NHS
Merton
Clinical Commissioning Group

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

Thursday, 27th March 2014

9.00am - Noon

Civic Centre, London Road, Morden, SM4 5DX

Chair: Dr Howard Freeman
Present:

EB	Eleanor Brown	Chief Officer (not present at start of meeting)
CC	Cynthia Cardozo	Chief Finance Officer
CCh	Dr Caroline Chill	GP Clinical Board Member
MC	Mary Clarke	Independent Nurse Member
PD	Peter Derrick	Lay Member: Chair of the Audit Committee/ Vice Chair
KE	Dr Kay Eilbert	Director of Public Health, London Borough of Merton
HF	Dr Howard Freeman	Chair Designate/ Clinical Leader
AM	Dr Andrew Murray	GP Clinical Board Member
SP	Prof. Stephen Powis	Secondary Care Consultant

In Attendance:

JK	Jenny Kay	Director of Quality (not present at start of meeting)
AD	Adam Doyle	Director of Commissioning
MJ	Dr Marek Jarzembowski	Chair, Local Medical Committee
DC	David Cotter	Commissioning Support Unit (for item 6.5; 7.4)

Supporting Officers

TF	Tony Foote	Board Secretary, South London Commissioning Support Unit

Member(s) of the Public:

Frances Cornford	Keep Our NHS Public
David Murray	Keep Our NHS Public
Brian Hennessey	Patients' Representative
Nick Garland	London Borough of Merton
Katharina Kieslich	King's College London
Daphne Hussein	Patients' Representative
Paul Pink	Not Stated
Name Illegible	Lower Morden Residents' Group
Name Illegible	Resident

ACTION

1. Welcome and Apologies for Absence

Dr Howard Freeman (HF) commenced by welcoming members and all in

attendance, noting that the meeting was in public, not a public meeting.

He expressed the Governing Body's gratitude to the London Borough of Merton for the use of the meeting room and explained that the CCG had been informed that it would no longer be permitted to hold meetings in public at 120 The Broadway, Wimbledon due to health and safety and fire regulations.

HF also informed the meeting that the CCG's Chief Officer – Eleanor Brown (EB) – would be joining the meeting later as she was at present receiving a petition from a local MP.

Apologies for Absence

Apologies for absence had been received from Clare Gummett.

2. Declarations of Interest

No interests additional to those contained within the CCG's Register of Interests were declared.

3. Minutes of previous meetings

To approve the minutes of the meeting of the Merton Clinical Commissioning Group on 23rd January 2014.

The minutes were approved as a true record of the meeting.

4. Matters Arising

4.1 Action log 23.01.14 – For Note

The Governing Body noted the progress made in relation to the actions.

5. Chair's and Chief Officer's Update

5.1 Chairs Update

HF stated that his verbal report would be both brief and positive.

The CCG had received favourable comments from NHS England (NHSE) and would, in future, be required to attend quality assurance meetings with NHSE on a quarterly basis only. This frequency of meeting being the lowest for London CCGs.

HF then informed the meeting that the Chief Officer's Report would be deferred until the arrival of EB.

6. For Agreement

6.1.1 Two Year Operating Plan

Adam Doyle (AD) presented this item and informed the Governing Body that the CCG was required to submit its Two Year plan to NHSE by the 4th April 2014. However, firstly it needed the approval of the Governing Body.

HF and other members of the Governing Body thanked AD and his Team for their hard work on this document and praised its clarity and comprehensive scope. Professor Stephen Powis (SP) suggested that the "Plan on a Page" be featured more prominently near the start of the document. AD agreed to make this amendment.

HF then invited questions from the public gallery.

Question 1
The questioner was under the impression that the Better Healthcare Closer to Home (BHCH) had been discontinued with the introduction of Better Services Better Value (BSBV); could the Governing Body clarify this?

Peter Derrick (PD) responded that the main concern of Merton BHCH was out of hospital care. As this continued to be a major issue, BHCH continued also. He added that the discontinuation of BSBV would not affect this. To further clarify this, HF explained that the Sutton and Merton BHCH programme had been dissolved and there was now a Merton-only programme.

Question 2
What would the Patient and Public Involvement (PPI) arrangements for BHCH be?

PD explained that there was PPI representation on the Nelson Development Project Board, as there would be with future projects too. The questioner then stated that there had been no recent PPI activity with the Nelson Project. AD replied that with the Nelson being now a year off completion it was recognised that PPI input would need to increase and he assured the questioner that this would be happening.

Question 3
Why had there been such short notice of the change of venue of the Governing Body meeting?

Tony Foote (TF) explained that there had, unfortunately, been a delay in making this change public and apologised on behalf of the CCG for this.

The Merton Clinical Commissioning Group Governing Body agreed the Two Year Operating Plan.

6.1.2 South West London Collaborative Commissioning

AD presented this item and explained that on the 18th February the CCG Chairs of the six South West London (SWL) CCGs issued a joint statement (Appendix 1 to the document) stating that they would not be continuing the BSBV programme or consulting on the options which emerged from that programme. Furthermore, the six CCG chairs, alongside NHSE, have clearly stated an intention to continue to work collaboratively to address the case for change in SWL.

AD added that the document explained the new way of working needed to support the Five Year Commissioning Strategy. He added that the CCG was required to submit its Five Year Strategy by the 20th June 2014 and, to achieve this, a robust governance structure was vital to support collaborative working across the six South London CCGs.

He highlighted the establishment of Clinical Design Groups (CGDs) to lead on work on the seven identified pathways.

HF noted that this document would be considered by all six SWL CCGs' Governing Bodies: four had already approved it, with Merton CCG, today, and one other still to decide. He then invited questions from the Governing Body members.

Mary Clarke enquired how a wide range of clinical opinion could be achieved across the CDGs. AD acknowledged the importance of this and work was ongoing to ensure that nurses and other allied health professionals were included alongside GPs.

Dr Andrew Murray (AM) then asked about the required skill mix and AD responded that, with regard to Merton CCG representation, the development of its Clinical Leads into Clinical Directors should help ensure this.

HF then invited questions from the public gallery.

Question 1
What were the PPI arrangements for this?

AD explained that the lay members (PPI Leads) of the six SWL CCGs had met last week to discuss this and agreed to collate a list of appropriate lay members for the CDGs. There would also be Patient Reference Groups to hold the CDGs to account.

Question 2
This question had been submitted prior to the meeting in writing. As the questioner was present she read it out to the meeting:

I note that you are planning to conduct the consultation process for your 5 year strategy during April-Mid May 2014 (Item 5). This period appears to be surprisingly short, given the scale of the programme and the range and the diversity of the stakeholders who you are required to consult. This period overlaps, almost perfectly, the run up to the local Council elections and the subsequent formation of the new Council administration. This will not only make any consultation with the local council highly problematic, it will also exclude many activists who will almost certainly be involved in the elections. This casts a very serious doubt as to the meaningfulness of the proposed consultation process.

Further, given that this process is due to start in a few days' time, I cannot find any advance publicity as to its nature, scope and any formal arrangements which are in place. Perhaps you would be kind enough to provide the details of your proposals.

Finally, for the residents of Merton to endorse your plans for change with any degree of confidence, the consultation must be meaningful and seen to be meaningful. Do your plans include publishing the proposals in the local newspaper and making them available in local GP surgeries?

EB had now joined the meeting. She stated that she understood the questioner's concerns but that the five year strategy was, at present, at a very high level. Formal consultation would only be statutorily required if the work on the Strategy gave rise to a proposal of significant change. The CCG would welcome such consultation if required.

The questioner then expressed a concern that the new way of working

would employ the analysis developed by the BSBV programme, and that this had already been declared both clinically and financially flawed. The questioner believed that this would lead inevitably to the decision to close local hospitals.

HF contested the claim that the analysis was flawed, that it had been signed off by NHSE and only required updating to take into account any recent changes and developments. He continued that BSBV had been discontinued and that a new process was now commencing. He also emphasised that should any major change - such as a hospital closure – be proposed there would be a full process of formal consultation. EB added that a number of factors had changed since the inception of BSBV, particularly the introduction of new quality standards.

The questioner said that as it had already been stated by the CCG that there were insufficient A&E consultants, nor the finances to train and employ more, A&E departments were certain to close.

EB replied that work was ongoing to see whether some hospital services could be provided elsewhere, such as in a non-acute setting. HF again stressed that a number of factors had changed since the inception of BSBV: changes to the training of A&E consultants and the significant improvement in the financial position of St Helier Hospital. He stated that there were no pre-conceived ideas or outcomes with this new approach and, as Chair of the Strategic Commissioning Board, he would ensure a fair and open process.

Question 3
What the public want is to not lose St Helier Hospital. If there are no pre-conceived ideas, the CCG should state publicly that that it has no plans at present to close St Helier's or decrease the services it provides. Furthermore, what was the CCG doing to obtain more funding from the government to protect services?

HF responded that there had never been any plans to close any SWL hospital but it was necessary that all such hospitals were fit for purpose. However, he emphasised that there were currently no major changes planned. With regard to government funding, HF informed the meeting that Merton CCG had recently been awarded the highest uplift in funding of any CCG, and that this would be invested in services.

The Merton Clinical Commissioning Group Governing Body approved the collaborative approach to developing a five year strategy and the proposed governance arrangements.

As EB had now joined the meeting, HF asked her to provide the Chief Officer's Report.

5.2 Chief Officer's Report

EB highlighted the following issues in her report.

CCG Development
An appointment of a Director of Quality has been made. Lynn Street will take over this role from Jenny Kay on the 1st June 2014.

The Executive Management Team has completed a full review of the resources required to deliver he Merton CCG 2-year Operating Plan. As a result of this review, the revised functions of the Director of Quality and the recognition of the increased clinical time required to deliver service change programmes. The CCG has identified increased areas of delivery for the Clinical Leads which require greater time commitment. The Clinical Leads will now take on the role of Clinical Directors with increased sessions to fulfil their roles. The Primary Care Support Team and Medicines Management Team will move from the Quality Directorate to the Commissioning & Planning Directorate.

The CCG's information governance toolkit has now been completed and published. Overall the CCG achieved a 70% satisfactory compliance with an original target of 66% and all requirements have been delivered at a level 2 or 3 standard.

Service Development

The Annual Pharmacy Needs Assessment (PNAS) **i**s currently in progress, to which the CCG is contributing. All PNAS are led by the Directors of Public Health and have to be published by 1 April 2015. Merton and Sutton CCGs have agreed completion by end of December for formal sign off by their respective Health and Well Being Boards in early 2015.

In order to support the use of technology in general practices and improve access, the South London Commissioning Support Unit (CSU) has appointed a project team to take forward the refresh of primary care IT in 2014/15.

As a result of visits by Age UK to the Practice Managers Forums in January/February, the following update and information sharing of the voluntary sector services available in Merton is planned:

- Attendance at the Practice Nurses Forum and Health Care Assistants Forum
- Voluntary services section on Merton CCG intranet and work with Merton Voluntary Service Council to obtain more information, and weblinks loaded for practices
- MVSC and Merton Healthwatch to host a short session at the Practice Leads Forum in May to update general practitioners regarding local voluntary care services.

Strategic Commissioning and Planning

Merton Call To Action work has been running since the beginning of March. Feedback to date has focused on: more integration of services, better access to health care, especially primary care, and more emphasis on prevention of ill health and ensuring health and wellbeing. The CCG is using the feedback in its 5-year Plan. A full report of responses will be posted on the web site and sent to groups visited by the CCG as part of the process during April.

Integration

The following has been achieved in the previous month:

- Review of feedback from NHS England on the first BCF draft
- Redrafting of BCF Plan to address feedback from NHS England and a more in-depth review of certain areas of the plan

- Final draft version of BCF plan completed
- Development of project delivery structure, including governance, structures, workstreams, work packages, roles and responsibilities. Workstreams include: Merton Model Development, Quality, Finance & Performance, IT and Data Sharing, Development of Workforce and Culture, Patient & Public Involvement
- Development of a formal project plan and meeting structure to deliver it
- Meetings of Merton Model Development Group (Workstream 2) held
- Presentation of BCF Plan to Merton Integration Board, MCCG Governing Body Seminar, LB Merton Cabinet and Health & Wellbeing Board
- 23 Merton general practices are using electronic risk profiling and the majority have submitted at least one set of data identifying number of patients reviewed

MC asked about the refreshing of Primary Care IT and hoped that this would result in greater links between the GPs and other providers. However, Dr Caroline Chill (CCh) explained that the refresh was of hardware rather than systems, but that the update should increase the links between members, the CCG and other organisations.

Peter Derrick (PD) suggested that it would be useful to include the names of the Clinical Locality Leads on Appendix 1.

The Merton Clinical Commissioning Group Governing Body noted the Chief Officer's Report.

6.2 Better Care Fund

AD presented this item and explained that, as part of the planning guidance for "Everyone Counts: Planning for Patients", there is a requirement for CCGs to submit a Better Care Fund (BCF) Plan.

The BCF (previously referred to as the Integration Transformation Fund) was announced in June 2013 with the aim of providing an opportunity to change local services so that people receive more integrated care and support in community settings. The Fund objectives are to provide protection for social care services and to support local transformation of services so that more people are supported in the community receiving integrated health and social care services. The Fund for Merton is £12,198,000, as from 2015/16.

A first draft of the BCF Plan was submitted to NHS England on the 14th February 2014. Good feedback was received from NHSE on the quality and content of the draft submission and advice was given on some areas to expand. The overall rating was '1', which signified 'no areas for concern'.

HF again thanked AD and all those involved in producing the BCF for their hard work in producing such a comprehensive document. There were no further comments from Governing Body members and so HF invited questions from the public gallery.

<u>Question 1</u>
Have the Governing Body members read this paper and all the others for consideration?

HF assured the questioner that all the members had read all the papers and, indeed had seen and considered previous drafts of the BCF document as well as discussing it at a recent Governing Body Seminar.

The Merton Clinical Commissioning Group Governing Body agreed the Better Care Fund submission to NHSE.

6.3 Financial Strategy and Plan – 2014-2019

Cynthia Cardozo (CC) presented this item and explained that the Strategy and Plan provided details on the CCG's funding settlement and the impact of this on the financial planning for the period 2014-19. It underpinned the need for the CCG to deliver on its objectives with realistic planning and prioritisation. The Plan was predicated upon NHSE guidance and the need to achieve annually a 1% surplus and maintain a 0.5 Percent contingency fund. The CCG was on target to achieve this for 2013/14.

The CCG had received a significant uplift in funding – based upon a growth in Merton's population and recognition that Merton had been historically underfunded – but many challenges, such as the acute overspend, remained and it was important to continue to look for good value.

Service developments/investments have been identified by Commissioning Managers in consultation with clinical leads during January and February 2014. As the current position on provider contracts is not clear, Executive Management Team agreed to the top 6 priorities (as shown below) proceeding from 1st April, with a view to revisiting the remainder in-year:

- Cardiology out of hospital
- MSK
- Better Care Fund
- IVF
- Dementia screening/memory clinics
- Bereavement Services

CC stated that, as part of the Business rules, a 2.5% non-recurrent reserve (£5.2m) is to be created of which 1% is to be used on transformation relating to the Better Care Fund. The 1% transformation fund will be carried forward recurrently in 2015-16 along with additional investment of £1.1m. The plan in 2014-15 for this reserve is shown in the Strategy document.
The above plan fully utilises the non-recurrent reserve in 2014-15. The repayment of £0.6m borrowed in 2013-14 from the SWL Risk pool will be paid across 2 years; £0.2m in 2014-15 and the balance in 2015-16. This £0.6m payment to Sutton CCG relates to an agreement that Merton CCG will pay a final contribution in 2014-15 towards the Community Learning disability team. The CHC legacy payment is a risk share contribution mandated by NHS England to pay legacy continuing care provision invoices in 2014-15. NHS England has stated that the funding has been included in the allocations for CCGs.

CC added that there is a key risk to the delivery of the required 1% surplus; as at the time of the meeting the CCG had an agreed contract with only Community Services and St George's Mental Health Trust contract. All other contracts remain unsigned.

ACTION

With regard to the Better Care Fund (BCF) CC stated that the CCG and Local Authority have worked together to plan for services within the £12.2m pooled fund. In order to ensure that maximum benefit is gained the CCG and LA will start the schemes in 2014-15 as detailed in a table included in the Strategy.

QIPP schemes were currently being finalised and implemented, and will align with the CCGs Commissioning Intentions. Specifically:

- Urgent Care and intermediate care
- Planned Care and diagnostics
- Prescribing
- Curtailing non-demographic growth

To ensure robust and recurrent delivery of QIPP the CCG will continue to have a QIPP delivery team that meets monthly, involving the Clinical Reference Group on assessing the viability and quality impact on QIPP schemes.

HF asked PD, as Chair of the CCG's Finance Commission, for his comments on the document. PD felt it was a very good document and extended his thanks to CC and her Team for their work in producing this. He noted that the CCG had sound contingencies in place and that looking forward to 2014/15, the QIPP was in a much healthier state than at the start of 2013/14.

There followed questions from Governing Body members.

MC asked whether the running cost allocation took into account the mobility of population and CC assured her that it did.

MC then commented that in 2013/14 the Clinical Quality Committee had had good input into discussions about the QIPP and hoped that this would continue in 2014/15. Again, CC gave assurances on this and that there would be a Quality workshop regarding the QIPP held.

SP asked about the risk element of the QIPP schemes and CC replied that all schemes had been independently assessed. Jenny Kay (JK) added that all schemes had also had patient and public involvement.

EB commented that the document showed the CCG to be in a very good position and able to invest.

HF invited questions from the public gallery.

<u>Question 1</u>
Have all GPs been involved in formulating the QIPP?

HF confirmed that Merton Practice Lead forums had an attendance rate of one hundred percent and that Practice Leads then met with their practices and locality groups to feed back accordingly.

The Merton Clinical Commissioning Group Governing Body agreed the Financial Strategy and Plan – 2014-2019

ACTION

6.4 Merton CCG Objective Setting and Board Assurance Framework 2013/14 and 2014/15

CC presented this item and explained that the paper consisted of two sections:

CCG Annual Objectives
As part of the annual planning process, and to support the implementation of the two year operating plan and five year strategic plan, draft annual corporate objectives for 2014/15 were proposed for discussion and development at the Governing Body seminar in February 2014.

The Board Assurance Framework (BAF)
This supports the CCG in the identification and management of risks to achieving these objectives, which includes both internal risks to the CCG and risks within the wider Merton health economy.

PD commented that the CCG's Finance Committee had seen various iterations of the BAF and good progress had been made in its framework and structure. He added that its contents would need to be refreshed in light of the 2014/15 objectives.

The Merton Clinical Commissioning Group Governing Body agreed the development of proposed corporate objectives for 2014/15 and plans in place to refresh the Board Assurance Framework and Corporate Risk Registers.

6.5 Policy Approval Schedule 2014/15

JK presented this item and informed the meeting that the CCG was required to review all existing policies and ensure that those of the Primary Care Trust were replaced appropriately by CCG policies. The schedule showed the policies which had been reviewed and the timetable for those still outstanding.

The Merton Clinical Commissioning Group Governing Body agreed the Policy Approval Schedule 2014/15

6.6 Merton CCG Financial Position - Month 11

CC presented this item and informed the meeting that the CCG was forecasting that the need for a planned surplus of £2.1m at the end of the financial year would be met.

CC highlighted the following issues:

- Acute commissioning is forecast to over perform by £4.6m; the full year forecast outturn position has improved compared to last month owing to a general reduction in elective activity reported at St George's and Epsom and St Helier NHS Trust.

- Non acute commissioning is forecast to underperform by £0.4m for the full year. This has worsened by £0.4m compared to previous month mainly owing to an increase in the full year forecast outturn for mental health and continuing care placements.

- QIPP - A year to date under achievement of £1.2m (18%) against plan is reported. Full year under achievement of £1.1m is forecast, which is 15% below target. The full year forecast has worsened from last month owing to lower than anticipated year to date activity for the long term conditions scheme.

- NHS Property Services (NHS PS) have billed for 2013/14 costs based on allocations to CCGs, a proportion of these costs are included within SLAs with providers. The CCG is currently liaising with NHS PS to resolve this, as there is an element of double billing where costs have already been passed on to providers, this presents a risk to the CCG of circa £0.3m.

HF asked PD, as Chair of the CCG's Finance Commission, for his comments on the report and the CCG's current position. PD stated that 2013/14 had represented a "difficult journey" but good progress had been made.

HF invited questions from the public gallery.

Question 1
In light of this report how could the CCG justify a cut in emergency services?

HF replied that there were no proposals before the Governing Body regarding major changes to services.

The Merton Clinical Commissioning Group Governing Body agreed the Merton CCG Financial Position - Month 11.

6. To Receive and Note

7.1 Merton CCG Balance Scorecard - Quarter 3

The Scorecard, and the good progress therein, was noted by the Governing Body

7. For Note Only

8.1 Approved Minutes of Committees of the CCG Governing Body

Clinical Quality Committee 06.12.13; 17.01.14; 14.02.14

Finance Committee 10.12.13; 23.01.14; 18.02.14

Audit and Governance Committee 10.12.13

The above minutes were all noted.

8. Any Other Business

There was no further business to discuss.

9. Questions from the Public

There were no further questions from the public.

HF stated that any public questions submitted prior to, but not addressed at, the meeting would be answered in writing and any such response attached to the minutes of this meeting.

10. Meeting Dates for 2013/14

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

Thursday, 29th May 2014, 9.00am - Noon
Venue: TBC

11. Closure of Part 1

The Chair declared the meeting closed at 10.40am.

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 March 2014

……

Dr Howard Freeman

Chairman

Date:

NHS
Merton
Clinical Commissioning Group
120 The Broadway
Wimbledon
SW19 1RH
Tel: 0203 668 1221

25th April 2014

Dear

I write with reference to your email of the 25th March 2014, and the questions that you wished to raise with the Governing Body.

As you were unable to attend the Governing Body meeting on the 27th March 2014 I hope you will find the following written responses helpful.

Why have the start of Governing Body meetings brought forward to 9am from 12.30pm and 2pm? Does the Govening Body think this will encourage more Merton residents to attend?

I appreciate entirely your sentiments and, of course, we are keen to have meetings which are as accessible to as wide a range of local people as possible. However, we are bound by our Constitution to ensure we have a quorate meeting, and so need to find suitable dates and times for the Governing Body members.

I acknowledge that arrangements made may not always be convenient for some but also that a change of time may enable different people to attend.

Thank you for your congratulations to Dr Freeman on his appointment as chair of the Strategic Commissioning Board of the South West London (SWL) Collaborative Commissioning group. I note your questions related to this.

What will be the cost of the six months' process culminating in the submission of the five-year strategy in June?

The costs of running the SWL Collaborative Commissioning programme up to June 2014 are estimated at approximately £1 million: this represents 0.05% of the overall budget for the six SWL CCGs. I appreciate that any expenditure must be justified and the use of this sum to plan for the future and support collaborative working with other CCGs should reduce all our costs.

Will the costs be equally shared by the six CCGs in SW London?

Each CCG pays on a per head of their population basis, so Merton CCG will pay less than £150,000.

Are there terms of reference for the SWL Collaborative and will they be published?

The terms of reference and overall governance arrangements for all elements of SWL Collaborative Commissioning are being finalised and will be published on the Merton CCG website as soon as they are available.

Does the five year strategy require unanimous or majority support of the six CCGs bearing in mind there might be differing views across the sector, and how confident is the Merton CCG governing body that agreement on a strategy can be reached?

The six SWL CCGs are all statutory bodies and each must formally sign off the five-year strategy. The Chief Officers and Chairs of all the South West London CCGs recognise the likelihood of differing views but our aim is to work collaboratively, not just with each other but also provider trusts and partners, to develop solutions that are acceptable to all.

What is the view of the Merton CCG on the reported £8.2 million expenditure of taxpayers money on the aborted BSBV process, which was abandoned following the withdrawal of support by GPs in Surrey Downs?

The six SWL CCGs have a commissioning budget of £1.6bn per annum. The £8.2m spent on the Better Services Better Value (BSBV) Programme over three years represents 0.2% of this aggregated annual budget. As mentioned previously, it would not appear unreasonable for any public body to set aside a small proportion of its budget to look in detail at future needs and plan for them; indeed, CCGs are expected to do this.

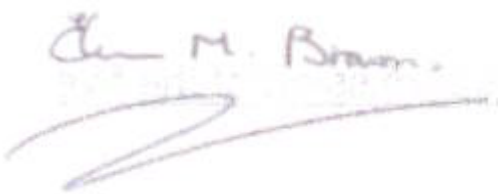
BSBV was crucial in identifying and quantifying the challenges faced by local hospitals and the local NHS in terms of clinical quality, workforce numbers, expected patient numbers and the finances available. The six CCGs will use this detailed analysis in developing their five-year strategy for local health services, taking into account any changes that have occurred since the work was originally undertaken.

I hope that I have been able to answer your questions satisfactorily and look forward to seeing you at future Merton CCG Governing Body meetings.

Thank you once again for your email. The CCG places great value on the views of local residents and recognises how these can help us improve all aspects of the service we provide.

Best wishes.

Yours sincerely,



Eleanor Brown
Chief Officer
Merton Clinical Commissioning Group