ANNUAL GENERAL MEETINGS 2019

MINUTES

NHS Guildford and Waverley CCG	✓
NHS North West Surrey CCG	✓
NHS Surrey Downs CCG	✓

Date	Wednesday 26 June 2019	**Time**	18:00 – 20:00
Venue	H.G. Wells Conference & Events Centre, Church Street East, Woking Surrey, GU21 6HJ		

Governing Body Members/ Attendees

Name (initials)	**Title**	**Attendance (✓) or Apologies (A)**		
		G&W	**NWS**	**SD**
Convener				
Dr Sian Jones (SJ)	Clinical Chair, Guildford and Waverley CCG			
Voting Members				
Dr Sian Jones (SJ)	Clinical Chair, Guildford and Waverley CCG	✓		
Dr Charlotte Canniff (CC)	Clinical Chair, North West Surrey CCG		✓	
Dr Russell Hills (RH)	Clinical Chair, Surrey Downs CCG			✓
Matthew Tait (MT)	ICS Chief Officer	✓		
Karen McDowell (KMc)	ICS Director of Finance	✓		
Jacqui Burke (JB)	Lay Member Audit for the Surrey Heartlands CCGs	✓		
Jonathan Perkins (JP)	Lay Member General for the Surrey Heartlands CCGs	✓		
Phelim Brady (PB)	Vice Chair/ Lay Member PPE, Guildford and Waverley CCG	✓		
Dr Will McKee (WM)	Vice Chair/ Lay Member PPE, North West Surrey CCG		✓	
Jacky Oliver (JO)	Vice Chair/ Lay Member PPE, Surrey Downs CCG			✓

Name (initials)	Title	Attendance (✓) or Apologies (A)		
		G&W	NWS	SD
Julia Dutchman Bailey (JDB)	Independent Nurse for the Surrey Heartlands CCGs		✓	
Vacant	Secondary Care Doctor for the Surrey Heartlands CCGs		-	
Dr Darren Watts (DW)	GP Member, Guildford and Waverley CCG	A		
Dr Justine Hall (JH)	GP Member, Guildford and Waverley CCG	✓		
Dr Seun Akande (AK)	GP Member, Guildford and Waverley CCG	A		
Dr Deborah Shiel (DS)	Woking Locality Lead, North West Surrey CCG		✓	
Dr Alex Henderson (AH)	Woking Locality Lead, North West Surrey CCG		✓	
Dr Jags Rai (JR)	SASSE Locality Lead, North West Surrey CCG		✓	
Dr Diljit Bhatia (DB)	SASSE Locality Lead, North West Surrey CCG		A	
Dr Asha Pillai (AP)	Thames Medical Locality Lead, North West Surrey CCG		A	
Dr Layth Delaimy (LD)	Thames Medical Locality Lead, North West Surrey CCG		✓	
Dr Andrew Sharpe (AS)	GP Member, Surrey Downs CCG			✓
Dr Louise Keene (LK)	GP Member, Surrey Downs CCG			✓
Dr Hannah Graham (HG)	GP Member, Surrey Downs CCG			A
In attendance				
Sumona Chatterjee (SC)	ICS Director for Surrey Wide Services		✓	
Clare Stone (CS)	ICS Director of Quality and CCGs' Chief Nurse		✓	
Elaine Newton (EN)	ICS Director of Corporate Affairs and Governance		✓	
Vicky Stobbart (VS)	ICP Director, Guildford and Waverley CCG (shared role)	✓		
Jack Wagstaff (JW)	ICP Director, North West Surrey CCG			✓
Colin Thompson (CT)	ICP Director, Surrey Downs CCG			✓
Vacant	Director of Public Health, Surrey County Council		-	
Justin Dix (JD)	(Minute-taker) Head of Corporate Governance and Risk		✓	

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1	**Welcome, introductions and apologies** Dr Sian Jones welcomed everyone to the meeting. Attendance and apologies were noted as above.
2	**Minutes from Annual General Meetings in public in 2018:** **a) Guildford and Waverley (24/07/18)** **b) North West Surrey (18/07/18)** **c) Surrey Downs (04/07/18)** The above minutes were NOTED.
3	**AGMs in Common presentation including:** **a) Surrey Heartlands Health and Care Partnership update** Matthew Tait gave a presentation. Key points were as follows: Locally the CCGs were endeavouring to work with the national direction of policy on integration care. Surrey Heartlands was an early adopter and thus at the leading edge of these changes. A short video was shown which set out how Surrey Heartlands was attempting to make a reality of national policy locally, bringing in the wider determinants of health and identifying the root causes of ill health. An example was looking at the first thousand days of a child's health, giving them the best start in life. Local boundaries were complex and Heartlands was not coterminous with Surrey County Council. There was close joint working with SCC, with neighbouring systems, the voluntary sector and districts and boroughs. A key aim was to keep decision making as locally appropriate as possible. Some areas such as children's services and ambulance services needed to be delivered 'at scale' but it was equally important to develop primary care for populations of around 30k – 50k and integrating services around these areas, looking as well at issues such as housing and wellbeing. There were 19 Primary Care Networks being developed to take this forward. Devolution gave the local system more power and autonomy and work was in hand to formalise the transfer of these responsibilities. One example was using estates more effectively using local flexibilities. Some specific initiatives included: • A new maternity helpline • Extra GP appointments • Capital funding for local hospitals • Integrated 111 services These were being underpinned by integrated management and a consistent direction of travel. There were significant local challenges such as: • CAMHS Services • SEND • Ambulance service transformation • Rising demand

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	• Financial stability • Dementia diagnosis and IAPT • Variations in outcomes and health inequalities Considerable support was being given to improvements in these areas. This included: • Greater focus on prevention and local intervention • Improve performance with partners A new health and wellbeing strategy had just been launched which focused on NHS Long Term Plan delivery and factors such as isolation, poverty, air quality and employment which play a big part in people's health and wellbeing. **b) Annual review of the CCGs** <u>Guildford and Waverley</u> Vicky Stobbart covered the highlights and challenges of the year for the patch and its 21 GP practices. Population was increasing and the local university population was a significant factor, as was the mixture of rural and urban characteristics. Highlights included: • Taking on most GP commissioning locally; • Improved psychiatric liaison services, particularly for patients with complex needs; • New integrated cancer care teams providing betters support to people with cancer and their GPs; • Improving LD Services particularly annual health checks and transition from children to adult services; • A new physiotherapy helpline using support, advice and instructional videos on exercise regimes. 55% of patients have not needed further referral. Challenges: • Fire at Chiddingfold surgery. Fortunately, it is hoped that the local practices will be back in their premises later this year. Better Care Together: This programme is aimed at improving urgent care, both access and standards of care. This is a joint programme with Royal Surrey. Underpinning this work has been extensive engagement with local and people and partners in the areas mentioned above, using the methodology for citizen engagement developed across Surrey Heartlands. <u>NW Surrey</u> Dr Charlotte Canniff and Jack Wagstaff spoke to this. The area was made up of 40 practices. The work of Karen Thorburn as Local Managing Director during the year was acknowledged.

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	Highlights included • Increased access to GP appointments, including over 14,000 new digital consultations. • Improved psychiatric liaison, particularly for patients with complex needs. • Direct access physiotherapy, avoiding the need to see a GP first. • A new urgent treatment centre at ASPH • Supporting people with SMI and ADHD • Relocation of GP services • Working with care homes The Big Picture Programme: This was launched in October 2018 and looks at urgent care and Weybridge Hospital. There has been extensive engagement with the local community on the exciting opportunities this offers. <u>Surrey Downs</u> Dr Russell Hills spoke to this. The area has three distinct localities and 30 GP practices facing towards Kingston, Epsom and East Surrey Hospitals. Highlights included • A partnership based community contract. This will fit well with future integrated care developments • Taking on GP commissioning locally • Improved MSK Services and direct access physiotherapy • Chest Pain Rapid Access in Dorking • Support to people with arthritis Improving Healthcare Together: This was a programme across Merton, Sutton and Surrey Downs to look at the challenges of the Epsom St Helier system. This was focused on meeting clinical challenges and making services sustainable. If the required capital can be secured this will potentially result in formal consultation in the autumn on building a new acute unit. All of the above work was underpinned by engagement and consultation with local people. In addition to the above areas there had been work on wheelchair services and Continuing Health Care. **c) Presentation of CCG 2018/19 Annual Accounts** Karen McDowell spoke to this. As statutory bodies the CCGs were subject to audit and had to report their accounts in full, which could be viewed online with the annual report. Allocations were: • **Guildford and Waverley CCG** had a budget of £300.5m of which £4.9m were management costs. The CCG achieved £6.5m of efficiency savings in 2018/19. Over half the spend was on acute hospitals and the rest was on a range of community, metal health and other services. The CCG had a deficit of £13.2m at the year end. In the current year the CCG was planning for a deficit of £3.2m but to achieve this will need efficiencies of £14.8m.

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	• **North West Surrey CCG** had a budget of £500.7m and spent £7.7m management costs. The CCG achieved 11.45m of efficiency savings. Over half the CCGs spend was on acute services. The CCG achieved a £2.6m surplus. In the current financial year the CCG was planning to break even. To achieve this the CCG will need to achieve efficiencies of £10.7m • **Surrey Downs CCG** had a budget of £379.9m and spent £6.7m on management costs. The CCG delivered £10.1m of efficiency savings. 60% of the spend was on acute services. However, the CCG did not have responsibility for GP services in that year. The CCG had a deficit of £11.5m at year end. In the current year the CCG will need to achieve £30.2m of efficiency savings to deliver a planned £0.3m surplus. SJ highlighted the range of ways in which local people could get involved in these issues, including attending public meetings, engaging in consultation, signing up to newsletters and social media.
4	**Questions from the public** The following questions were raised at the meeting: *What was happening with the new sexual health contract? This was perceived as a failing service with patients having to be sent to Kingston because of local failings, but the contract had been extended.* The sexual health contract was run by Surrey County Council and the CCGs were trying to influence public health and the providers they commissioned. The difficulties were acknowledged. There were some signs of improvement and GPs could now get a one-day service for their patients. There was however a lot to do to improve online access to advice and provide home testing kits. Travel to clinics was also being looked at closely and additional appointments at ASPH for sexual health services was being looked at. *Suicide rates were very high but the strategy did not seem to prevent suicides including children.* The need to operationalise the suicide prevention strategy was acknowledged. Work was being done with partners and there were some signs of reduction in suicide. GP practices were very concerned about access to help when people expressed suicidal thoughts and this would be a focus for the ICPs as they developed. There was scope to improve the quality of data to support decision making in future. *Arthritis – could nutritional services be improved?* This was agreed and it was acknowledged that there was more scope for nutrition across a range of areas. *Suicide – a lot of people who commit suicide have had no contract with mental health services. More awareness was needed.* This was acknowledged *The loss of Community beds at Leatherhead was of concern to local people.* This was acknowledged. The local PCN arrangements would help support local people with alternative services.

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	When would the new build at Weybridge take place? CCGs did not hold any capital assets and were having to seek help from central government. It was necessary to put in a business case and then undertake the build. This would probably be three years in total. *How much of the investment in mental health services would support drug and alcohol dependency?* These services were also commissioned by Public Health and had been subject to a reduction of 20%. This was being discussed and was a very difficult position for all the partners. These services were not protected in the local government budget. An analysis of the highest service users had revealed that a third of them had drug and alcohol problems. It was possible that pooling of resources in the ICP might be of benefit to this but there was also a need for more community support and awareness. A lot of work was being done on misuse of opioids and how benzodiazepine use could be reduced *How much of local funding was spent on the private sector and are these services difficult to monitor?* There were definitional problems as to what constituted a private provider so this was not easy to answer. There was a general challenge about getting assurance from providers, particularly private providers, as services developed and the system changed with the introduction of ICPs. Generally the sums were very small and often tended to be in specialist areas such as IVF, GP out of hours services, and so on. *What views do CCGs have on vaping?* Vaping was being actively discussed in the public health community. However there was a lack of data about long term effects. *What opportunities were there with CCGs coming together to improve patient and public involvement?* The ICS had been innovative in its approach. PPGs would be more engaged as PCNs developed and ICPs could become more involved with local boroughs and districts. However the new system was embryonic. There were good opportunities for citizen engagement around mental health, and there were plans for paediatrics services to engage with parents. The possibilities were significant but there was a need for a consistent and co-ordinated approach. It was also noted that there would need to be a lot of engagement around prevention but this could be organic in nature and grow up from the community level. *The turnout at tonight's AGM was poor compared to the previous year's G&W. Could there be something at ICP level in future?* This was acknowledged. Tthe AGM was a formal statutory requirement and every effort was made to ensure meaningful engagement at local level in addition to the mechanisms outlined above. *What is a PCN?* These are groups of practices working together and covering areas of 30k – 50k. This would mean about 5 PPGs could start working together to do things on a larger scale.

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	PPGs were not resourced to do the work they needed to do. There was a need to find imaginative ways to fund events and engage with people at the community level, focusing on what people are interested in. This was acknowledged but had to be done at the most local level. *Concerns were expressed about developments in Surrey Downs particularly Molebridge. The PPG was on the verge of folding up.* This was acknowledged. The following question was submitted in advance of the meeting: *Mr Allan, from Guildford and Waverley has asked about DDA compliance and the height of parking meters, which he feels work well for wheelchair users. However, this can in turn, he believes, disadvantage non-wheelchair users i.e. people with spinal problems who find bending down a problem. He notes in his question that he has had responses from all the acute trusts that they state are DDA compliant in their parking arrangements.* The CCGs noted that as this is an operational matter for trusts, we cannot add to the responses he has received but would wish to assure him that we require all providers to be DDA compliant as part of our contracting arrangements.
5	**Meeting close** Meeting closed at 19.45.