South West London
Merton Clinical Commissioning Group
Sutton and Merton Borough Team

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

held on Thursday 27th September 2012
at

120 The Broadway, Wimbledon, London, SW19 1RH

Chair: Dr Howard Freeman
Present:

PA	Dr Paul Alford	Merton CCG GP Clinical Board Member
EB	Eleanor Brown	Chief Officer
MC	Mary Clarke	Nurse Member
VD	Dr Valerie Day	NHS SWL Sutton and Merton: Interim Public Health Director
PD	Peter Derrick	Lay Member: Chair of the Audit Committee/ Vice Chair
HF	Dr Howard Freeman	Chair / Clinical Leader
CG	Clare Gummett	Lay Member: Patient and Public Engagement Lead
GH	Dr Geoff Hollier	Merton CCG GP Clinical Board Member
KMcK	Karen McKinley	Chief Finance Officer
SP	Prof Stephen Powis	Secondary Care Consultant

Appointments to the governing body are designate until the authorisation of the CCG.

In Attendance:

AM	Dr Andrew Murray	Chair Merton, Sutton & Wandsworth LMC
MN	Mark Needham	Director of Commissioning and Planning
MW	Dr Martyn Wake	GP/ Joint PEC Chair

Supporting Officers

SH	Sima Haririan	Merton Healthcare General Manager
CJ	Charlotte Joll	Better Service Better Value Programme Director
JM	Jackie Moody	Head of the Business Support Unit: NHS SWL - Sutton and Merton

Members of the Public:

LM	Lucy Milton	Integrated Health Care Specialist. Leo Pharma

ACTION

1. Welcome and Apologies for Absence

The Chair opened the meeting by welcoming board members and supporting officers and members of the public. The meeting was taking place in public and questions from the public would be taken at the Chair's discretion.

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The Chair advised that Clare Gummett had been appointed Lay Member: Patient and Public Engagement Lead, the previous day and would be arriving later.

The Chair explained that Dr Andrew Murray, Chair Merton, Sutton & Wandsworth Local Medical Committee (LMC), was in attendance for the first time. He had been invited to attend Part 1 meetings as a participating observer and Part 2 meetings by invitation.

Apologies for Absence
There were no apologies for absence.

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 to declare interests in respect of items on the agenda if appropriate.

Prof. Stephen Powis drew attention to the fact that he is a Royal London Hospital NHS Foundation Trust board member.

Additional declarations were received during the meeting. These are noted in the minutes against relevant agenda items.

3. Minutes of previous meetings

3.1 To approve the minutes of the Merton Clinical Commissioning Group Governing Body meeting held on Wednesday 13th June 2012

The minutes were approved with a single amendment to item 1.

The appointment of the Director of Public Health would be made by NHS Sutton and Merton and transfer to London Borough of Merton in April 2013.

4. Matters Arising

There were no matters arising that were not on the agenda.

5. Chair's Update

The Chair updated the board on progress since the June meeting. This included the appointment of senior members of the organisation: Karen McKinley, Chief Finance Officer Designate, and Mark Needham, Director of Commissioning and Planning.

The CCG had received positive feedback from the mock site visit. Documents to support application for authorisation would be submitted on 28th September 2012.

The CCG Constitution had been circulated to member practices. 90% to date had signed to confirm their support.

The CCG had engaged widely through the 360°stakeholder feedback. The Chair thanked Sima Haririan for her support in following up responders.

ACTION

6. For Agreement

6.1 Draft Merton CCG Governing Body Terms of Reference (2012/13)

In April 2012 Sutton and Merton PCT resolved to establish a committee of the PCT for the purpose of devolving responsibilities to the Merton Clinical Commissioning Group (MCCG). The committee was known formally as Merton Clinical Commissioning (Delegation) Committee (CC(D)C). The CC(D)C terms of reference were to be reviewed once the emerging CCG had confirmed its constitution, governance arrangements, governing board membership with the member practices and an interim governing board had been established.

The duly revised terms of reference presented to the governing body at this meeting brought together the terms of reference contained within the CCG's constitution with elements that reflected areas of shared accountability with Sutton CCG, whilst in full shadow, as a committee of the Sutton and Merton PCT Board, the statutory body until 31st March 2013.

EB confirmed that the CCG would be continuing to work with Sutton CCG on the totality of the PCT budget and the Professional Executive Committee.

The Merton Clinical Commissioning Group Governing Body was requested to:
1. Approve the terms of reference for the Merton CCG governing body.
2. Note that, subject to the terms of reference being agreed, the final meeting of the Clinical Commissioning (Delegation) Committee will take place immediately after this meeting.

The recommendations were agreed and noted accordingly.

CCG Authorisation Evidence: 6.2-6.6

The Chair drew attention to the suite of documents being presented to the governing body for agreement in preparation for the application for authorisation.

The Merton Clinical Commissioning Group Governing Body was requested to:

1. Review and approve the attached documents.
2. Agree that amendments made as a result of this meeting, or subsequently, be approved by Chair's Action.
3. Agree that Chair's Action be taken on any other documents required for submission by the 1st October deadline. These will be presented to the next board meeting for ratification.

The recommendations were agreed for items 6.2 – 6.6. Comments and amendments are noted in the minute against each item.

6.2 Merton CCG Constitution

An earlier draft of the Constitution had been seen by the governing body in June. Since then document had been further developed and circulated

ACTION

more widely. AM confirmed that the LMC agreed that the document was fit for purpose.

In response to a suggestion from MC about ensuring that the vision and strategic goals in the Constitution cross referenced with those in the Integrated Strategic Operating Plan (ISOP), EB confirmed that this would be taken forward in the next iteration of the ISOP. **MN**

Pg. 41 Para 5.1.6 MC noted that this paragraph also applied to Paras 5.1.3; 5.1.4; and 5.1.5. **EB**

The item was agreed.

6.3 **Commissioning Support**

Merton CCG Structure

EB advised that the structure was as at a specific point in time and may change as the balance of functions being undertaken by the CCG and Commissioning Support Unit (CSU) was finalised within the £25 per head cost envelope. Discussion was ongoing with the CSU and other CCGs in South West London regarding models for managing continuing care and corporate governance in particular.

Re: Adult Safeguarding 0.4 WTE Band 7 post

MC highlighted that the seniority and WTE of the post may need to be reviewed in light of patient safety and quality issues raised by the Francis Inquiry and Winterbourne View Hospital report. EB advised that this is a shared post with the Local Authority and was still under discussion.

Re: Children Safeguarding Nurse

In response to a question from MW about how this post related to the current PCT arrangements, EB advised this would be a successor post and had been increased to 1 WTE from 0.5 WTE.

Re: Child Death Co-ordinator role

EB confirmed that this was a shared role with Sutton CCG. The structure would be amended to reflect this. **EB**

Re: Director of Quality post 0.5 WTE

MC sought clarification over whether this reflected the Executive Nurse role. EB confirmed that a nursing background was required for the post.

The Chair drew the discussion to a close noting that the chart would be updated as the structure developed. The updated structure chart would be brought to the next meeting. **EB**

Memorandum of Understanding with the Commissioning Support Unit

The Chair described work undertaken with the CSU and CCGs across SW London to bring the MoU to this point. The MoU had been co-produced by the CCGs and CSU to ensure that both were financially viable and credible organisations. Senior leaders in the CCG had supported and signed the MoU. The Chair requested the governing body to confirm their support.

PA sought assurance that the CCG was satisfied that the CSU was functionally viable. The Chair confirmed that the MoU represented positive co-working and was assured that the CSU wanted to work collaboratively

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with CCGs.

EB advised that:

- CSU leaders attended the monthly CCG Chief Officer's meeting.
- The full service level agreement was expected towards the end of October within which functions would be fully outlined.
- it should be borne in mind that, in shadow working arrangements, staff moving into roles within CCGs and CSU may have residual responsibilities to hold in the PCT.

MC declared an interest at this point in the meeting: in a second role at NHS London she worked on the PCT Assurance process.

MW asked where responsibilities for mental commissioning would lie. EB replied that it would hosted and managed by Kingston CCG on behalf of the five SW London CCGs, by CSU-employed staff.

SW London CCGs Framework for Collaboration with the CSU

EB stated that the document described a framework for CCGs in SW London to collaborate to support effective clinical commissioning. Together with the MoU with the CSU, it described ways of working in the future.

GH sought confirmation that the framework was considered to be a significant shift from historical ways of working with PCTs and that it would give greater influence to clinical commissioners.

EB responded that already operational mechanisms were in place for addressing issuse with the Acute Trusts. These would be strengthened over time.

6.4 **Committees of the CCG Governing Body - Terms of Reference:**

The Committee terms of reference were also contained in the Constitution document. There was a general action to ensure that the documents were cross-checked to ensure they matched. **EB**

Audit

PD commented that, given the scale of the organisation, it would be helpful if a finance committee element be incorporated into the Audit Committee. The Chair noted that this matter had been acknowledged in discussion at the cluster Finance Committee and Joint Boards.

The Audit Committee Terms of reference were agreed noting that they would be amended to reflect review of financial position and returned to the next meeting of the governing body for ratification. **KMcK**

Clinical Quality

MC requested that the governing body consider the role of the committee to review staff survey data as well as patient experience surveys (ref: 7.1.4). **EB**

The membership of the committee within the Constitution needed to be matched to the terms of reference presented and agreed.

AM sought clarification on the forum for involvement of clinical leaders

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from Acute Trusts. EB responded that they would be invited ad hoc to the Quality Committee. MW highlighted that there were existing mechanisms such as Clinical Quality Review Groups where matters could be tracked through with acute trusts.

PA raised a question about where serious incident monitoring and sign off of investigation reports would be carried out in future. The Chair responded that governance processes were under discussion and that clarity at the point of handover from the PCT would be required.

The Chair drew attention to the increasingly high profile duty for CCGs to improve primary care and suggested that this be within the committee's remit. The governing body agreed. **EB**

The terms of reference were agreed subject to amendments being made. They would be returned to the next meeting of the governing body for ratification.

Remuneration

These terms of reference were agreed without amendment however the Chair requested that consideration be given to setting up a Charitable Funds committee. This was because Sutton and Merton PCT had charitable funds for community use that were likely to pass to the CCGs.

PD expressed agreement that this committee be added to the structure. KMcK would draft terms of reference for agreement at the next meeting. **KMcK**

6.5 **CCG Organisational Working Arrangements, including terms of reference for:**

Executive Management Team (EMT)

VD requested that there be more explicit reference to the CCG relationship with Public Health to strengthen involvement mechanisms. EB and VD would take this forward. **VD/EB**

MC suggested that the CSU account managers be added to the membership. This was agreed. **EB**

MN noted that the terms of reference may be reviewed over time to strengthen governance around decision-making and providing assurance to the governing body with a clearer plan for delegation to EMT. **MN**

The terms of reference were agreed and would be returned to the EMT and governing body for agreement in the event that changes discussed were made.

Practice Leads Forum

EB explained that the terms of reference and the role of practice leads had arisen from discussion with clinicians about clinical leadership.

The Chair emphasised that this group would be a critical link between GP practices and governance structures. The proposed terms of reference were the best view at present recognising that understanding how the group might best operate would evolve over time.

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GH suggested that to ensure full attendance at the meetings there be more explicit reference to arrangements if the substantive member could not attend. For example, have nominated deputies that would attend instead. This was approved and would be amended. **EB**

PD queried where the roles and responsibilities around innovation and improvement would be covered. EB explained that this would be within the Clinical Reference Group. Also the CCG website would also provide a place for evaluation of new ideas in future.

The terms of reference were agreed subject to these amendments being made.

Practice Manager's Forum

The terms of reference were agreed with one amendment, to include generic roles under membership, not Practice Manager's names. **EB**

Practice Nurses Forum

MC requested that the membership include the fact that Nurse Board member may attend on an ad hoc basis. The terms of reference were agreed subject to this amendment being made **EB**

6.6 **Equality and Diversity Strategy 2012/16**

SH had been involved in developing the strategy and was invited to introduce this item by the Chair. The strategy built on existing work with the Sutton and Merton PCT Equality and Diversity Lead on statutory duties and local programmes such as the Health Diversity Programme in Merton. It set out the CCG's vision for embedding equality and diversity in future commissioning and employment practices and took account of the statutory duties the CCG would hold once authorised.

During 2012/13 the CCG would continue to base its objectives on those set through the grading process undertaken jointly with the PCT and external stakeholders.The CCG would continue working with established and developing stakeholder groups to publish its own action plan on an annual basis from April 2013.

VD declared an interest relating to her team's input to the demographics section then highlighted, from the ' Reducing inequalities' section (pg.8), that there were issues other than social class that impact on infant mortality and low birth weight in Merton. For example, other protected characteristics.

Board members congratulated SH and those who had brought the strategy to this point, noting that it had been well received at the mock site visit for authorisation.

The strategy was agreed.

6.7 **Risk Management Framework 2012/13: position statement**

EB explained that the CCG is required to submit to the National Commissioning Board its approach to risk management as part of the emerging CCG's application to the NHS Commissioning Board for

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authorisation. The paper provided a position statement confirming the intention to adopt the NHS South West London (NHS SWL) Risk Management and Assurance Policy during 2012/13, whilst Sutton and Merton PCT remained the statutory body.

The governance arrangements for 2012/13 were noted. The CCG would be in a risk share arrangement with Sutton CCG until 31st March 2012. The CCG would be developing its own corporate objectives and risk management and assurance policy for 2013/14 onward.

PD emphasised the need to identify key risks for the CCG post-authorisation. EB advised that further development would be undertaken with input from governing body members.

Recommendation
The Merton Clinical Commissioning Group governing body was requested to note the CCG's approach to risk management in 2012/13.

The Chair requested the governing body to agree the paper. The item was agreed.

6.8 **Draft Integrated Strategic Operating Plan (ISOP) 2012/13 to 14/15**

This paper provided an update on progress of the development of the ISOP and the expected delivery timeframe for final submission to the Board. The ISOP is the combined Commissioning Strategy and Operating Plan for Merton CCG derived from current PCT strategies and incorporating CCG commissioning aspirations. It is a key document for to achieve the CCG authorisation as an independent statutory body.

MN described the 170 page document as summarising the DNA of the CCG. It set out how it wished to work with other organisations in a sustainable health economy as a clinically-led and membership organisation. The iterative nature of the document would allow for further input from CCG member practices and the Board in October however it was necessary to upload the present version as part of the suite of authorisation documents by 28th September.

Recognising the medium term nature of the current version, PD suggested that, whilst keeping a focus on key issues – such as CCG vision and financial constraints - future documents be more succinct. This was supported by board members. MN commented that more accessible summary versions could be available for different audiences, including the general public.

MN

Recommendation
The Merton Clinical Commissioning Group governing body was requested to agree to Chair's Action on the full document.

The governing body agreed the recommendation and that the current version be submitted as part of authorisation evidence. It was noted that further development of the ISOP and Board discussion on Quality, Innovation, Productivity and Prevention (QIPP) would take place in October.

ACTION

6.9 Better Services Better Value (BSBV)

Charlotte Joll, BSBV Programme Director, introduced this overview and update on BSBV. The history of the programme, the case for change and timelines for the next steps were outlined. Through the presentation the BSBV programme board was seeking the governing body's written support to go out to consultation on the plans. The letter would be attached to the Pre-Consultation Business Case (PCBC) that had been already supported by other CCGs, including Sutton.

Particular attention was drawn to the changes necessary to address the financial challenge facing SW London CCG s. An annual saving of £70 million needed to be achieved by 2016/17 because demand growth exceeded increase in income.

Provider trusts would be expected to make savings in addition to the standing Cost Improvement Programme (CIP) to achieve a 1% surplus to satisfy the requirements of Monitor for Foundation Trust status. The Chair questioned the slide which showed the SWL acute provider financial challenge which suggested that St Helier would be showing a net deficit of £11.5m. (CJ agreed to check this figure and has since confirmed that this figure referred only to St H
elier Hospital and not Epsom and St Helier and included some additional costs associated with the St Helier redevelopment).

A summary of local plans and investment in out of hospital care was provided and the potential savings shown. The financial imperative for acute service reconfiguration was outlined including reference to Safe and Financially Effective services (SaFE) on which approved levels of clinical/consultant level was based.

The Chair questioned the use of SaFE because it was not a widely known process in SW London. CJ acknowledged this and responded that it was used as a proxy to approximate the level of investment required.

CJ outlined the next steps for the PCBC and consultation, noting that there had been a delay to the start because governance arrangements were having to be changed as a result of NHS Surrey wishing to join the consultation process.

A rigorous, careful and exhaustive process to decide how best these changes could best be delivered had been undertaken. It was acknowledged that the local community were concerned and angry about the proposals, however it was necessary to go out to consultation with all stakeholders and a public engagement programme had been developed.

Claire Gummett arrived and this point in the discussion.

The Chair invited comments and questions from governing body members.

The Chair raised a question about which bodies were going out to consultation. CJ advised that the consultation was currently under NHS SW London governance arrangements recognising the CCGs were the commissioners of the future. Governing body members supported the Chair's suggestion that the decision-making committee be chaired by a CCG Chair and that this would be a condition for Merton CCG confirming

ACTION

their support for the consultation. **CJ**

It was noted that in Surrey, although NHS Surrey was the formal body it was likely that NHS Surrey Downs CCG would wish to be closely involved. MC sought clarification on whether NHS Surrey Downs CCG was required to provide a letter of support. CJ responded that a meeting would be taking place in the following week at which this would be confirmed.

CJ

PD commented that there may be other CCGs in Surrey that had an interest in BSBV, and supported to view that CCG Chair lead.

The Chair highlighted financial issues that would arise for CCGs should BSBV proposals be taken to Judicial Review. This would be unaffordable for CCGs and would put organisations at risk of failure. He had requested that NHS SW London give assurance that costs related to a potential judicial review be covered post April 2013. Confirmation of the position had not been received to date.

MC commented that JR also required a high level of manpower to support.

In response to a question from SP about whether other CCGs had raised similar matters, CJ advised that they had not. The NHS Surrey question had arisen after their letters of support had been received.

EB noted that CCGs wished to work together on BSBV but would require risk share arrangements around these specific elements.

BSBV would be discussed at the NHS SW London Joint Boards of five PCTs immediately after this meeting. As a Non- Executive Director PD advised that he would suggest at that meeting that legacy funding be put aside separate from PCT/CCG budgets.

PA supported this and declared an interest because he has worked on BSBV over the previous eighteen months.

MN drew attention to the link between the out of hospital plans in the ISOP and BSBV.

EB sought clarification about how BSBV interfaced with the St Helier Hospital's Future Project. CJ responded that there were two proposals within the St Helier futures project that were at variance with the BSBV models which related to maternity services and acute medical beds. It was noted that meetings were being set up with St Helier Hospital to look at potential alignment and differences.
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The Chair agreed that it was critical to link these: the consultation would be difficult for the public and Merton CCG and bringing the two together may ameliorate the situation to some degree. In response to the suggestion that the St Helier's Future Project be brought into the consultation, CJ advised that the project was not sufficiently developed at this stage and that going out to consultation on current BSBV models would not preclude change and what would be implemented in the future.

MC supported adjusting BSBV proposals to include the Project if possible

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and sought assurance that innovative methods of consulting with the public were being devised. CJ would circulate the communication plan.

CJ

MC requested that an in depth equality impact assessment be undertaken. The integrated impact assessment would be circulated.

CJ

AM drew attention to the fact that, due to financial pressures, the CCG needed to be fully aware of the detail of the consultation and how it correlated with the CCG's own plans. KMcK advised that that all CCG Chief Finance Officers were involved.

Recognising the degree of difficulty of the questions being addressed VD expressed support for the questioning the wisdom of proceeding with consultation when a key factor, the St Helier Hospital Future project was still under development.

Also, the interface between BSBV, CCGs (individual GPs and the organisation as a whole), the local authorities and the PCT was not clear For example, CCG requirements may be quite different from those of the PCT.

The Chair agreed, saying that the CCG would have a statutory requirement to work with the local authority and Health and Wellbeing Board. It was known that the local authority did not currently support BSBV proposals.

MW highlighted that the Chair of the NHS SWL Joint Boards needed to be aware of the CCG's concerns. CJ noted that a Joint Board discussion on the draft establishment agreement would take place that day. The agreement had been circulated to CCGs and stakeholders. It recommended that representative from all seven CCGs be on the committee. This would enable CCGs to influence processes.

CG suggested that it would reflect better on the CCG if patients and the public were aware of all possibilities around St Helier Hospital at the time of the consultation.

Regarding NHS Surrey, EB asked for assurance that they were fully committed, were contributing to funding BSBV and that their own modelling for the future was understood. CJ confirmed that financial contribution had been raised and acknowledged that specific models may differ.

SP gave his perspective on a number of the elements discussed stating that financial and quality reasons for review of services were clear, however further clarity on governance and risk around Transition was required for 2012/13 and post 2013/14. The delay to consultation be difficult but it was important that it was done well and if substantial options were arising from with the health system it did not make sense to not include these in the consultation

CJ advised that the Post Consultation Business Case would provide opportunity to include changes.

The Chair drew discussion to a close, summarising as follows:

- if the consultation is t be CCG led, it must be that throughout and

ACTION

the BSBV team will need to develop a new way of working with CCGs
- there has to be some form of under-writing any costs accrued to the CCG as a result of the consultation
- The need for service change and consultation is agreed but the CCG would wish to understand in greater depth the implications of the further options that might arise from the St Helier's Future Project and whether this would change current consultation plans **CJ**
- During this transition year there is an assumption that plans would require endorsement by the National Commissioning Board
- NHS Surrey must be involved on the same terms as other CCGs and the financial element must be resolved.

Governing body members concurred with this summary.

Recommendation
The Merton Clinical Commissioning Group Governing Body was requested to provide written support for Better Services Better Value to go out to public consultation.

The governing body agreed to re-consider the recommendation at a later date subject to the points raised being addressed and discussed with the Chief Officer and Chief Financial Officer.

6.10 **Financial Position: Month 05**
Merton CCG and Sutton and Merton PCT

KMcK introduced the report which contained the financial position for the CCG and the PCT recognising the risk share with Sutton CCG in 2012/13. She explained that the format of the report would develop to reflect CCG specific requirements and to bring QIPP and Finance reporting together. **KMcK**

Key financial risks were identified as over-performance in the acute sector and slippage on the QIPP programme. Local acute Trusts were working with the CCG/PCT to address the challenges and to confirm cap and collar arrangements.

The CCG and PCT have contingency, reserves and a planned surplus that will be used to mitigate many of the in-year risks.

The financial performance shows a year to date deficit against plan and a full year breakeven against plan, due to phasing of the overall QIPP plan.

Forecast Outturn - The PCT was reporting breakeven at Month 5.

The Chair drew attention to the pressure from the acute Trust and that reserves being used by the PCT in 2012/13 would not be available to CCGs going forward.

Recommendation
The Clinical Commissioning Group Governing Body was requested to review and agree the financial position.

The item was agreed.

ACTION

6.11 **Merton Quality, Innovation, Productivity and Prevention (QIPP) Report**

KMcK introduced the report and drew attention to the degree of slippage on schemes. EB confirmed that all schemes were being reviewed to assess the position and identify ways to mitigate the risks.

MN noted that the work on Long Term Conditions was important to continue but unlikely to realise financial benefit in 2012/13. He also suggested that it may be beneficial in future to have fewer but more cost effective schemes.

In response to a question from MC about effective commissioning of continuing care KMcK responded that there were no concerns.

PA emphasised the need to pursue cap and collar arrangements with the acute Trusts.

In future Finance and QIPP reports would be together as one item.

Recommendation

The Clinical Commissioning Group Governing Body was requested to review and agree the latest Merton CCG QIPP report.

The item was agreed.

7. To Receive and Note

7.1 **Chief Officer's Report**

The report was noted.

Items 7.2 and 7.3 were re-positioned on the agenda.

7.4 **NHSSM Performance Management Report: Month 04**

The Merton Clinical Commissioning Group Governing Body was requested to consider the scorecard and agree any actions.

The report was noted.

7.5 **Implementation Plan Update- Communication and Engagement Strategy**

The update on progress was noted.

7.6 **Merton Borough Business Support Unit Activity Report – Q1 2012/13 Apr- Jun 2012**

The report was noted.

7.7 **Better Healthcare Closer to Home: Nelson LCC and the Mitcham LCC – Highlight Report**

The report was noted.

The Chair advised that planning permission has been granted for the development of the Nelson Hospital site.

ACTION

8. Any Other Business
There was no other business discussed.

9. Date of the next meeting
The next meeting ordinary meeting of the governing body would take place on 22nd November 2012.

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 27th September 2012

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Dr Howard Freeman

Chairman

Date: