NHS
Merton
Clinical Commissioning Group

Minutes of Part 1 of the
Merton Clinical Commissioning Group Governing Body

Thursday, 16th May 2013
at

120 The Broadway, Wimbledon, London, SW19 1RH

Chair: Dr Howard Freeman
Present:

DA	David Avis	Interim Chief Finance Officer
EB	Eleanor Brown	Chief Officer
MC	Mary Clarke	Independent Nurse Member
PD	Peter Derrick	Lay Member: Chair of the Audit Committee/ Vice Chair
KE	Dr Kay Eilbert	Director of Public Health, London Borough of Merton
HF	Dr Howard Freeman	Chair/Clinical Leader
CG	Clare Gummett	Lay Member: Patient and Public Engagement Lead
GH	Dr Geoff Hollier	GP Clinical Board Member

In Attendance:

AS	Andy Smith	Interim Director of Commissioning and Planning
JK	Jennifer Kay	Director of Quality
DF	Dr David Finch	Better Services Better Value Team (for item 3 only)
RT	Rachel Tyndall	Better Services Better Value Team (for item 3 only)
AM	Amelia Whittaker	Associate Director of Commissioning: NHS South London CSU (for item 8.1 only)

Supporting Officers

JM	Jackie Moody	Corporate Affairs Manager: NHS South London CSU
JN	Joanna Nurse	Communications Lead: NHS South London CSU
TF	Tony Foote	Board Secretary: NHS South London CSU

Members of the Public:

Please see Appendix A

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1. Welcome and Apologies for Absence

Dr Howard Freeman (HF) commenced by welcoming members and all in attendance; noting that the meeting was in public, but not a public meeting. HF added that the Governing Body appreciated how important to people the item on Better Service Better Value was and that it was also of great importance to the CCG. Accordingly, the meeting had been designed to allow appropriate time for consideration of this matter. After the presentation questions would be received from governing body members, followed by questions from members of the public.

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The Chair stated that no consent was given to take photographs of the meeting, and gave a standard safety announcement.

Apologies for absence were received from Professor Stephen Powis

2. Declarations of Interest

The Merton Clinical Commissioning Group Governing Body is required to maintain a register of members' interests which can be made available on request. At meetings of the Governing Body members are expected, if appropriate, to declare interests in respect of items on the agenda.

Mary Clarke (MC) declared a potential interest with regard to item 3: that she was an Associate Non-Executive Director (non-voting) of the board of Croydon University Hospital, providing clinical support.

Peter Derrick (PD) commented that as this constituted a non-pecuniary interest it was acceptable for MC to remain in the meeting but not to vote. Governing body members present agreed with this summation.

3. For Agreement (i)

3.1 Better Services Better Value

- Draft Pre-Consultation Business Case
- Governance Arrangements

The Chair welcomed members of the BSBV team.

Dr David Finch (DF) introduced himself as a Wandsworth GP, based in a Battersea practice for many years, and the Medical Director for BSBV programme.

He explained that the origin of the Better Services Better Value (BSBV) programme had been informal discussions between clinicians in South West London, and the shared belief that healthcare could be provided more effectively and to a higher quality. This was based upon concerns that senior specialist clinicians were not always available when needed – such as at weekends or during the night. NHS London examination of outcomes for patients had shown that hospital mortality rates were higher at such times and that up to five hundred lives a year could be saved if senior consultants were present at all times. There was also an argument for centralising services; for example, this had brought about improved outcomes for stroke patients across London.

Similarly, there were accounts from across London of "bulging" and overloaded Accident and Emergency (A&E) departments, and patients attending who could more appropriately be seen in primary care. It became clear that the issues were many and complex and that clinicians across acute and primary care needed to work together in a whole system approach.

It is BSBV's aim to find the best way forward. Clinical working groups were established to review certain areas – e.g. maternity; end of life care; geriatrics – and propose better ways of working. These groups had the

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quality of the service as their central requirement but also recognised the cost challenges and the need for a realistic financial view. The recommendations from these reviews were to move towards centralising hospital services coupled with transformational change in primary and community services. DF stated the he had originally been opposed to centralising services but now realised that this could promote better quality services and enable funding to be used more effectively.

DF stated that the specific proposals contained in the business case, generated by clinicians in conversation with public representatives, set out their best proposals for dealing with the complex issues and to provide better quality services within available resources. They would all result in a decrease from five to three major sites, with St Georges NHS Trust as the major acute hospital supported by different variations.

The BSBV team now wanted to take these proposals to a wider audience and to hear other views.

The Governing Body then put questions to the BSBV team.

The Chair commented on the recent press coverage of A&E departments experiencing problems with capacity. How, with the proposal to decrease the number of A&E departments and the business case's assertion that eighty per cent of patients currently using St Helier's would continue to do so, could similar, or worse, problems be avoided in future?

DF responded that A&E departments were often dealing with emergencies plus non-urgent cases that would be more appropriately seen by a GP. The aim of the proposals was to increase overall capacity within the system by providing extended Urgent Care Centre (UCC) facilities (networked with major A&E departments), along with improvements in primary care and planned care. This should alleviate the pressure on the remaining A&E departments. Rachel Tyndall (RT) added that eighty per cent of current St Helier attendees would continue to do so, although fifty per cent would be seen by the UCC.

PD enquired as to the opening hours of UCCs. RT said that on major sites these would be open continuously; this could also be the case in more local sites but might depend upon specific need. For example, there may be an overnight link to GP out of hours services.

PD then asked – with patient safety and financial constraints in mind - was maintaining the status quo ever considered. RT said that it had been considered but the working groups had shown the local NHS could not continue to be financially viable, and no change would result in no improvement in quality of care. DF added that he was not aware of any local clinician who thought the status quo either safe or sustainable.

Jenny Kay (JK) asked how quality outcomes would be measured/tracked during transition. DF appreciated that safety/quality was paramount during the implementation phase. However, it was still only early in the overall BSBV process and there would be time to learn from other service reconfigurations. There were now national and London-wide quality markers that would guide service provision and audit.

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RT noted that the markers were focussed on hospital-based quality of care and that, with the proposed shift of care to primary and community care, there was concern about quality in those sectors too. The CCGs had set up an Out of Hospital programme to take account of this.

Eleanor Brown (EB) concurred that BSBV would not be possible without the corresponding changes in primary and community care. She provided two examples of change that had shown positive outcomes to date: end of life care services across Sutton and Merton had been expanded and that for those requiring this service more were able to die in their preferred place; working with the local authority, community services and mental health services for more integrated, holistic care would support further movement of services from an acute setting.

Clare Gummett (CG) enquired as to the definition of what would be considered appropriate for treatment at A&E versus UCCs. DF said that A& E would deal with life threatening major trauma. UCCs would be staffed by senior qualified clinicians who would deal with whatever patients presented with but would need 24 hour back up of emergency care services. Patients and/or GPs would not be expected to decide which place (UCC/A&E) was most appropriate. NHS 111 would direct patients appropriately at the initial contact. UCCs will routinely be the first port of call as major trauma centres would have an UCC as an initial "gateway". St Helier Hospital was a current example of this: If a patient attended a UCC, they would be seen.

EB stressed the importance of communication in ensuring public awareness of changes. RT said that implementation of changes would be gradual; the main changes to hospital sites would not be effective for another five years. During this period, primary care and the 111 service would improve and public knowledge and understanding increase.

The public then had the opportunity to put questions to the BSBV team.

Question 1 (from Dr Phillip Howard, local physician)

Dr Howard thought BSBV the "most expensive piece of fiction we were likely to see", having already cost £6m with further cost of £200,000 pa to progress it. He believed that Merton CCG did not have the legal right to consult on the potential closure of services. He wanted to know who would bear the brunt of the costs and who would take legal and professional liability if a patient was to die whilst being taken to a specialist centre rather than their local hospital?

RT conceded that the programme was not cheap, but they were working to a very high standard. The totality of healthcare cost was £2.8 billion p.a. In 2013/14 the BSBV budget was £2 million p.a. with £750K earmarked for the consultation process. This cost would be met by the member CCGs and NHS England.

The Chair confirmed that legal advice obtained stated that, under the Health and Social Care Act, Merton CCG had the power to consult on significant service changes to health care.

DF commented that the BSBV programme focussed on improving quality

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of care for all patients and that great courage was required to re-configure services.

Question 2 (Ms Mary Pink)

The Health and Social Care Act stated that any member with a financial interest (or appearance of) must stand down for decisions. Did any members of the Governing Body have links to Assura Medical/Virgin Care?

The Chair reminded the meeting that Governing Body members had already had the opportunity to declare any additional interest to those contained in the Register of Interests. Ms Pink acknowledged this but asked if there was anything further for the members to declare.

GH stated that he was a Merton GP and had never had any links with Assura Medical/Virgin Care. Ms Pink asked GH whether he belonged to a limited company. GH said that, prior to the existence of the CCG, he had been in a Practice Based Commissioning Group and a company bank account had been established from which staff could be paid. He added that all members of the group held only a nominal £1 share in the company which had been wound up as it no longer served any purpose. The company had not been a provider of healthcare services.

The Chair stated that he had resigned from Dr Howard Freeman & Partners on 31st March 2013, and from Assura Medical before that. Ms Pink asked the Chair when he had resigned from Assura Medical, and whether he had held an interest in Assura whilst he was Medical Director of the BSBV programme, but the Chair could not recall the exact date.

RT emphasised that one of the strengths of BSBV was that CCG Chairs provided clinical leadership.

Question 3 (Siobhain McDonagh, MP for Mitcham and Morden)

Ms McDonagh asked how the intended consultation could be considered valid if six of the fourteen weeks allotted to it fell within the school summer holidays. This would have a significant impact as many people would be away on holiday; there may be problems in using school halls for meetings; that CCG members themselves may not be available to attend meetings with the public; and that the public may have limited access to those that could assist them bring together their arguments.

RT said that, although not yet definite, it was likely the consultation period would start in June. The BSBV team was aware of the possible clash with the holiday period and, with this in mind, had already extended the initial twelve week period to fourteen. The team felt that any delays in consultation would be detrimental to services. DF added that clinicians were concerned that the systems currently in place were not safe and the sooner discussions could begin about changes, the better.

Ms McDonagh did not see this as a genuine effort to engage people and, as an act of goodwill and requested that the consultation period not commence until September.

Question 4

Ms McDonagh asked whether it was true or not that St Helier currently provided the safest maternity services of all the hospitals involved in BSBV. She said that last year there were 3,000 births at St Helier's, and 5,000 at St George's. With the proposed closure of the St Helier maternity unit, how would St George's manage 8,000 births on one site?

RT stated that, against national quality markers, all local maternity services required improvement. She stated that the capacity of a single maternity unit had been considered and, with a consultant and midwife led service, this should be of a higher quality than that previously provided.

Regarding elective care centres, Ms McDonagh raised the question of why hospitals would send their patients elsewhere. RT responded that there were benefits to moving elective care off site.

Ms McDonagh then stated that St Helier A&E saw 90,000 patients last year. How large would the UCC have to be to deal with such volumes? RT said that, again, this had been taken into account, including the need for appropriate care parking space.

Ms McDonagh then asked how, with the proposed closure of the renal unit at St Helier, St George's would absorb this increase in patients on the current site. RT agreed that this could have been a problem but Surrey patients would be able to attend renal services in Surrey.

Ms McDonagh felt there was a lack of detail to the BSBV proposals and so it was difficult to argue against them. It was clear what patients would be losing, but not what would be replacing them.

DF drew attention to the chapter in the Pre-Consultation Business Case on out of hospital services (available on the BSBV website).

Recommendation(s)

Having considered both the Pre-Consultation Business Case and the contributions made to the meeting, the Merton Clinical Commissioning Group Governing Body:

(i) Noted the Pre-Consultation Business Case Presentation.

(ii) Responsibility for consultation under the NHS Act 2006 (as amended) lies with NHS England and the seven CCGs who have duties of public involvement and consultation (sections 13Q and 14Z2 respectively). However, the 2006 Act does not allow CCGs to form joint committees with themselves or other bodies in the way that primary care trusts could. For that reason, it was proposed that the governing body of each CCG should form its own committee, as should NHS England. The seven CCG committees to then meet in common, but each will take the necessary decisions in relation to the BSBV programme on behalf of its CCG.

Accordingly, Merton Clinical Commissioning Group Governing Body agreed the governance proposal to create a Committee of

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the Governing Body: no member voted against this. Accordingly, the Governing Body nominated its three members for this Committee: Ms Clare Gummett; Dr Geoff Hollier and Professor Stephen Powis.

Throughout the meeting there had been a number of interruptions from the public. However, during the latter stages of the question and answer session these had increased significantly. Accordingly, the Chair decided to adjourn the meeting for a short period with the hope that it could resume in a more conducive atmosphere.

After a period of ten minutes the Governing Body returned to the room and the Chair made efforts to continue with the other business on the agenda. However, the level of interruptions from the public remained significant and the Chair proposed that the governing body move to exclude the public due to the level of disruption.

The Governing Body left the room and continued the meeting in another room.

4. Minutes of previous meetings

4.1 To approve the minutes of the Merton Clinical Commissioning Group Governing Body meeting held on Thursday, 21st March 2013

The minutes were approved as an accurate record of the meeting.

5. Matters Arising

5.1 Governing Body Action log – for note

The Governing Body noted the actions taken.

6. Chair's Update

The Chair formally welcomed Dr Kay Eilbert (Director of Public Health) to her first meeting of the Governing Body.

The Chair noted and congratulated Kingston Hospital on its great achievement in attaining Foundation Trust status.

The Chair informed the Governing Body that the two GP practices in Raynes Park – the Pepys Road Surgery and Dr H M Freeman and Partners – had now formed one practice, named the Lambton Road Medical Practice.

7. For Agreement (ii)

7.1 Draft Merton CCG Prospectus

JK introduced this item and invited comments on the draft Prospectus.

CG said that she had taken the draft to a local Patient Participation Group meeting and was given a number of suggestions and comments. EB and

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MC also had suggestions they wished to make.

It was agreed that all such comments/suggestions should be submitted by the following week and these would then be incorporated, as appropriate by 31st May 2013. **JK**

Recommendation (s)

The Merton CCG Governing Body approved the Prospectus subject to the suggested amendments being incorporated as appropriate.

7.2 Draft Quality Strategy 2013/14

JK introduced this paper, which she felt represented a CCG response to the findings of the Francis Report, and highlighted the four key quality goals:

- High quality services
- Driving continuous improvement in quality and outcomes
- Working with local authority and other partners to promote health for Merton residents
- Ensuring that children and vulnerable adults are protected from harm (safeguarding)

JK also brought to the Governing Body's attention the specific quality objectives for 2013/14 and beyond and the work plan for their implementation. She added that this was a document that would continue to evolve and the Governing Body would be updated regularly.

KE commented that the Strategy seemed mainly about internal matters and could feature more about the direct effect upon patients. JK said she would be happy to discuss this further with KE outside of the meeting. **JK** MC requested that the role of the CCG's Clinical Quality Committee should be mentioned in the Strategy and JK agreed to add this. **JK**

Recommendation (s)

The Merton CCG Governing Body approved the Quality Strategy subject to the suggested amendments being incorporated as appropriate.

7.3 Merton CCG and Sutton and Merton PCT Financial Position: Month 12

DA presented this item and stated that the accounts for 2012/13 had been submitted to auditors on the 22nd April 2013. These showed that the PCT exceeded its planned surplus (£25.2m) and achieved one of £30.4m.

The Merton CCG Governing Body approved the Financial Position statement for Month 12.

7.4 Budget Book 2013/24 & Medium Term Financial Strategy (MTFS)

DA presented this item and explained that the paper was an update of an earlier draft that had been considered previously by both the Finance Committee and the Governing Body. However, as a number of issues still

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remained uncertain a definitive final draft would not be available for a further two weeks. The budget was required to show a £0.5 contingency and a 1% surplus.

The main changes from the earlier draft were:

- Specialist Commissioning – the transfer from general acute to specialised had risen from £26.2m to £32.3m
- The £4.3m demographic reserves stated in the earlier draft had now been used in final settlement of general acute SLAs.
- There would be a shortfall to the draft budget of £1.8m.This was due to unexpected additional transfers to secondary care dental and net charges relating to assets transferred to PropCo.

DA explained that the CCG would submit its financial plan by 21st May 2013 and should do so with a £0.5m contingency and a forecast to break even.

PD said he agreed with this proposal regarding the submission of the plan and that the issue of transfers to Propco created great uncertainty.

HF enquired that, if there was a failure to make the 1% surplus, would the accounts still be qualified. DA stated that they would not.

MC enquired about the top slicing from CCGs for specialist commissioning, how would this be monitored and would Merton CCG be refunded any monies not spent. DA stated that any monies unspent would remain with NHSE. DA also confirmed that the prescribing budget included specialised commissioning.

Recommendation (s)

The Merton CCG Governing Body approved the Budget Book 2013/14 & Medium Term Financial Strategy

8. To Receive and Note

8.1 NHS Sutton and Merton (NHSSM) and Merton CCG Performance Management Report: Month 12 (inc. Director of Commissioning's report)

Amanda Whittaker (Associate Director of Commissioning: NHS South London CSU) attended for this item and explained that this was an integrated report: relating both to Merton CCG and NHSSM as the period in question was the final month of 2012/13. Next month's report would be solely of the CCG. AW then highlighted the main areas of the report:

Healthcare Acquired Infections (HCA)
That NHSSM reached its target for 2012/13. There were still some issues relating to St George's but these were being followed up.

MRSA
NHSSM did not reach its target for 2012/13. The majority of reported cases related to St George's.

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Accident and Emergency
Both St Helier and St George's met their targets for 2012/13.

Mixed Sex Accommodation
There were a number of breaches reported across South West London. Of particular concern was the performance of St George's Intermediate Care Service.

Cancer Waits
NHSSM achieved the targets for 2012/13.

In response to questions from the Governing Body AW stated that it was at present unclear whether the overall acute contract would be beneficial to the CCG although it appeared that the majority of growth in elective care related to Sutton rather than Merton. AW also assured the Governing Body that the next month's report would be entirely Merton-specific and that she would enquire whether the London Organisational Health Intelligence (produced by NHSE) would be available for future reports. **AW**

AS (Interim Director of Commissioning and Planning) introduced his supplementary report on Mental Health and Community Services. He confirmed that the recently appointed Mental Health Commissioning Manager would play a major role in monitoring this contract with regular reports to the Governing Body. He also stated that, with regard to Community Services, it appeared that a number of service specifications metrics were not currently being reported on and this would be reviewed.

Recommendation (s)

The Merton CCG Governing Body noted and discussed the Performance Management Report.

8.2 Chief Officer's Report

The report contained the following items:

CCG Development
It had been agreed that JK would manage the Medicines Management Team and the Patient and Public Involvement Manager.

New Appointments
Adam Doyle had been appointed as Director of Commissioning.
David Avis was currently Interim Chief Finance Officer, although a permanent appointment had been made and would be announced formally shortly.

CCH Website
The CCG website was now up and running and its development would continue.

Service Development
The CCG was represented at the official opening of Concord and Consortia Houses – new supported housing for clients with learning disabilities. This development marked the final stage of the closure of the

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Orchard Hill Hospital.

South London Academic Health Science Network (SLAHSN)

The SLAHSN was a new partnership across South West London with the aim of driving lasting improvements in patient care by sharing innovations across the health system. The CCG looked forward to working with the SLAHSN in future.

A&E Services

All CCGs were reviewing arrangements for A&E provision, including local review arrangements for critical times. Progress on this would be reported through the CCG's Clinical Quality Committee.

Recommendation (s)

The Merton CCG Governing Body noted and discussed the Chief Officer's Report.

8.3 Update on South West London and St George's Mental Health Trust's Application for Foundation Trust Status

AS confirmed that the final date for transition (September 2013) remained unchanged although certain milestones in the timeline for Foundation Trust status had been rescheduled. The CCG was kept informed of developments and the Mental Health Commissioning Manager would be attending future steering group meetings.

Recommendation (s)

The Merton CCG Governing Body noted the update.

8.4 Out of Hours Review Report

JK presented this item and explained that the report had been commissioned by South London Cluster but was now slightly out of date. The report's recommendations would be considered by the CCG's Clinical Quality Committee and Out of Hours Working Group.

MC felt that the report was a good legacy of Cluster and its recommendations should inform the Out of Hours procurement service specification. The Governing Body supported this. **AS**

Recommendation (s)

The Merton CCG Governing Body noted and discussed the update.

8.5 Immunisation and Measles – Assurance Report

KE presented this item and stated that the current uptake of the MMR vaccination was 77%. In March 2013 there had been one case of measles reported in Merton but there was a risk of more cases due to the low level of immunisation.

HF was concerned with the Merton rate of immunisation compared to the general London rate and had hoped that the new GP contract would have addressed this. KE responded that a task group had been established with

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an action plan to work with Practices. KE also stated that there were some concerns with the accuracy of the figures and that recent improvements in MMR uptake had not yet been incorporated. It was hoped that up to date comprehensive figures would be available in September 2013.

Recommendation (s)

The Merton CCG Governing Body noted and discussed the report.

9. Governing Body Committee Reports

9.1 Audit Committee Report – 28th March 2013

Recommendation (s)

The Merton CCG Governing Body noted the report.

10 Approved Minutes of Committees of the CCG Governing Body

10.1 Merton Clinical Committee – 12th April 2013

JK commented that concerns remained about aspects of Community Services and the Committee would continue to pursue these with the Service.

10.2 Finance Committee – 19th March 2013

The minutes in section 10 were noted.

10. Any Other Business

There was no further business to discuss.

11. Meeting Dates for 2012/13/14

The Merton Clinical Commissioning Group Governing Body meets in public every two months.

Thursday 18th July 2013 at 120 the Broadway, Wimbledon, SW19 1RH

Closure of Part 1

The governing body resolved that the public now be excluded from the meeting because publicity would be prejudicial to the public interest by reason of confidential nature of business to be conducted in the second part of the agenda.

Agreed as an accurate account of the meeting held on Thursday 16th May 2013.

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Dr Howard Freeman

Chairman

Date: