right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MINUTES

MERTON CLINICAL COMMISIONING GROUP

GOVERNING BODY PART 1

29th September 2016
Chaucer Centre, Canterbury Rd, Morden SM4 6PX
1.00pm – 3.45pm

In attendance:

Voting Members

PD	Peter Derrick	Lay Member: Audit and Finance /Vice Chair
AD	Adam Doyle	Chief Officer
CG	Clare Gummett	Lay Member: Patient & Public Engagement Lead
JH	Julie Hall	Nurse Member
TH	Dr Tim Hodgson	GP Member (left meeting at 3.40pm)
AH	Andrew Hyslop	Chief Finance Officer
AM	Dr Andrew Murray	Clinical Chair
SP	Prof. Stephen Powis	Secondary Care Consultant (joined meeting at 1.45pm)
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM

Non-Voting Members

LS	Lynn Street	Director of Quality and Governance, MCCG
KP	Karen Parsons	Deputy Director of Commissioning Operations
JF	Julie Freeman	Director of Primary Care Strategy – London-wide LMCs (Deputising for Dr Marek Jarzembowski – left 1.45pm)

Other Officers in Attendance

DC	Thereasa Burns	Corporate Affairs - SECSU
CC	Chris Clark	Director of Performance, Planning and Informatics
SL	Sophie Lyon	Communications & Engagement - SECSU
MW	Michelle Wallington	Principal Assoc. Communications & Engagement - SECSU
TF	Tony Foote	Note Taker – SECSU

Members of the Public in Attendance

Graham Barker	Merton Residents Healthcare Forum (PEG Member)
Logie Lohendran	Merton Senior Forum
Maurice Groves	Merton Resident

Apologies:

Dr Carrie Chill	GP Member
Dr M Jarzembowski	Chair, Local Medical Committee

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	Dr Andrew Murray (AM) welcomed all to the meeting and noted the apologies for absence received.	
2.	**Declarations of Interest**	
	No interests additional to those currently shown on the Register were declared.	
3.	**Minutes of Previous Meeting**	
3.1	To approve the minutes of Part 1 of the meeting of the Merton Clinical Commissioning Group Governing Body of the 21st July 2016.	
	Clare Gummett (CG) requested that the reason for being unable to attend the July meeting (a change to the original date) be noted in the minutes. This was agreed. The Governing Body **APPROVED** the minutes as a full and accurate record of the meeting.	
4.	**Matters Arising and Action Log**	
4.1	Actions arising from the Merton Clinical Commissioning Group Governing Body of the 21st July 2016. (numbers shown as per action log)	
	The Governing Body noted that the following actions were now complete: 10; 2; 7.2. The following verbal updates were also received: 6.1 <u>Primary Care Strategy</u> Karen Parsons (KP) informed the meeting that the consultation process was due to end on September 30th and that feedback would be collated and used to inform a further draft of the Strategy. AM asked when the Governing Body could expect a further substantive update and KP confirmed that one would come to the November meeting. 6.3 <u>Estates Development Plan</u> KP confirmed that work was continuing to align commissioning intentions with estates and that she would provide a more comprehensive update to the next Governing Body meeting.	**KP** **KP**

5.	Chair's Update and Chief Officer's Report	
5.1	Chair's Update	
	AM highlighted the following areas of his update: <u>Leadership changes</u> AM stated that AD (Adam Doyle) would be leaving his role of Chief Officer for the CCG, with a last working date of 19th October 2016. AM added that AD had brought enthusiasm, insight and dedication to the CCG and the people of Merton, nurturing the talents of a fantastic team of staff and making sure that patients were always at the heart of the CCG's work. He had helped steer the organisation through some particularly difficult times recently and on behalf of the Governing Body AM thanked AD for his dedication and for ensuring the financial outlook for Merton CCG was in a more positive position than might have been expected As the CCG was entering a period of transition it was important to maintain focus on providing the best possible heath and care for local people while also delivering financial sustainability. Accordingly, AM announced that KP, current Director of Commissioning Operations, would be taking on the role of Chief Officer until the end of the financial year. AM added that KP had a wealth of experience having most recently been the Chief Operating Officer at Surrey Downs CCG. Sue Hillyard was also moving to a new role nearer home in Yorkshire. Sue joined the CCG in January to lead a number of key work programmes for the CCG. AM thanked her for all her great work during the year. The Governing Body members took this opportunity to also thank AD for his efforts: Dr Tim Hodgson (TH) said how much he had enjoyed working with AD. Peter Derrick (PD) complimented AD on his great energy and lateral thinking, and that he had been a pleasure to work with. CG commented that AD's support of patient and public engagement had been invaluable. Dr Dagmar Zeuner (DZ) thanked AD for his efforts in promoting integration between the CCG and the Local Authority. KP and Lynn Street ((LS) also offered their thanks to AD. <u>Better Care Fund (BCF)</u> AM explained that in November 2015 it was announced that Councils which provide Social Care to Adults would be allowed to increase their share of Council Tax by up to an extra 2% if it was all used to fund the increasing costs of Adult Social Care services. This was known as the 'Adult Social Care precept'. A total of 144 out of 152 London boroughs, counties, metropolitan districts and unitaries in England will have deployed the adult social care precept over 2016-17. However, in 2016/17 Merton Council froze council tax and so did not apply an annual increase in council tax nor add on the Adult Social Care precept. AM stated that he and AD had met with Merton Council colleagues and made the following points:	

	• For 2017/18 the CCG would not be in a position to provide any extra investment above the mandated contribution into BCF. • For 2017/18 the CCG will also need to consider whether it can even invest the full mandated amount. • That Merton Council should as a minimum deploy the Adult Social Care precept in 2017/18 • That the CCG encouraged Merton Council to provide additional investment in Adult Social Care and noted that raising council tax would facilitate this. • That the CCG would consider extra joint investment into BCF projects with the Council only if it was satisfied that the Council was providing adequate funding for social care (including use of the precept for this purpose) and confident that there would be demonstrable savings on the wider CCG spend as a result of any investment. • Merton CCG would respond to Merton Council's consultation on council tax and would share this with the Governing Body prior to doing so. AM then asked Governing Body members for their views on the CCG's position. DZ, stating that she could not speak directly on behalf of the Local Authority, commented that the decision made by Merton Council had been done so by elected members and so must be respected. DZ added that it was also important for the CCG and the Local Authority to maintain good relations and AM agreed with this. Members appreciated the importance of a clear mandate for AM and AD to take this matter forward and **APPROVED** the following: • The suggested approach on taking forward discussions with Merton Council • Using the points in the Chair's Update in the CCG's response to Merton Council's consultation on council tax • Using the points in the Chair's Update when engaging with stakeholders and partner organisations The Governing Body **NOTED** the Clinical Chair's Update.	
5.2	Chief Officer's Report	
	AD highlighted the following areas of his update: <u>Staffing Changes</u> AD welcomed the newly joined staff, as mentioned in his update and mentioned in particular Andrew Moore (Programme Director for Financial Recovery) who had already brought additional rigour to the Financial Recovery Plan. In addition to the changes contained in the update, AD stated that in recognition of how challenging the forthcoming Planning Round was likely to be Chris Clark had been appointed Director of Performance, Planning and Informatics for the next 6 months. In light of his imminent departure from the CCG, AD's role of Governing Body	

	Lead for Children's Safeguarding would be taken over by LS. This action was supported by both the Merton Safeguarding Children's Board and the local authority. AD then took the opportunity to thank the Governing Body for its support during his time at the CCG. He acknowledged the chairmanship of AM and the all-round strength of the Governing Body with both its encouragement and appropriate challenges. AD also said he was confident that the CCG would be in good hands with the very strong and capable team of directors and staff. The Governing Body **NOTED** the Chief Officer's Update.	
6.	**Quality and Performance**	
6.1	Minutes of Clinical Quality Committee: 06.07.16; 12.08.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	The minutes were noted and CG provided the following verbal summary. <u>Kingston Hospital</u> Following the Care Quality Commission's inspection of Kingston Hospital NHS Foundation Trust Hospital, and its report indicating "Requires Improvement" particularly in A&E, medical care, older people's care, CCG along with the Head of Quality made an announced visit to the Trust in July. They visited A&E, Maternity and the Older People's Unit. It had been a particularly quiet day for A&E and maternity, so it was not possible to get a true feel for them, but both had been impressed by the staff and services on these wards. However, CG and the Head of Quality, had been less impressed with the older people's unit which was cluttered, crowded and very noisy although it was acknowledged that there were plans to build a new state of the art ward in the near future. CG added that Duncan Barton, Director of Nursing, had attended the August Quality Committee meeting and had said that he had not been surprised by the recent CQC report. He had added that the Trust was seeking more nurses by recruiting in the Philippines and Europe, and providing a two week induction and on-going training. <u>St. George's</u> As stated in the Clinical Chair's update, St George's was not formally reporting nationally their waiting time performance for Referral to Treatment. The Clinical Quality Committee was, therefore, not confident of the waiting times reported by them and would not be fully assured until the system failures at the Trust were resolved. <u>100 Day Cancer Waiting Time Breaches</u> CG stated that the Governing Body was very concerned that the 100 day breaches had occurred over a considerable length of time. Although assurances had been given that this matter was being monitored, this was not sufficient and concerns remained that patients' care and treatment were being affected by these breaches. CG understood that the Director of Quality and Governance (LS) had put Contract Performance Reporting in place and the Clinical Quality Committee would continue to monitor this closely.	

	MIAPT CG said that the Clinical Quality Committee was pleased that since May 2016 this service has met the national waiting times target and this is expected to continue. The key focus now was on achieving the recovery rate target which had dropped for the last two months of reporting, including communication and engagement with GPs to understand why people were not being referred in to the service. This service, together with Complex Depression and Anxiety Service (CDAS) were vital for many in the community, but take up remained a challenge. Accordingly, it feels that the service is not reaching those requiring help in the best way. Work is being done to improve the situation and this will be monitored. KP agreed that this service was causing concern. A recovery plan was in place and, as part of this a stocktake was undertaken that highlighted ten areas for further development. Continuing Healthcare (CHC) CLCH has started to provide the CHC service for Merton, but does not currently have the capacity to deliver some of the key transformational pieces. Specifically, the high calibre nursing posts required, which appear to be very difficult to recruit to. This is one of the largest risks to service delivery and an area of continuing concern. The CHC panel meets regularly and has made a vast difference as, in the past, assessments have been poor and a correct assessment is vital. The Clinical Quality Committee continues to receive monthly updates on this service. Safeguarding Adults The annual Safeguarding Adults Report has been received. This had provided some level of assurance, but there remained some confusing figures supplied by the Local Authority regarding Deprivation of Liberties. The Clinical Quality Committee has requested further information on this issue and for future reports to include more detailed information and figures to provide a fuller assurance of adult safeguarding. The Governing Body **NOTED** the Minutes of Clinical Quality Committee (06.07.16; 12.08.16) and the summary from the Committee Chair.	
6.2	CCG Month 03 Quality/Month 04 Finance & Activity Report	
	KP informed the Governing Body that this report provided an update on CCG achievement against national and local performance and quality standards (at Month 3); finance performance (at Month 4); and contract activity performance (Month 4). Where available, more recent quality performance information may also be included in the report for areas where an exception report had been provided. The report covered the four main domains as defined by the NHS England CCG Improvement and Assessment Framework 2016-17. These were: Better Health, Better Care; Leadership and Sustainability. The report itself had been further refined following comments and suggestions by the Governing Body.	

	• Scorecards showing areas of risks for the Better Health and Better Care domains – along with key local indicators – were included, along with exception reports. • A scorecard showing financial performance, along with key risks and mitigations were shown. • The Sustainability and Leadership sections will be included as further information and guidance was released by NHS England. • The activity performance section had been further developed. The activity summaries for general and acute specialties (referrals; first and follow-up outpatient attendances; elective and emergency admissions); and A&E attendances had been provided as at Month 4 in this report. Additionally, a commentary on significant variances from planned activity has been included. AM welcomed the changes to the report and thought it was now in a really helpful and clear format. He thanked Chris Clark for his work on this. AD commented that it was encouraging that the issues contained in the report were also those being considered by the Clinical Quality Committee, and that this showed a good level of integration. CG noted the inclusion of finance information and that this helped to provide a fuller picture. The Governing Body **APPROVED** the CCG's Month 03 Quality/Month 04 Finance & Activity Report.	
6.3	Patient Stories	
	LS asked CG to introduce this item. CG welcomed the introduction of Patient Stories to the Governing Body agenda and that it would help all focus on the patient. She added that although the story was a personal on, it was likely that any concerns expressed would be shared by other patients. LS then read out the patient's story that concerned the care provided by the District Nursing Service. The patient was general very content with the care provided although had some concerns arising from occasional difficulties when trying to contact the service. The full version of patient's story is attached at appendix one of these minutes. AM asked how Community Services (provider of the District Nursing Service) made use of feedback such as patient stories. LS confirmed that this was a standing item on provider meeting agendas. The Governing Body **NOTED** the Patient Story.	
6.4	EPRR Self-Assessment Audit 2016-17	
	LS explained that all NHS organisations were required to carry out an annual self-assessment against NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and submit their assessment to NHSE. Presented to the Governing Body now was the final formal return of Merton CCG's EPRR Assurance to NHSE for 2016/17. It had been reviewed and	

	updated by South East Commissioning Support Unit on behalf of the CCG, based upon the updated EPRR progress made since last year. For 2016/17 the CCG had only one “amber” outstanding action and with the training and exercising sessions now arranged (see paper for details) this rating should become “green” following review in December 2016. This would then change the CCG’s overall rating from the present “Substantial” to “Full.” TH asked how the CCG was able to assure itself on this matter. LS responded that this was achieved by assurance from all the CCG’s providers and she was content that this had been provided. The Governing Body **APPROVED** the EPRR Self-Assessment Audit 2016-17.	
6.5	Conflicts of Interest Policy	
	LS presented this item and informed the Governing Body that in June 2016 NHS England issued revised statutory guidance on managing conflicts of interest for CCGs. The aim of these revisions was to strengthen the CCG’s ability to identify and manage conflicts of interest and increase public confidence in decision making processes. The CCG’s Conflicts of Interest Policy had been updated to reflect this revised guidance and the specific amendments made were shown in the paper presented. PD highlighted the need to find a balance between transparency and confidentiality. AD stated that the CCG would be appointing a Conflict of Interests Guardian who would act as a safe point of contact for any queries from staff. PD referred to the proposal that a third Governing Body Lay Member be appointed. AD said that this had already been discussed by the Governing Body but, in light of the forthcoming significant changes and the move towards collaborative working, no decision had yet been made to go out to appoint this role. The Governing Body **APPROVED** the Conflicts of Interest Policy.	
6.6	Merton CCG Patient & Public Involvement Report 2015/2016	
	LS explained that the report presented demonstrated how the CCG had involved patients, members of the public, local communities, carers, local groups and organisations in shaping health services in the borough between 1 April 2015 and the 31 March 2016. The CCG had fulfilled its statutory obligation to involve patients and the public in commissioning activity, including both individual and collective duties. LS highlighted the large public events that had been held and also the statement by Healthwatch Merton which acknowledged the good work undertaken by the CCG. CG thought the report was excellent but suggested that future reports capture more of the regular on-going involvement as well as the high profile one-off events. AM welcomed the report as very encouraging and was impressed at the high level of engagement activity. He asked what lessons could be learnt from this activity. LS accepted that improvement was always possible and that more could still be done in reaching black or minority ethnic communities. DZ	

	suggested greater collaboration between the CCG and the Local Authority on engagement and that this could assist in involving hard to reach groups including teenagers. AM asked that targets to engage better with harder to reach groups were included in the Engagement Strategy. The Governing Body **APPROVED** the Patient & Public Involvement Report 2015/16.	**LS**
6.7	Safeguarding Adults Q1 (2016/17) Report	
	LS stated that the Quarter 1 report (Q1) set out the CCG's safeguarding arrangements and activity within commissioning and provider services across the whole health economy of Merton. It provides the Safeguarding Executive Group with assurance that the CCG is meeting its statutory duties and requirements for safeguarding adults at risk. The report also outlined progress made in priority areas. Including: • Assurance • Training • Prevent • Safeguarding referrals and Mental Capacity Act and Deprivation of Liberty Safeguards activity data • Safeguarding activity The Governing Body **APPROVED** the Safeguarding Adults Q1 (2016/17) Report.	
6.8	Safeguarding Children Q1 (2016/17) Report	
	LS informed the Governing Body that the Q1 report provided assurance to the CCG that, as a commissioner of healthcare services, it had effective arrangements in place to safeguard children and young people. All actions identified in the Q4 2015/16 report had been achieved in Q1 2016/17. LS acknowledged the still outstanding need to appoint a named safeguarding doctor. It had been agreed internally that this function would be incorporated into a Clinical Lead role and she was continuing to explore this option. As an interim arrangement the Designate Nurse has covered the key functions of the role. Professor Stephen Powis (SP) enquired about the issue of level 3 safeguarding training at CLCH, the provider of community services in Merton. LS explained that CLHC had inherited a low level of this training amongst staff from the previous provider and they had submitted an action plan to achieve compliance. The Governing Body **APPROVED** the Safeguarding Children Q1 (2016/17) Report.	
7.	**Commissioning and Operations**	
7.1	Commissioning and Operational Planning for 2017/18 and 2018/19	

KP said that the paper presented summarised the NHS England requirements for all CCGs to deliver operational plans and negotiate provider contracts by December 2016 that will determine the delivery of locally commissioned care in 2017-18 and 2018-19.

The paper provided a route-map from August to December 2016 with all CCG key milestones in developing commissioning intentions, activity modelling and growth forecasting, QIPP planning and the Contracting process. This was shown in four areas:

Local Commissioning Intentions (Proposed)
The CCG had recently reviewed all care delivered in Merton and collated all commissioning ideas to feed into proposed local commissioning intentions within the following specific categories:

- Planned Care
- Unplanned Care
- Medicines Optimisation
- Other Commissioning Intentions

In addition to local intentions, much of the commissioning for 2017-18 and beyond will be determined by the Southwest London Sustainability and Transformation Programme (STP). As part of the Southwest London transformation work the CCG had identified the following areas of planned care where an opportunity for better value for money had been proposed through the Right-Care programme (values shown were estimated savings opportunity if delivered within 2020):

- Rheumatology (Biological Drugs) – estimated at £466k
- Community Audiology and Hearing Aid Services (Outpatients) – estimated at £421k
- Digestive System Procedures and Disorders (Elective) - estimated at £440k
- Eyes and Periorbita Procedures and Disorders (Elective) - estimated at £93k

Once early STP plans were published in September, the CCG would be able to agree and publish its high-level commissioning intentions. However finalised detailed commissioning plans (agreed at Southwest London regional level) will not be completed until the final STP plan is submitted on 24th October 2016.

Completion Date: 15.09.16 – Achieved

Activity Modelling for 2017-18 and 2018-19
It was expected that a month 4 freeze and month 5 flex position would be available at the time modelling needs to be completed. Accordingly, the CCG would focus on a 6-month rolling run-rate to make the best prediction of trends in activity to the end of 2018-19. This would take into account QIPP plans for 2016-17 to give a forecast outturn and an unmitigated activity projection for 2017-18 and 2018-19.

Completion Date for Unmitigated Activity Model: 12.09.16 - Achieved
Completion Date Operating Plan: 31.10.16 – In progress

	Applying QIPP, Savings and STP Transformation Plans To build the final operating plan, the Performance and Informatics team will work closely with the Finance and Commissioning teams to quantify the real-terms effect of transformational plans on activity at a point-of-delivery and provider level. In some cases the effect of QIPP schemes may also need to be quantified at a speciality and even HRG level. QIPP schemes with an in year effect for 2017-18 and 2018-19 are currently under continuous development as new savings opportunities are identified and quantified. The earliest sight of the STP planning is likely to be around the middle of September 2016, with finalised plans being signed off on 24th October 2016. Following this milestone there should be a clear quantified mitigation effect on operating plans. Completion Date: 24th October 2016 – In progress Negotiating and Agreeing Contracts Due to the shortened commissioning window and the need to secure appropriate contracted activity for the next two years, it is possible that the structure of provider contracts will look considerably different to previous contracts. In particular commissioners were more likely to look to commission PODs of care as a block (e.g. Urgent care), with any adjustment for QIPP and CQUIN. The CCG has briefed the CSU of this requirement and the CSU had agreed to provide the resource necessary to analyse activity data in preparation for contracting. Completion Date: 31st December 2016 There followed comments and questions from the Governing Body. PD acknowledged the value in working across South West London with regard to acute contracts and also the clear importance going forward of the STP. He wondered what the impact of this would be upon South West London Collaborative Commissioning. AD commented that the CCG would be notifying providers tomorrow about the commissioning plan and accepted that more thought was needed about how the CCG would work with its partners in South West London. However, he stressed that the CCG was in a good position due to its understanding of the situation. PD then asked about the “road-map” diagram for the stated work and whether it would include and patient and public engagement. AD responded that the CCG’s on-going engagement showed that the Commissioning Planning reflected the public’s general concerns although robust engagement would be needed to finalise the details. KP agreed with this and that engagement would come later in the process. AM added that each piece of work would be treated as an individual project and engagement would be a built-in part of the process. The Governing Body **NOTED** the Commissioning and Operational Planning for 2017/18 and 2018/19.	

7.2	Evaluation of Commissioned Services	
	KP explained that the review of Effective Commissioned Services formed a significant part of the CCGs Financial Recovery Plan. In July 2016, the Governing Body agreed to review all commissioned services and procedures within an equitable, open and transparent process that realised benefits for the whole population of Merton matched against need and the available budget. Accordingly, three work streams had been developed as part of this programme: • Prior Approvals • Effective Commissioning Initiative Criteria • Review of Acute and Non Acute Services/Procedures <u>Prior Approvals</u> South West London CCGs were currently using the 2014/15 criteria for some referrals classed as 'Prior Approval' before proceeding with the procedure. However, this was not currently being applied consistently by GP Practices. Prior Approvals have been prioritised by the CCG's Clinical Reference Group and the process is being rolled out in GP Practices who will be informed of the CCG's expectation that the Prior Approval process will be followed. Savings were difficult to estimate. <u>Effective Commissioning Initiative (ECI) Criteria</u> The SWL CCGs have worked with the South East Commissioning Support Unit (CSU) to examine the current ECI policy list and it was clear that the existing policies were due for review and, due to a lack of specificity in some of these, such reviews would require use of the most recent available clinical evidence. This process may require the SWL CCGs to engage with stakeholders. <u>Review on Acute and Non Acute Services/Procedures</u> The SWL STP Chief Officers have set up a number of delivery groups. However, these have not yet been mobilised and so Merton CCG, so as to maintain momentum, continues to progress this work. KP added that the paper presented also included a list of procedures which Richmond CCG's Governing Body had approved; its aim was to increase thresholds and disinvestment. The Governing Body was asked to review and decide if Merton CCG should follow decisions made by Richmond CCG without running them through its own process. KP explained that the Governing Body was being asked to consider the following: 1. Agreeing the CCG's approach to Prior Approvals and ECIs 2. Agreeing to align the CCG's process with the other SWL CCGs 3. Agree to support one of the following options: Option 1: Review Richmond CCG's efficiency options and agree to allow EMT to	

	implement the thresholds and disinvestment given in Table 1. EMT would review the impact in relation to the pathways and assess risks to these. Option 2: The CCG to continue with its own process for areas reviewed and agreed by Richmond CCG and take them through the agreed Decision Tree. Finally, KP referred the Governing Body to the list at Appendix 4 of the paper that showed the Merton services currently being reviewed by the CCG. AM asked how this list had been decided upon. AD stated that all services had been considered and the list now presented was used for testing the process. Future lists would include more services including those which the CCG was not statutorily obliged to provide. AM asked the Governing Body whether it would be content to include the services considered by Richmond CCG (table 1 of the paper) and use Richmond's process to consider these. SP commented that, in principle, all the SWL CCGs should be working together on this; not just Richmond and Merton. KP agreed that Merton should continue with its own process but had to also work with the other CCGs. AD said that both Richmond and Merton were further ahead of the other SWL CCGs and that both had reached similar conclusions. It may be that the other CCGs would also share these conclusions but there was a risk that waiting for them to catch up may have a detrimental effect upon the CCG's Financial Recovery Plan. AM shared this concern. AD added that if it was not possible to align all the SWL CCGs on this matter it was his opinion that Merton and Richmond should proceed together. Julie Hall (JH) asked whether any decision to de-commission a service would be risk assessed and would the potential "knock on "effect of a de-commissioning on other services be taken into account. KP gave an assurance that both these issues were covered by principles that formed the evaluation criteria. DZ added to this that the impact on the Local Authority had also to be considered and the CCG needed to think "across the system". JH also raised the issue of the need to acknowledge the difference in populations and local needs should Merton and Richmond work together. DZ commented that the CCG needed to be more positive when communicating the need to evaluate services to the public. She said that the CCG had always had a duty to spend its funding wisely and that, in light of the current financial position, evaluation of services was an important part of fulfilling this duty. KP acknowledged this as a valid point and would take this into account. TH thought it was sensible that as Merton and Richmond were the "trailblazers" they should align strategies. PD, having been assured that Richmond would be considering essentially the same services as Merton, agreed with this. At this point AM referred the Governing Body to the two options for consideration. It was finally agreed that neither option was entirely acceptable and that Merton should continue working to its own process whilst, in parallel,	

	KP would produce a "hybrid" third option that would be circulated virtually for Governing Body members to consider. The Governing Body **APPROVED** the CCG's approach to Prior Approvals and ECIs. The Governing Body **APPROVED** the CCG's intention to align its process with that of the other SWL CCGs The Governing Body **DID NOT APPROVE** either of the options put forward and requested for work be undertaken to produce a further option.	**KP**
8.	**Finance**	
8.1	Minutes of Finance Committee: 26.04.16; 23.05.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	The minutes were noted and PD commented that the main issues for discussion at the meetings had been the budget for 2015/16 and the Financial Recovery Plan. The Governing Body **NOTED** the minutes of the Finance Committee.	
8.2	Finance Report – Month 5	
	Andrew Hyslop (AH) summarised the CCG's financial position. In order to reduce the CCG's original planned deficit from £6.0M to £0.6M a number of additional savings measures were required to be identified. Of this £5.4M reduction an aggregate £2.7M was identified through the release of the RTT reserve (£2.0M) and further budgetary reductions (£0.7m), leaving a shortfall of £2.7M. Since the July Governing Body meeting a detailed review of budget setting identified that some budgets were likely to underspend in year. This primarily reflects a delay in the commencement of the referral management and complex patient case finding services. Therefore the savings shortfall had reduced to £2.033M. During month 5 a further review has reduced the shortfall by £978K to £1.055M. The main driver of this review was the reversal of prior year balance sheet net provisions for disputed sums that are unlikely to be required, all of which are non-recurring. A number of additional measures have been identified to close the remaining shortfall. These include: • An assumption that the CCG will receive a quality premium payment (£200K non-recurring). This sum is not guaranteed and should be considered a risk, which is why we were not permitted by planning guidance to build this into the sculpting of the original control total. • A review of material block contracts to recover an element of investment in services which have either slipped beyond the planned start date or where there are significant vacancies which are impacting upon service delivery (£200K non-recurring). • Reflecting the anticipated benefit in a national reduction in category M drug pricing which is due to incrementally take effect in the second half	

	of the year. An amount of £200K (recurring) has been assumed. • An initial review of CHC indicates scope for further measures to counteract the rising trend of expenditure. These measures, are targeted to release a further £455K (recurring) in 2016/17. These additional measures were prospective and should be considered to carry a higher degree of risk. AH added that there were a number of significant movements against plan. These included: • Significant underperformance on acute contracts. Before the impact of QIPP is applied to these budgets it is forecast that expenditure will be £5.1M below plan. The key driver of this reduction appears to be a sustained reduction in GP referrals and an unexpected fall in maternity expenditure. • Since the previous Finance report a more robust view of QIPP performance has been applied. It was now forecast that the QIPP programme will deliver a reduced aggregate saving of £4.7M. This is a shortfall of £2.6M against the budgeted programme of £7.3M. • Despite growing 2015/16 outturn expenditure by 15%, the CHC budget is facing increasing pressure. This is comprised of both sustained organic growth in new cases and the impact of a national price increase in funded nursing care back dated to April 2016. • The underlying position on prescribing is beneficial and this reflects a position that is shared by other CCGs across South West London. If the £1.2M QIPP target is removed, expenditure is forecast to be £0.9M below budget. PD welcomed the report as a very comprehensive summary of the CCG's position. The Governing Body **APPROVED** the Finance Report – Month 5.	
9.	**Governance**	
9.1	Board Assurance Framework (BAF)	
	LS stated that the CCG had developed a comprehensive risk management framework which was designed to identify specific risks, responsibilities and mitigating actions at both a strategic and operational level within the organisation. Through various committees and reports, CCG staff were able to escalate the most important of these to the Executive Management Team and, via the Corporate Risk Register, to the Assurance Framework. With regard to the current BAF, no new risks had been added to, or de-escalated from, it. However, Risk 1000 had been revised to reflect the current status of the continuing healthcare service, which has now been mobilised with the new provider. PD confirmed that the Audit and Governance Committee had reviewed and approved the BAF. DZ asked that a risk relating to the de-commissioning of	

	services be added to the BAF and AD assured her that this would be done by KP and LS The Governing Body **APPROVED** the Board Assurance Framework and **CONFIRMED** the following: • That the risks described represent the main strategic risks to the delivery of the CCG's plans. • That the mitigating controls adequately increase the probability of the CCG delivering its plans • Any gaps to mitigating controls or actions that would provide improved assurance of delivery to the Executive Team.	**KP/ LS**
9.2	Annual Audit Letter	
	PD explained that he Annual Audit Letter summarised the key findings arising from the work carried out the by the CCG's External Auditors for the year ended 31 March 2016. He added that the draft letter, in which the Auditors had awarded the CCG an "Unqualified" opinion, had been seen at the May Governing Body and final version now presented contained no further changes. The Governing Body **NOTED** the Annual Audit Letter.	
10.	**Key Actions to Communicate with the Organisation**	
	AM said that the key actions would be contained in the Chair's and Chief Officer's updates.	
11.	**Any Other Business**	
	There was no additional business to discuss.	
12.	**Meeting Close**	
	Part 1 of the Governing Body meeting closed at 3.45pm.	
13.	**Date of Next Meeting**	
	24th November 2016 1.00-5.00pm Venue: Merton Hall, Wimbledon	

Appendix 1

Patient Story

Mrs X has been with Merton District Nurses, both day and night services for 18 years following resection of her bowel and stoma formation due to cancer.

Initially her husband managed the stoma however Mrs X developed post-operative complications including wound infection which required further surgery and formation of a second stoma. This has proved difficult to manage and was too complex for her husband to look after and Mrs X was referred to the District Nurses who visit three times a week. Unfortunately Mr X died six years ago.

As well as her regular day visits Mrs X sometimes needs to contact the night nursing service if her stoma is problematic.

Mrs X told her story to a Band 5 District Nursing team member and has given her consent for her story to be shared.

I'd like to firstly say that I find the service excellent and would not be able to cope all these years without their care and attention. I had surgery for cancer as you know and unfortunately following complications of infection my wound was gaping and I needed a stoma to my tummy. Caring for my stoma became very difficult with a wound and a fistula to consider. My husband who was very good and without real difficultly had cared for my previous stoma for 8 years but was unable to carry on as usual with the stoma and the district nurses were called in by the GP.

I usually expect the day staff any time between 9am and 5pm, I am used to waiting for them as I know they are busy. It's only if I have a meal it's a nuisance but this can't be helped. I feel on the whole I am treated as an individual. The staff generally know me quite well. They always leave me comfortable and very often they do things like cover my feet with a blanket. They do consider my safety too. They have to lock my front door especially at night and pop the keys through the letter box. If I don't know them they usually introduce themselves and me to them. All the nurses are friendly and yes, I would say they are compassionate. I am well treated by the staff and feel safe and confident in their care. They are always professional.

I always have everything laid out for the nurses which helps and pleases them. The staff usually read the care plan if they are not familiar with the procedure, in fact I

usually leave it open for them with everything else. Staff wash their hands and I always leave a towel out for them.

The majority of staff involve me in the whole procedure, asking questions, chatting and they appreciate my help and input. I like to chat a lot. There is only one staff member who doesn't ask for my help or advice. She has had a lot of experience with this kind of thing in the past so I don't think it's a problem for her. I am so used to the way my stoma is done and have had it for such a long time I am used to helping them. She probably feels she knows what she is doing but if staff are unsure they usually ask me. It's not a problem, she doesn't visit much and she is otherwise very pleasant and caring. I usually feel I can advise them as I watch it being done all the time. I think having frequent leaking episodes has little to do with the member of staff who does it and more about the stoma itself. It's not straightforward.

The stoma specialist nurse writes out my care plan, she reads it through with me and asks me to sign it usually once every month or two if changes are made. Things changed with the previous lot of employers. The Silver Nitrate is applied less frequently now and it has been like this for a while. I have the stoma specialist nurse who is only able to visit once a week. I am very lucky to have her care. She is the only one able to apply silver nitrate to the overgranulation which really seems to reduce it and means the bag stays on longer. Silver nitrate was being put on by the district nurses three times a week but this stopped some time ago. I feel if the district nurse was able to apply the silver nitrate the stoma would be less problematic. I don't know if it would make any difference in my visits but I think it might make a difference. I have asked about it and was told it would continue this way. The stoma nurse has to cover a large area now and is unable to come more than once a week.

Actually when I think about it my main 'bugbear' is when I try to get through to the service by phone during the day either to inform them that I do not need a visit or to arrange the next visit. Very often I have had to call the night staff when my bag has leaked. It is fine when I hear a real person at the end of the line but if I get the answerphone I am never really sure that the message has been received and I worry.

I am usually able to get through to Y or Z but when I get the answerphone it is a long winded message and I am never sure if the message has been left or if my message is clear so I usually end up phoning again to make sure. Having a person to actually

speak to is better. I know that Y has already left and Z is leaving soon. I don't know what the situation will be in the future.

If I phone about 8am I get the answerphone but if I try later I can usually speak to someone but it can be frustrating. It is fairly easy to contact the night nursing team, apart from one occasion when the phones had not been switched over.

I feel I know many of the staff quite well. I feel confident I could raise things with either the day or night team as they have known me like yourself for some time. I don't really get to meet the team leader but I know I could contact district nurse A in charge if I was unhappy about something.

The nurse who transcribed the patient's story, assured Mrs X that she would follow up with colleagues about the Silver Nitrate treatment and contacting the nurses.

Mrs X shared her response to the Friends and Family question 'How likely are you to recommend our service':

Oh yes, definitely, without a doubt, it's great. The first one extremely likely.