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NHS
Merton
Clinical Commissioning Group

MINUTES

MERTON CLINICAL COMMISIONING GROUP

GOVERNING BODY PART 1

24th November 2016
Time: 1.00 – 4.00pm
Merton Hall, 78 Kingston Road, Wimbledon SW19 1LA

In attendance:

Voting Members		
CChi	Dr Carrie Chill	GP Member
PD	Peter Derrick	Lay Member: Audit and Finance /Vice Chair
CG	Clare Gummett	Lay Member: Patient & Public Engagement Lead
JH	Julie Hall	Nurse Member (arrived after the start of the meeting)
AH	Andrew Hyslop	Chief Finance Officer (Interim)
AM	Dr Andrew Murray	Clinical Chair
SP	Prof. Stephen Powis	Secondary Care Consultant (arrived after the start of the meeting and left before its conclusion)
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM
Non-Voting Members		
CCl	Chris Clark	Director of Performance, Planning &Informatics (Interim)
LS	Lynn Street	Director of Quality and Governance
LW	Liam Williams	Director of Commissioning Operations (Interim)

Other Officers in Attendance		
MW	Michelle Wallington	Principal Assoc. Communications & Engagement - SECSU
TF	Tony Foote	Note Taker - SECSU

Members of the Public in Attendance	
Graham Barker	Patient Engagement Group Member
Steve Bowman	Patient Engagement Group Member
Sue Clark	Merton Residents Healthcare Forum
Eileen Fairclough	Merton Residents Healthcare Forum
Logie Lohendran	Patient Engagement Group (Vice Chair)

Apologies:

Dr Tim Hodgson	GP Member
Karen Parsons	Chief Officer (Interim)
Dr M Jarzembowski	Chair, Local Medical Committee

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	Dr Andrew Murray (AM) welcomed all to the meeting, particularly Liam Williams (LW) and Chris Clark (CCl) who were attending as non-voting members of the Governing Body for the first time. Apologies received were noted and AM informed the meeting that both Julie Hall (JH) and Professor Stephen Powis (SP) had given notice that they would be late in arriving.	
2.	**Declarations of Interest**	
	The Governing Body **APPROVED** the Register of Interests as a full and accurate record.	
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 29th September 2016.	
	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 29th September 2016.	
	The following actions (numbered as per action log) were noted as now completed or on today's agenda for consideration: 6.3; 6.6; 7.2. Action 6.1 (Primary Care Strategy) had been discussed at the meeting of the Primary Care Commissioning Committee meeting that had been held directly before the Governing Body meeting. Minutes of that consideration would be available on the CCG's website presently. The Governing Body **NOTED** the Action Log.	
5.	**Chair's Update, Chief Officer's Report and Patient Story**	
5.1	Chair's Update	
	AM highlighted the following issues from his update: • South West London - Sustainability & Transformation Plan (STP) • St George's Hospital - Care Quality Commission Status • East Merton Model of Health & Wellbeing • The Rowans Surgery Procurement • Better Care Fund • One Public Estate – Additional Funding Announcement AM then provided a verbal report on activities since the report had been written.	

	Discussions regarding collaborative working with other South West London CCGs had continued and it was now proposed that Merton and Wandsworth CCGs should come together as a single commissioning unit, sharing selected functions. This proposal was now out to consultation with CCG staff. AM informed the meeting that the CCG's self–assessed rating of "Substantial" for Emergency Preparedness, Resilience and Response had been accepted by NHS England. There followed questions and comments from Governing Body members. Peter Derrick (PD) requested more detail about the successful application of additional funding from the One Public Estate. Dr Dagmar Zeuner (DZ) explained that the first tranche of this funding was £187k to be followed by a second tranche, bringing the overall total to £350k. PD asked whether there was any risk to the CCG attached to this and DZ assured him that this would be closely monitored. AM thanked DZ for her work in achieving the successful application. With regard to the STP, Clare Gummett (CG) emphasised the importance of the public being kept fully informed of its progress. AM acknowledged the need of clear communication for all and, in particular, addressing misleading reports of hospital closures. In response to a question from the public gallery, AM agreed that the CCG should make greater efforts to promote positive aspects of the CCG's work and it would endeavour to do so in future. The Governing Body **NOTED** the Chair's Update.	
5.2	Chief Officer's Report	
	In Karen Parson's (KP) absence, Andrew Hyslop (AH) highlighted the following areas from the report: • The appointment of new staff and changes in the status of others. AH also noted that today's was Lynn Street's (LS) last Governing Body meeting before she left Merton CG for a new post with NHS Improvement. On behalf of the Governing Body and the CCG as a whole, AH thanked LS for her contribution and wished her well in the future. • As part of the CCG's Financial Recovery Plan and the STP intentions, all its current clinical thresholds have been reviewed for the services it will and will not commission from hospitals. The thresholds set out the factors which must be present before a patient is referred to hospital for treatment based on the clinical evidence for effectiveness. In some cases, clinical evidence may suggest that the CCG should not commission certain procedures that are not clinically effective: for example we only commission 'cosmetic' procedures in exceptional cases. As a result of this, all treatments which offer no proven clinical value for patients have been eliminated and the CCG is now moving on to consider treatments where evidence is weak, there are safer or more effective alternatives and the balance of cost, risk and clinical evidence is weakest. This is a core function of CCGs and it is working with is GPs and Providers to identify areas where thresholds should be amended.	

	As with all CCG decisions, the best outcomes for patients were at the centre of considerations and the CCG would engage with patients and the public about any future changes. The CCG would also work closely with the Health Overview and Scrutiny Committee, Healthwatch Merton and other key stakeholders on the best way to involve local people in these discussions. The feedback from this will be presented to GB members at its away day on the 6th December 2016 for consideration. The CCG was also working with the other South West London CCGs to ensure as many of the existing policies are common as all want to minimise variation across the area as a whole. The Governing Body **NOTED** the Chief Officer's Report	
5.3	Patient's Story	
	LS introduced this item and explained that the CCG's aim was always to keep people well, and fully supported the Expert Patient Programme (EPP). Steve Bowman, also a member of the Raynes Park Patient Engagement Group (PEG) was joining the meeting to share his views on his experience of the EPP. Mr Bowman's written account can be found at Appendix 1 of these minutes. Mr Bowman said that he had joined the EPP two years ago due to his diagnosis of type 2 diabetes. There had originally been twelve members and each week they would they would discuss various issues and share their experiences He had always found this very useful and felt strongly that it would be a worthwhile experience for other people in his position. He recommended that Governing Body members sit in on an EPP session to see for themselves the work it was doing. AM thanked Mr Bowman for his contribution and asked how it had helped him in dealing with his condition. Mr Bowman replied that he was already quite sufficient with his own condition but the EPP had been very useful for his caring for other family members with similar conditions. Dr Carrie Chill (CCh) asked Mr Bowman whether he had any ideas for getting more people involved in EPPs. He replied that more leaflets about it in places such as libraries would be helpful. LS also thanked Mr Bowman and added that it was very useful for the CCG to focus on how it could help people manage their conditions. She added that in September there had been a self-management conference that had been very well attended. The Governing Body **NOTED** the Patient's Story.	
6.	**Strategy**	
6.1	Estates Development Plan – Update	
	Liam Williams (LW) presented this item and explained that the Governing Body approved the second iteration of the CCG's Estates Service Development Plan at its July 2016 meeting. The plan had been developed in collaboration with a wide range of local stakeholders and the formation of a Local Strategic Estates Group (SEG) was key to developing a robust understanding of the available estate and aligning it to the CCG's Commissioning Intentions. The Plan focused on NHS owned estate and that	

owned by General Practice. But also took into account the local authority regeneration projects in Morden and Mitcham town centres. The main objectives of the Plan were to:

- Understand the health and social care needs driving the development of new models of care and how the estate will need to respond to these.
- Describe the Merton NHS estate as it is now, including opportunities and constraints.
- Establish how the estate can best facilitate the delivery of the new models of care.
- Identify the priorities for investment and opportunities for savings, short and long term.

Prior to presenting the Estates Service Development Plan to Governing Body, Merton considered key initiatives which would assist the Plan's development.

- The London Borough of Merton's One Public Estate initiative. This secured central government funding aimed at creating partnerships to deliver ambitious projects to transform local services and use capital assets more effectively.
- East Merton Model of Care and Wilson Hub development.
- The Estates and Technology Transformation Fund (ETTF) and Primary Care Improvement Grant (PCIG).

LW stated that the purpose of the update presented was to provide the Governing Body with an update on Merton's progress with:

- The One Public Estate (OPE)
- Wilson Hub development in East Merton
- NHSE ETTF & PCIG initiatives.

The OPE has been planning how health and social care bodies can improve utilisation and the efficiency of their public estate. In doing so, OPE has worked with communities to ensure that a place-based approach is taken, providing expertise and resource to promote sustainable communities to have the capacity to better support their own residents.

Additionally, of particular importance to OPE were two particular local opportunities: the Council-led redevelopment of Mitcham Town Centre, and the redevelopment of the nearby Wilson Hospital site.

With regard to the Wilson site, a health needs assessment was undertaken in 2014 looking at the East of the borough and indicated the population is more ethnically diverse and there are areas of social deprivation where health outcomes are significantly poorer than those in the West of Merton. Accordingly, there was a compelling case for developing services that reflect these needs and to deliver these in purpose designed facilities closer to home. To facilitate this, the CCG is sponsoring the development of a modern healthcare facility in East Merton on the Wilson Hospital site to house a range of; primary, community and acute care services that provide a real alternative to services delivered in a hospital setting.

As part of the OPE, a project manager has been appointed by the London Borough of Merton to commence in January 2017 to take forward the CCG and Borough elements of the work. A workshop has been planned with key CCG, CHP and London Borough of Merton representatives to develop the programme of work that will enable a planning application to be submitted in

	December 2017 with a paper to go to the Health and Wellbeing Board in January 2017. With regard to the ETTF, the General Practice Forward View (GPFV) acknowledges the requirement to invest in premises and technology to enable transformation across a range of health and social care services. By 30th June 2016, Merton CCG had submitted applications for premises investment in line with the CCG's Estates Service Development Plan. Specifically, applications were submitted to invest in Colliers Wood Practice, Patrick Doody Centre and Wideway Surgery. The total capital investment (excluding VAT) for the three sites was circa £2.7m. Schemes must be completed by 31st March 2019. The CCG was informed at the beginning of November that the three applications were supported in principle to move to the next stage of due diligence. The total provisional capital investment allocated to this premises transformational fund equates to 66% of the submitted investment application; circa £1.8m. Revenue consequences of these schemes were approved at Primary Care Commissioning Committee in June 2016. Therefore, one ETTF application was not successful: the Wimbledon Town Centre scheme. This would have been a brand new third party development at a minimum cost of £6m. Merton CCG was not successful in prioritising this over other London schemes, primarily due to the embryonic nature of this proposal. As an alternative, to help build capacity for Wimbledon Town Centre, the Prince's Road surgery has submitted an Improvement Grant to extend their premises. The PCIG represents NHS England's funding additional capital monies beyond ETTF, translating to an overall investment (up to 2020/21) of £900 million1. PCIG aims to invest in GP Practices at a local level; and these schemes are by their nature Practices interested in applying for a London Improvement Grant Fund were required to submit an Expression of Interest by 30th September 2016. Six local GP Practices submitted a PCIG application: Central Medical Surgery, Alexandra Road, Mitcham Medical Centre, James O'Riordan Medical Centre, Colliers Wood and Grand Drive Surgery. The total amount of these bids equates to circa £675k. Merton CCG's Primary Care Team is working with these Practices to submit the requested documentation and evidence to NHS England. Revenue consequences of these schemes were approved at Primary Care Commissioning Committee in June 2016. PD stated that any issues relating to Estates and/or Finance must be considered firstly by the Finance Committee before coming to the Primary Car Commissioning Committee. LW acknowledged this but commented that the timescales in place were "very tight". AM noted that on the appendix to the update Patrick Doody was named as a GP Practice and that this was incorrect: Patrick Doody was a site and not an actual practice and this needed to be amended. The Governing Body **NOTED** the Estates Development Plan – Update.	**LW**
6.2	London Health and Care Devolution - Update	
	AH presented this item and explained that in December 2015, all thirty two CCGs, London Councils, the Mayor of London, NHS England and Public Health England came together as 'London Partners', and signed the London Health and Care Collaboration Agreement. This produced the commitment to	

	work more closely together to support those who live and work in London to lead healthier independent lives; prevent ill-health; and to make the best use of health and care assets. Central government and national bodies backed this vision through the London Health Devolution Agreement, and invited London to explore devolution – the transfer of powers, decision-making and resources closer to local populations – as an important tool to accelerate transformation plans and respond to the needs of Londoners more quickly. AH emphasised that devolution was a formalisation of what the CCG was already trying to do. AM agreed with this and that the principles and general direction of travel were shared. However, AM added, he felt that the update lacked specific proposals. CG was concerned at the lack of any mention of patient engagement and was reluctant to sign off on the project without greater specific detail. PD urged caution with regard to devolution and shared CG's reluctance on any formal approval. SP also felt that important details were lacking and, whilst welcoming certain general aspects, remained unsure that full devolution was required. DZ highlighted some of the work on preventative work that was being undertaken, specifically a project underway in Haringey. CCh supported the preventative work but shared the general concern at the lack of detail. The Governing Body: • **NOTED** progress and the forward timescales to the next Devolution agreement for London, building on the commitments and priorities agreed in December 2015. • **REVIEWED** and **PROVIDED** comments on the current proposals as they support specific Devolution Pilot requests and enable the potential to devolve certain powers across London partners, including CCGs. • At present, **DID NOT SUPPORT** the development of the final Devolution agreement(s) or the delegation authority to a named individual (e.g. CCG Chair) to agree and sign off the agreement on behalf of the CCG. AM thanked the Governing Body for its very clear and helpful comments and that he, with the aid of AH and Karen Parsons, would compose a response that fully reflected these.	
7.	**Quality and Performance Governance**	
7.1	Minutes of Clinical Quality Committee: 15.09.16; 05.10.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	CG, Chair of the Clinical Quality Committee, provided a verbal update. The new Director of Nursing and Quality Standards, Vanessa Ford, had attended the October Clinical Quality Committee meeting and presented about the three services which opened this year: the Memory Assessment Clinic at The Nelson; the ASD/ADHD clinic and the establishment of Street Triage Service. The Trust was expecting to become smoke free by middle to end of 2017. The areas of most concern to Ms Ford were the community mental health services for adults and recruitment and retention of staff as well as the issues around financial constraints. CG and the Head of Quality had visited the Assessment and Recovery teams	

located at the Wilson on an announced visit and were impressed by the team leaders and their teams commitment and thoroughness. Their impressions of the new Director of Nursing were also very positive.

With regard to the CCG's Staff Survey, there had been a deterioration in all responses this year which was concerning. The results of the survey showed a theme relating to the impact of a high number of interim staff. A subsequent staff workshop raised issues over bullying and harassment and these findings were considered at an Equality & Diversity System workshop and reported back to the Quality committee, where it was recognized that more work was needed.

For Quality and Performance matters the positives to note were:

- Ambulance waits 8 minute responses; LAS did not achieve 75% across London, but local performance was well above at 85% of patients being reached within 8 minutes.
- IAPT met its 50% target for the recovery rate, but there was concern that the service continued to deliver a poor performance with the actual first treatments, well below what they should be. This issue was being closely monitored.

The challenges were:

- Patients admitted, transferred and discharged from A&E within 4 hours
- Referral to treatment – 18 week wait – not met.

CG turned then to the major concerns over St George's Hospital.

The Care Quality Commission's (CQC) inspection report regarding St George's was published on 1st November 2016 and the Quality Summit was held on 2nd November attended by the Chief Officer and Director of Quality & Governance for the CCG. The main issues highlighted were:

- St George's received an overall rating of inadequate in the domains of well led and safe - with a recommendation that the Trust is put into special measures.
- Key issues related to estates with some areas rated as in a 'state of disrepair', in particular 16 out of 51 operating theatres require a complete refurbishment
- 53% of medical staff working with children had not completed Level 3 safeguarding training
- Community EOLC not inadequate
- The Trust received commendations for Maternity, Renal Services and caring staff

A particular area of concern to the Clinical Quality Committee from the CQC report highlighted was the unacceptably low level of safeguarding training as we have been receiving quarterly reports which did not evidence this.

The Committee asked for an update to come back to the next meeting on the actions taken by the CCG. CG had been in discussions with the CCG's Safeguarding Lead Nurse who, in turn, had received an assurance from the Deputy Named Nurse for Safeguarding Children & Young People at St Georges that the CQC data was inaccurate (due to the data issues) and that at a manual cleaning of the medical staff training figures conducted in the last 2 weeks 96.6% of medical staff were compliant.

	Finally, CG and the Head of Quality had made an announced visit to the Trust the day prior to CQC report being published, visiting A&E, Moorfield's Eye Hospital Outpatients and a cancer ward. Overall, they had been impressed by the caring, professional and supportive staff they had met. LS (Director of Quality and Governance) added that the low level of safeguarding training at St George's had been a significant concern although a new Chief Nurse had now been appointed and was committed to addressing this. LS added that the CCG would be supporting the Trust with this. The Governing Body **NOTED** the minutes of the Clinical Quality Committee.	
7.2	CCG Governing Body Assurance Report & Scorecards: Month 6 2016/17	
	Chris Clark (CCL) highlighted the main aspects of the report. <u>Good Performance</u> • Ambulance waits - Red 1 8 Minute response times – the London Ambulance Service did not achieve the 75% target across London. However, local performance was once again significantly above target, with 85.0% or category (red 1) patients reached in under 8 minutes. • Improving access to psychological therapies met the 50% target for the recovery rate. However, CCl added, the real challenge was now to publicise the service more to increase patient take-up. • People with long term condition feeling supported to manage their condition(s) • Antimicrobial resistance: appropriate prescribing of antibiotics in primary care <u>Challenged performance</u> • Percentage of patients admitted, transferred or discharged from A&E within 4 hours • Referral to Treatment (18 week wait) was not met in August. CCl explained that this was historically an area of good performance and discussions were ongoing with St Helier's regarding its recovery plan. There followed comments and questions from the Governing Body. AM welcomed the new format of the report and that it make complex information very understandable. JH asked whether the increase in urgent care could be expected to plateau shortly. CCl thought that there would not be a speedy solution and that more public education about the appropriate use of services might be needed along with an increase of services available in primary care. LW added that there was a national rise in urgent care demand and the CCG needed to work more closely with the Local Authority about how this could be addressed. The Governing Body **APPROVED** the Assurance Report & Scorecards: Month 6 2016/17.	

8.	**Commissioning and Operations**	
8.1	Commissioning and Operational Planning for 2017/18 and 2018/19	
	A verbal update by CCl and LW was provided. CCl informed the meeting that under guidance of the national regulator, CCGs were required to submit two-year Operating Plans. The CCG had submitted its draft today; it observed the need to find the balance between what the CCG wanted to achieve locally in Merton and aligning this with the "bigger picture" of South West London and the STP. LW explained that the CCG was currently seeking to agree two year contracts with providers and the deadline for these was 23rd December. CCGs had been advised that if it appeared likely that this deadline would not be met they should notify NHSE by early December, with the possibility of undergoing mediation/arbitration to reach a settlement. LW added that the need to build the out of hospital capacity was crucial to the commissioning/planning process, with the need to provide the right care at the right place the central underpinning principle. JH asked whether arbitration was likely to be needed. LW explained that NHSE had been clear that its expectation was that arbitration would not be required and the CCG was working very hard and closely with its acute colleagues to ensure this. The Governing Body **NOTED** the Commissioning and Operational Planning for 2017/18 and 2018/19 Update.	
9.	**Finance**	
9.1	Minutes of Finance Committee: 21.07.16; 22.09.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	PD (Chair of the Finance Committee) highlighted the following issues from recent Finance Committee meetings: • The CCG's current financial positon • Financial planning for 2017/18 PD commented that he was still cautious about the CCG achieving its control total of £0.6m and was particularly concerned about the impact of the cost of continuing healthcare may have upon this. The Governing Body **NOTED** the minutes of the Finance Quality Committee	
9.2	Finance Report – Month 7	
	AH stated that the CCG continued to report that it would achieve its target of a control total of a £0.6m deficit. He then identified the main potential variances to this. • Continuing Healthcare – there was another increase in the full year forecast to £11,241k which is an increase of £101k. Whilst the deterioration is significant in the context of the CCG's control total, it is much smaller than the change between M5 and M6 • Mental Health Placement deteriorated in the month by £71k to an adverse variance of £620k. There were four new patients in the	

	month with three departures. However, one of the new patients has attracted a particularly expensive care package which accounts for the majority of the uplift in the forecast. • Overall across the CCG, the full year forecast for electives deteriorated by £468k n the month to a full year forecast adverse variance of £566k. Performance/activity data to M6 continues to show total referrals reducing absolutely and significantly lower than budget. However, over the same period, elective admissions have remained fairly constant at about 1,600 spells per month since June 2016. There is therefore a possibility that the lagged financial effect of the recorded reduction in referrals will positively impact on the CCG's finances. There followed comments and questions from the Governing Body. AM acknowledged that the QIPP for 2017/18 was likely to be between £10 - £15m and that every effort to achieve this must be made. However, of equal importance was the need to continue to transform the delivery of healthcare in Merton. JH asked about the progress in reducing the backlog of Continuing Healthcare patients. LS sated that there were two different backlogs: a historical one that the new providers had inherited and this was almost resolved; a second new one about which discussions with the providers were ongoing. The Governing Body **APPROVED** the Finance Report – Month 7.	
10.	**Governance**	
10.1	Minutes of Audit and Governance Committee: Date 23.06.16; 21.07.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	PD (Chair of the Audit and Governance Committee) highlighted the following issues as from the recent Audit and Governance Committee meeting: • Register of Procurements • Declarations of Interests • Board Assurance Framework The Governing Body **NOTED** the minutes of the Audit and Governance Committee meeting.	
10.2	Board Assurance Framework (BAF)	
	LS highlighted the following aspects of the BAF: Risk 954 has been removed, with the agreement of the Clinical Quality Committee, as it was no longer representative of a risk facing the CCG. A new risk had been drafted and would be considered for inclusion on the assurance framework by the Clinical Quality Committee. Risk 962 has been reworded to reflect the current status of the risk. Risks relating to transformation were discussed at the September Audit and Governance Committee and the Executive Management Committee, where it	

	was agreed that they required review to better reflect their current status. This will be carried out with the responsible executive directors prior to the next Audit and Governance Committee. The Governing Body **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 these plans • Any gaps to mitigating controls or actions that would provide improved assurance of delivery to the EMT	
10.3	Remuneration Committee – Revised Terms of Service	
	PD (Chair of the Remuneration Committee) explained that the CCG's Constitution had been comprehensively reviewed by the CCG in partnership with SECSU Corporate Affairs. A number of updates were identified, including three minor changes to the terms of reference for the Remuneration Committee. The changes, considered and approved by the Remuneration Committee at its July 2016 meeting are as follows: • Section 5 Secretary – Change South London CSU to South East CSU • Section 6 Quorum – Change Chairman to Chair • Section 10 Other Matters – Change "These terms of reference will be reviewed August 2013" to "These terms of reference will be reviewed annually". Additionally, a further amendment agreed by the Committee Chair was now also proposed. Specifically, the addition of: "The Committee will also review the findings of the Annual CCG Staff Survey and make recommendations as appropriate." The Governing Body **APPROVED** the Remuneration Committee – Revised Terms of Service.	
11.	**Key Actions to Communicate with the Organisation**	
	AM said he would identify the key actions and include them in his next bulletin to Practices.	
12.	**Any Other Business**	
	There was no additional business to discuss.	
13.	**Meeting Close**	
	Part 1 of the Governing Body meeting closed at 3.00pm.	
14.	**Date of Next Meeting**	
	26th January 2017Venue: Chaucer Centre, Morden	

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MINUTES

MERTON CLINICAL COMMISIONING GROUP
GOVERNING BODY

15th December 2016
Room 6.2/3, 120 The Broadway, Wimbledon, SW19 1RH

In attendance:
Voting Members

CChi	Dr Carrie Chill	GP Member
CG	Clare Gummett	Lay Member: Patient & Public Engagement Lead
TH	Dr Tim Hodgson	GP Member
AH	Andrew Hyslop	Chief Finance Officer (Interim)
AM	Dr Andrew Murray	Clinical Chair
KP	Karen Parsons	Chief Officer
SP	Prof. Stephen Powis	Secondary Care Consultant (arrived 1.55pm)
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM

Non-Voting Members

CCl	Chris Clark	Director of Performance, Planning & Informatics (Interim)
MJ	Dr M Jarzembowski	Chair, Local Medical Committee
LW	Liam Williams	Director of Commissioning Operations (Interim)

Other Officers in Attendance

AMo	Andrew Moore	Financial Recovery Programme Director (Interim) (for items 3.1; 3.2; 3.3)
MW	Michelle Wallington	Principal Associate, Communications & Engagement
TF	Tony Foote	Note Taker - SECSU

Apologies:

Peter Derrick	Lay Member: Audit and Finance /Vice Chair
Julie Hall	Nurse Member
Lynn Street	Director of Quality and Governance

Members of the Public

Clare Jackson-Prior	KOSHH
Sue Clark	Merton Residents' Healthcare Forum
Sandra Ash	
David Ash	
Cypren Edmunds	Healthwatch Now
Daphne Hussein	

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	AM welcomed all, including the members of the public present, to the meeting.	
2.	**Declarations of Interest**	
	The Governing Body **APPROVED** the Register of Interests as a full and accurate record.	
3.	**For Consideration/Approval**	
3.1	Evidence Based Commissioning	
	AMo presented this item and reminded the Governing Body of what it was being asked to do. Specifically: • Note the process which is on-going to work with the South West London (SWL) CCGs to develop revisions to clinical thresholds • Endorse the principles adopted • Await the final form of the policies for approval at a future meeting AMo stated that Merton CCG was a member of the SWL collaborative and as such has signed up to the SWL Effective Commissioning Initiative. This document identified agreed thresholds for treatments for which restricted access has been agreed and has been in place in its current form since 2014. The access criteria were based on evidence of clinical effectiveness and have been developed by the South West London Public Health Network. AMo added that the existing thresholds were due for refreshing to ensure they remained relevant and reflective of current circumstances. The advantages of doing this on a collaborative basis with other SWL CCGs were that: • all SWL patients have common access to evidence based treatments and we don't expose patients to a 'post-code lottery'. • providers are not exposed to having to apply different sets of rules to patients from within SWL, as this could add complexity and compliance costs. • as the six SWL CCGs are increasingly working together within the Sustainable Transformation Programme they can share the work of maintaining the thresholds and ensuring the whole system acts fairly and transparently to ensure consistent access for patients. • referrers have a widely shared understanding of what the latest evidence says and apply the same thresholds, particularly as many GPs work across different practices and borough boundaries. • sharing across SWL may assist in case of challenge relating to a clinical policy decision. AMo reflected that other actions additional to refreshing thresholds were also needed: ensuring that referring clinicians were aware of policies; educating patients about alternative options to secondary care; having good practical processes in place; managing compliance by secondary trusts with the policies. Finally AMo referred the meeting to the list in the paper presented of the	

	fifteen procedures that have already undergone an initial review. There followed questions and comments from the Governing Body. AM said that he agreed with the need to refresh thresholds in line with changes in clinical evidence and the need to ensure cost effectiveness. CG referred to the Social Care Act and the vital need to address inequalities in access to treatment. She added that, in any refresh the involvement of the public and patients was of great importance. TH asked for an assurance that there would be real clinical input to the process. AMo gave this assurance and that Merton GPs were very interested in having an input and ensuring fair and equal access for all. CChi raised the following questions: (i) would the involvement of Public Health so far in the process continue; (ii) would there be a consensus to the proposals across SWL. With regard to (i) DZ stated that Public Health was committed to remaining involved In response to (ii) AMo replied that a single SWL position was the preference but that each individual CCG had the right to make its own decisions.. LW said that work was ongoing into identifying alternatives to hospital care. TH asked what happen if it was not possible to reach a consensus across SWL. AMo explained that, whilst this may be a possibility, there would be a great of work done across SWL, with each CCG, to ensure as far as possible a consensus before Governing Bodies were asked to make a final decision. DZ emphasised the need to review the process for individual funding requests and room must be left for exceptional cases and clinical discretion. AM stressed the importance of patient pathways and ensuring current providers – musculoskeletal and pain management services in particular – would have the capacity to deal with a potential increase in demand. LW commented that he had attended a meeting regarding this issue yesterday and work was ongoing. MK said that pain management was of great importance and all components must be available to patients. Again, LW said this was being addressed with a gap analysis being undertaken across SWL. The Governing Body: • **NOTED** the process which is on-going to work with the South West London (SWL) CCGs to develop revisions to clinical thresholds. • **ENDORSED** the principles adopted. • Would **AWAIT** the final form of the policies for approval at a future meeting.	
3.2	Review of IVF	
	AMo explained that, at present due to financial constraints, Merton CCG did not provide a NICE compliant IVF service. Any review of IVF services would involve consultation about possible changes and implications of these, and would need to then return for final Governing Body consideration. With regard to what other CCGs were doing, AMo explained that Croydon CCG was currently in a process of full consultation on decommissioning IVF services and Richmond CCG had agreed to a review.	

	AM acknowledged IVF as a very difficult and sensitive issue and that it was clinical effective for some patients. However, there was also a need to be mindful of the current financial position and what was in the best interest for the most residents of Merton. CG also recognised the sensitivity of this matter and that any public consultation on it would need to be very thorough. DZ commented on the importance of recognising that the equality duty upon CCGs did not include poverty as one of its formal characteristic, but that this must also be taken into account. AMo agreed to this The Governing Body: **AGREED** to put the current policy for access to IVF and specialised fertility treatments under review, with a view to making a decision at a future meeting to change the criteria for access to these treatments.	
3.3	Surgery Readiness Option	
	AMo explained that the SWL Sustainable Transformation Plan (STP) highlighted increasing prevention as a key theme to improving outcomes of patients and address the pressures across the whole system. One area which the CCG notes that has been examined in other CCGs and for which there is an emerging evidence base, is the policy of increasing patients' fitness before elective surgery is undertaken in particular addressing smoking and excess weight. It was generally agreed, AMo continued, that it was preferable for patients to be as ready as possible for any operation and that this encouraged the best outcomes to such procedures. DZ stated that she welcomed any efforts to ensure patients were as fit as possible prior to an operation. However, she cautioned that it was important how this was raised with individual patients and that making sure patients had all the sufficient information and support to make their own choices rather than coercion was likely to be more productive. The Governing Body: **AGREED** to the development and engagement on a proposal that would guide relevant patients through a funded and well-structured stop-smoking or weight management process before undertaking elective surgery.	
3.4	South West London Medicines Optimisation Work Stream	
	LW presented this item and explained that the paper presented sets out the case for Merton CCG to review and manage resources within the medicine optimisation portfolio, specifically related to prescriptions for gluten free products and prescriptions for medicines available 'over the counter'. The proposal sets out a process across the STP in SWL to achieve system wide change to optimise the use of medicines, support the transformation of primary care and improve patient outcomes. AM added that this issue had already been reviewed thoroughly within the CCG and that the proposed plan had been developed by SWL Pharmacists approved by the SWL Clinical Board.	

	KP stated that it had also been considered by the SWL Chief Officers' Group who agreed that all its CCGs should work together to agree on areas to be reviewed. The Governing Body: **AGREED IN PRINCIPLE** to the additional work around gluten free and over the counter medicines being progressed to enable a SWL approach to be developed.	
	AM then invited comments and question about the general area of Evidence Based Commissioning from the public gallery. <u>Question 1</u> The questioner explained that her daughter suffered from coeliac disease and, whilst they were able to afford the appropriate foodstuffs, there had to be provisions in place for those who could not. AM acknowledged this was an important point and that the CCG needed to ensure that the full potential impact and significance of changes to prescribing for patients with coeliac disease was understood. There would have to be an assurance that impact assessments had been undertaken to avoid the possibility that those who require specific foodstuffs were not deprived of these due to cost. <u>Question 2</u> The questioner raised the issue of the on-going availability of vitamin D and vitamin supplements on the NHS. AM noted that there were different thresholds for prescribing vitamin D: in cases of severe deficiency prescribing higher doses would be appropriate. However, AM acknowledged, there was a "grey area" when prescribing for a patient who had progressed from deficiency to needing to maintain a healthy level with regular supplements. TH raised possibility of targeted patient engagement in certain areas to enhance understanding, and that Coeliac could be productive area for this. <u>Question 3</u> The questioner asked why, if the evidence that is going to be used is so clear, was this not being employed nationally, rather than on a SWL basis. AM responded that there were significant differences nationally and that a South West London local focus was the pragmatic approach to delivering changes at scale. <u>Question 4</u> The questioner asked for an assurance that any engagement on these matters would include the general public and not solely Patient Participation Groups. AM agreed with this aim completely. <u>Question 5</u> The questioners asked why more publicity was not given to Governing Body meetings. More members of the public should be encouraged to attend. There were too many late changes to meetings – venues and times – and the CCG's website was not clear or easy to use. It had also not been possible to find the papers for today's meeting and the meeting itself had not been listed on the CCG's schedule of events.	

	MW replied that the change of venue had been posted on the website – both on the front page and in the "Our Governing Body" section – on the 1st December. TF added that the CCG aimed to make Governing Body papers accessible to the public no less than five working days before each meeting and it was rare that this was not achieved. He added that the papers were clearly signposted within the "Our Governing Body" section on the website. With regard to today's meeting not being listed on the CCG's schedule of events, AM explained that the meeting was originally to have been solely a Governing Body seminar to which the public would not be invited. The addition of a public section to the meeting had been a recent one. CG commented that she understood the questioner's concerns and shared their wish to promote public attendance at Governing Body meetings CG added that measures were currently taken – such as contacting directly members of the public who have expressed an interest in attending - and asked the questioner if they had any other ideas for this. AM assured the questioners that the issues they had raised would be looked into. <u>Question 6</u> The questioner referred to an incident earlier in the meeting when he and his wife had started to film proceedings and AM had shown concern about this. The questioner commented that other organisations such as KOSH videoed their meetings and made them available via their website. AM replied that his concern was that no notification was given of an intention to film the meeting and that it might make some of the members feel uncomfortable. AM added that meetings in public were already sound recorded. The questioner responded that it was important to make the contents of meetings as accessible as possible and that listening to two hours of a recording was not a "very attractive proposition". <u>Question 7</u> The questioner referred to item 3.3 - Surgery Readiness Option – and asked for further detail regarding the importance of other options being available to patients. MJ responded that pain management clinics and smoking cessation services would be prime examples of these. <u>Question 8</u> The questioner raised the issue of being registered with a GP Practice in one borough but living in another under a different local authority, asked how this would affect her opportunity to be involved in any patient engagement. AM gave an assurance that the CCG would be consulting with entire registered populations of member practices	
4.	**Any Other Business**	
	There was no additional business to discuss.	
5.	**Meeting Close**	
	Part 2 of the Governing Body meeting closed at 2.10pm.	
6.	**Date of Next Meeting**	
	26th January 2017 Venue: 120 The Broadway, Wimbledon SW19 1RH	