that this year's part of the project would be under target whereas next year's would be over. He had therefore asked for the slippage to be carried forward to the new financial year. GB291113/113

14 Clinical Safety and Patient Quality Report

In Eileen Clark's absence, Alison Pointu spoke to this item. The aim was to give assurance about the quality and safety of the services the CCG commissioned. She highlighted some key points in the report. GB291113/114

- There were continuing concerns about SECAMB. Measures had been taken by the lead commissioner (NHS East Surrey CCG) but this was still an issue. GB291113/115

- Surrey and Borders Trust were working with the lead commissioner for mental health (North East Hants and Farnham CCG) to address some issues with standards of care. GB291113/116

- There were continuing concerns regarding Health Care Acquired Infection. This was an issue across the country and this year's targets were exceptionally challenging. GB291113/117

Denise Crone asked about walkarounds and in particular the Meadows. She said we should consider joint visits with Healthwatch. This was AGREED. GB291113/118

Dr Wali noted the relationship between antibiotic prescribing and CDiff infections. There had been an antibiotic awareness week between 18th and 24th November to help address this across hospital and community. GB291113/119

The CCG was working with Surrey and Borders to improve medication reviews of patients in the community which was currently an area of concern (in response from a question by Dr Loveless it was confirmed that this was mainly depot antipsychotics). GB291113/120

Nick Wilson asked whether the discrepancy in trust CDiff targets was due to different baselines and it was confirmed this was the case and was based on the previous year's outturn. GB291113/121

Nick Wilson also said that there seemed to be concerns about the pattern of inspection findings at Surrey and Borders and were CCGs collaborating to address these? Alison Pointu said that there was effective working both with other CCGs and the local authority and regular reporting to the Clinical Quality Committee was expected. There were a number of action plans coming out of this work that would need monitoring over time. GB291113/122

Dr Fuller summarised by noting that the key concerns at the moment seemed to be with SECAMB and Surrey and Borders and that work would continue to address these. GB291113/123

15. Performance report

Keith Edmunds led on this item. There were overlaps with other reports, and CDiff amd MRSA were covered in the quality report. Integrated Access to Psychological Therapies (IAP) was also red rated but this was probably due to the fact that this was a relatively new service. Performance was at 11% against a national target of 15% but this was partly due to the fact that the target had been incorrectly set and should in fact be at 11% along with other Surrey CCGs. Attempts were being made to resolve this with NHS England. GB291113/124

SECAMB were missing one of the two Category A targets; this was a SECAMB wide target not just Surrey Downs. GB291113/125

Two week breast cancer referrals – the numbers were low and providers were seeking to address this, particularly the Royal Marsden, by employing extra staff. GB291113/126

Alison Pointu asked if there were any audits around breast cancer referrals for patient choice and it was confirmed that five out of nine were patient choice, and there was also some concern (being investigated) that patients did not understand the urgency of the referral. Dr Gupta said this was often the case with people going on holiday but still counted as a breach. GB291113/127

16. Finance report

Keith Edmunds spoke to this item. GB291113/128

The forecast based on seven months was for a £700,000 surplus which was lower than the target. Key pressures on budgets were: GB291113/129

Over activity in acute trusts, with a trend for greater than anticipated outpatient and unplanned care episodes; GB291113/130

Epsom, Surrey and Sussex were all over budget and Kingston was under compared to contract; GB291113/131

Queries and challenges of £2.4m had been raised with providers and most of these were still outstanding. A cautious assumption had been made that £0.5m of these would be successful when predicting the year end surplus. GB291113/132

There were problems in prescribing, particularly with price pressures as well as the volume of drugs prescribed. GB291113/133

Specialised commissioning: the process was nearly resolved but the outcome was a £12.5m cost pressure against a £7m assumption. There were £2m of other cost pressures which the CCG was seeking to address. Maternity and other growth areas were being looked at as appropriate. GB291113/134

CSU and other overheads were being reviewed. GB291113/135

On balance Keith Edmunds felt that the CCG had covered most of the issues but there were two points he wished to bring to the attention of the Governing Body: GB291113/136

- The opening balance sheet had not been resolved although the detail of the liabilities being transferred had been released by NHS England. GB291113/137

- Less than 10% of retrospective claims for CHC had been resolved. GB291113/138

Dr Fuller asked Dr Wali to comment on the cost pressures in medicines management. He said that the overspend was in the area of £1.3m but there was a long lag on the data. The increase in volume may be due to identifying more people for treatment which could have a beneficial impact on hospital referrals. Drug price fluctuations were significant with one example being a twenty eight fold increase in a single month. All options for use of generics were being explored as was improved software to aid prescribing decisions. The medicines management team were also being asked to review unnecessary medications. GB291113/139

It was noted that there was no option to revisit the specialist commissioning figures. GB291113/140

Gavin Cookman asked about opening balances. He asked how pressure could be bought to bear on NHS England to resolve this given the demands that were expected in 2014/15. GB291113/141

Keith Edmunds said that there were two mitigating factors: GB291113/142

- The CCG did now have the working papers for review and verification, along with the other Surrey CCGs. The PCT ledgers were open for inspection. GB291113/143

- This had a high national profile and he felt a solution would be brokered, despite the timetable slipping. GB291113/144

Gavin Cookman asked it closing the accounts could be achieved within timescales given this issue? Keith Edmunds said that monthly balance sheets were being produced and this year's accounting was clear. He hoped that the matter would be resolved in January or February ahead of the year end process commencing. GB291113/145

Nick Wilson noted the immediate cost pressures but felt that the bigger issue was the lack of a sustainable medium term financial plan. He asked when this would be available. GB291113/146

Keith Edmunds said that this had formed part of the work done on the Out of Hospital strategy over the summer. This would be refreshed to aid future planning, although it would not be easy. GB291113/147

Miles Freeman said he was concerned to see the planning guidance and the CCG's two year allocation in December. GB291113/148

Peter Collis said that Surrey Downs was not alone on the issue of balance sheets and asked if we were working with other CCGs on this? Miles Freeman said that we would seek a common approach with other CCGs if necessary, and the support of the Area Team. GB291113/149

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Dr Gupta said that he noted a number of variations in reductions in admissions and out-patients. Miles Freeman said there was confidence in the figures but they needed to checked for disaggregation from larger sets of numbers. Large swings and changes did need to be checked but they were consistent with expenditure figures. GB291113/150

Denise Crone said that in some cases planned activity was the same or less than previous years and asked why this was. It was clarified that the data came from different sources and plans had been based on best assumptions given that not all the data was available. It was agreed to follow this up outside the meeting. GB291113/151

17. Audit Committee minutes

Peter Collis drew the Governing Body's attention to the summary in the cover sheet. He said that Conflicts of Interest amongst staff was an important part of governance and the committee liked the BMA guidance for GPs. He drew attention to the issue of rebates in the pharmaceutical sector and whether these constituted a bribe. NHS Protect had now indicated they were not concerned if this was at CCG level. The minutes were NOTED. GB291113/152

18. Clinical Quality Committee minutes

These were NOTED without further discussion. GB291113/153

19. Remuneration and Nominations Committee.

Gavin Cookman gave a verbal update on today's meeting. Key highlights were: GB291113/154

- Policy embedding was felt to be important and would be followed up at the next meeting. GB291113/155
- There had been an oversight that meant that the CCG was not included in the NHS national staff survey. This would be followed up with a local survey. GB291113/156
- Clinical lead pay scales were agreed. GB291113/157
- Lay member remuneration would be bought to the Governing Body as the committee members were conflicted. GB291113/158
- A process for recruitment to senior posts including Chief Finance Officer had been agreed. GB291113/159
- HR data from the CSU was shared giving information on staff sickness, training and other key performance indicators. Work was needed on talent management and succession planning. GB291113/160

20. Policies and Procedures

Karen Parsons introduced this item and outlined how the policies had been developed. All the policies had been circulated to Governing Body members for discussion. GB291113/161

The following policies were AGREED by the Governing Body. GB291113/162

- Policy for the creation, development, implementation and review of policies and related procedural documents
- Fraud, Bribery and Corruption Policy
- Standards of Business Conduct Policy
- Gifts and Hospitality Policy
- Equality and Diversity
- Business continuity policy
- Complaints policy
- Equality and Diversity Policy

21 Personal Health Budgets

Karen Parsons gave an update. She felt this needed more in-depth discussion in a seminar setting. .A number of patients were being selected to hold personal health budgets from October 2014. A task and finish group was looking at the process. As much as anything this was about a cultural shift in the way we perceived and worked with patients. Phase 2 between March and October would look at the learning from implementation. It was noted that this was open to both children and adults. GB291113/163

22. Any other business

Cliff Bush noted that Health watch would go live in late January or early February. GB291113/164

Dr Wali asked that recommendations from the Prescribing Clinical Network be ratified at the Governing Body in future. GB291113/165

Action Justin Dix

23. Questions from the public

Bob Mackison asked about virtual wards and it was agreed Dr Fuller would speak to him outside the meeting to explain these. GB291113/166

Bob Mackison asked about Miles Freeman's declared interests and he confirmed that LDM consulting was a sole trader consultancy with no web site. GB291113/167

Bob Mackison asked about CDiff sampling criteria and noted that these varied between different providers and did not constitute a level playing field. Dr Gupta said this was bought up in clinical meetings and was being investigated. Miles Freeman said there would probably be greater standardisation in future as part of duty of candour arrangements. GB291113/168

Rosemary Najiim said that she did not feel that costs could be reduced by transferring care into the community unless care was better co-ordinated particularly in the area of diagnostic tests. GB291113/169

Dr Steve Loveless said that this was understood and the review of primary care standards was aimed at reducing duplication in the system. GB291113/170

Dr Jill Evans said that she also felt that the Referral Support System would help to resolve this. Dr Fuller said that the heart failure pathway had been revised for this reason as well. GB291113/171

Bob Mackison asked about EDICS and the referrals that were picked up by Epsom Hospital and hoped they would continue with this work. Dr Fuller said all the former EDICS clinics were being reviewed for effectiveness and value for money. It was noted that patient choice was also a factor. Dr Williams said that patient outcomes were as important as patient choice. GB291113/172

Summary of actions recorded

033	Karen Parsons	Check that equipment to support discharge was part of winter capacity planning
165	Justin Dix	PCN recommendations to be ratified at Governing Body