right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MINUTES

MERTON CLINICAL COMMISIONING GROUP

GOVERNING BODY PART 1

21st July 2016
1pm – 4pm
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
AD	Adam Doyle	Chief Officer
JH	Julie Hall	Nurse Member
TH	Dr Tim Hodgson	GP Member
AH	Andrew Hyslop	Chief Finance Officer
AM	Dr Andrew Murray	Clinical Chair
SP	Prof. Stephen Powis	Secondary Care Consultant
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM
Non-Voting Members		
CC	Cynthia Cardozo	Director of Transformation
LS	Lynn Street	Director of Quality and Performance, MCCG
MJ	Dr M Jarzembowski	Chair, Local Medical Committee
KP	Karen Parsons	Deputy Director of Commissioning Operations
Other Officers in Attendance		
MW	Michelle Wallington	Principal Assoc. Communications & Engagement - SECSU
DC	David Cotter	Principal Associate Corporate Affairs - SECSU
PB	Paul Brown	RSM
TF	Tony Foote	Note Taker - SECSU
Members of the Public in Attendance		
Sue Clark		Merton Residents HC Form

Apologies:

Clare Gummett	Lay Member: Patient & Public Engagement Lead
Sue Hillyard	Director of Commissioning Operations

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	Dr Andrew Murray (AM) welcomed all to the meeting, particularly Julie Hall	

	(JH) who was attending her first Governing Body meeting as the newly appointed Nurse Member.	
2.	**Declarations of Interest**	
	The following stated interest of JH was declared: Currently working on a short term contract via the Venn Group at Medway Hospital NHS Foundation Trust. This would be added to the Register of Interests.	**TF**
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 26th May 2016.	
	The minutes were **APPROVED** 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 26th May 2016.	
	The following verbal update was received to the Action Log: <u>Review of Revised Governing Body Agenda Format</u> LS stated that it was intended to introduce "Patient Stories" to the September Governing Body agenda.	**LS**
5.	**Chair's Update and Chief Officer's Report**	
5.1	Chair's Update	
	AM highlighted the issue of Clinical Leadership from his update: Good progress was being made, interviews had been carried out and the following appointments confirmed: Clinical Director: Unplanned (including urgent) Care – Dr Caroline Chill Clinical Director: Planned Care – Dr Vasa Gnanapragasam Clinical Director: East Merton Model of Health and Wellbeing – Dr Doug Hing Clinical Director: Transforming Primary Care – Dr Karen Worthington Clinical Director: Proactive and Preventative Care – Dr Dagmar Zeuner This will be communicated to all member practices presently. Additionally, AM provided a verbal update on a subject not included in his report: St George's NHS Trust. The Trust was facing very significant financial challenges, with a deficit of £55m. With regard to areas of concern, AM highlighted Estates and IT. For Estates, the Trust had both a long term strategy but was also intending to address some pressing urgent matters. With IT, there was a concern that these were actively impacting upon staff being able to carry out certain	

	duties. The Trust's new leadership structure had set its priorities: • Improve accountability • IT • Patient Safety • Governance and Risk Management • Finance • Improving relations with staff • Collaborative working with St Helier's Dr Caroline Chill (CChi) asked whether there was a target date by which the Trust expected to be "back on track". AM stated that there was no timeframe for this as yet. Dr Marek Jarzembowski (MJ) enquired about concerns with the 2 week wait target. AM responded that the CCG had raised this with the Trust and the Clinical Quality Committee would continue to monitor performance.	
5.2	Chief Officer's Report	
	Adam Doyle (AD) highlighted the following areas from his report: <u>Staffing changes</u> The following new members of staff have joined the CCG: • Chris Clark - Deputy Director of Performance and Informatics will support the performance and business intelligence function within the commissioning directorate. • Valentina Covey - Deputy Head of Medicines Optimisation. • Karen Parsons - Deputy Director of Commissioning Operations (Interim). Also recruited, in conjunction with Richmond CCG, was Andrew Moore as Director for the Financial Recovery Programme. There has been significant scrutiny of the number of interim staff being employed by the NHS over the past few months and AD would be taking a paper to the next Remuneration Committee that summarised where the CCG is against interim to permanent staff. The majority of vacancies had now been recruited to but there remained some difficult to recruit to posts that he was currently working through. <u>CCG Planning and Financial Assurance</u> The CCG is in financial recovery, meaning that it has to find a way to rebalance its books over the next few years. Due to significant in-year pressures the CCG ended 2015/16 at a break-even position and without its required 1% surplus (despite achieving its savings plan for the year). NHS England has informed the CCG that its deficit should be no more than £0.6M for 2016/17 and this presented a sizeable challenge for the organisation. However, Merton is not the only London CCG with financial difficulties: the financial position across SW London as a whole is challenging - as it is across the NHS and wider public sector.	

	The CCG has developed a Financial Recovery Plan and NHS England is monitoring its implementation and the CCG's performance each month. AD was pleased that the Plan was on the agenda and would welcome comments on this from all Governing Body members. <u>Transforming Care Partnership</u> Merton acts as the lead CCG for the Transforming Care Partnership (TCP). The TCP programme aims to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home. <u>Continuing Healthcare</u> AD was pleased to announce that there has been a very successful mobilisation of CHC services from the South East Commissioning Support Unit to Central London Community Healthcare (CLCH). He thanked James Holden, Commissioning Manager for his excellent work supported by the Director Team in ensuring this smooth transition. <u>Mitcham Carnival and Wimbledon Guild Village Fair</u> The CCG was well represented at both these events and the CCG is evaluating how it can improve its outreach engagement events further.	
6.	**Strategy**	
6.1	Primary Care Strategy	
	Cynthia Cardozo (CC) presented this item and explained that Merton's Primary Care Strategy proposed that to address health inequalities and practice variations care should be high quality, holistic and utilising evidence-based care. There was also the requirement for care needs to be integrated, proactive and with a focus on prevention and self-care. To deliver this the CCG needed a highly skilled and sustainable workforce with modernised estates and technology. Merton has twenty four Practices; a population of approx. 205,000 which is served mainly by three acute trusts; one community provider, one Local Authority and one Mental Health Trust. The proposed model is that within Merton there would be four networks, or localities, of healthcare providers each serving populations of approx. 50,000. These localities would be geographically based: two in the East and two in the West, as shown in Appendix 1. The services in the localities would be co-located and cover those detailed in paragraph 4.1. Such a model would enable delivery of London's strategic framework for Primary Care around accessible, pro-active and co-ordinated care. This would be further supported by the localities coming together as a multidisciplinary group to review performance and share learning through peer support. The strategy recognises the importance of enablers, and two of these - IT and estates – were to be considered later on the agenda. Others include training and education, decision support tools, engagement with key	

	stakeholders; clinical leadership and a commitment to work innovatively. Should the Governing Body approve the strategy it would then be communicated to all key stakeholders either through current meetings or, in the case of GP Practices, a workshop in September. The new model is planned to be mobilised by 1st April 2017. The strategy recommends that a detailed implementation plan is developed that covers the criteria, timeline, performance measures and costs for rapid access to primary care and develop a proposal for the future of urgent care services. There followed questions from the Governing Body. Julie Hall (JH) asked whether the localities would overlap. CC replied that although they would not overlap it was expected that there would be strong links between the localities and regular meetings for sharing good practice and peer support. JH also asked about the role of patient and public engagement for the Strategy. CC explained that there would be such engagement as part of the consultation and that Practices' Patient Participation Groups would be involved. AM added that the recent research carried out by Merton Healthwatch regarding issues of access to services would also need to be addressed and that the Strategy would benefit from greater detail on the plans for engagement. Dr Tim Hodgson (TH) commented that he would like to see some overlap between this Strategy and that for Community Services. Professor Stephen Powis (SP) enquired about resources for the Strategy: would extra resources be required, particularly for capital expenditure. CC said that there would be a need for additional resources, adding that there was also scope for funding to be diverted from other existing projects: Out of Hours Service; Better Care Fund; Walk-in Services. CC said that capital expenditure was covered by the Estates Development Plan (featured later on the agenda) but that bids had already been made to the Estates and Technology Transformation Fund (ETTF). CChi welcomed the pooling of resources and working across boundaries and the benefits these would bring. AD added that all were agreed on the importance of strong and vibrant primary care services. Dr Dagmar Zeuner (DZ) asked about the role of the GP Federation and emphasised the importance of an open dialogue with communities to manage expectations. AM replied that the GP Federation would be discussed in more detail in the Estates Development Plan and agreed with the need for clear communications and strong engagement. MJ said that the Local Medical Committee welcomed the commitment to primary care but highlighted some of the potential challenges: resources; workforce; quality of records. AM acknowledged these and pointed out that workforce issues were included in the Strategy's workplan. Peter Derrick (PD) also welcomed the Strategy and added the following comments. That the location of the four primary care hubs was crucial; that patients may need to sometimes be seen by GPs other than their own and this needed to be explained and managed carefully; that, anecdotally, the	

	need for seven day, 8.am – 8.pm services may not be as great as initially thought. AM said that it was important to be sure that provision did match need. With regard to the location of the hubs, CC stated that a workshop for Practices would be held to discuss this. With the above comments and caveats, the Governing Body **APPROVED** the Primary Care Strategy.	
6.2	IM&T Strategy	
	CC explained that the strategic IT objective is "to have in place robust and fit-for-purpose ICT systems and services that support service transformation and enable integration across commissioners and care providers." The Strategy now presented covered four themes: • Inter-operable ICT that enables integrated care • Patient access and self-care • Intelligence to support care and commissioning • Strategic approach to ICT in GP practices The Strategy is aligned to South West London IT Strategy and the South West London Local Digital Road Map, which the Governing Body approved at its June meeting. It proposes to establish an IMT Delivery Group for Merton, with its initial meeting scheduled for 17th August 2016. Work has already commenced on data sharing agreements to enable interoperability across twenty four practices this year. DZ welcomed the Strategy but felt that the approach to IT could be more ambitious: using IT – such as tele-care - to innovate service models. CC agreed with DZ's general point but felt that tele-care had already been tried with only mixed results. Julie Hall (JH) asked whether IT links would also be made with the London Ambulance Service and CC gave an assurance that they would. CChi stressed the importance of both clinicians and patients being educated in the use of IT and CC responded that South West London-wide plans were in place for this. The Governing Body **APPROVED** the IM&T Strategy.	
6.3	Estates Development Plan	
	CC stated that the Plan presented described the current position on Estates based on information collected in 2009. A more recent exercise had been undertaken with results only received in the past few weeks. The Plan details progress on the implementation of Better Healthcare Closer to Home such as the Nelson Health Centre and the rebuild of the Wilson site. Also included were details of some long term regeneration plans for Merton that the Local Authority is considering, including Morden town Centre and Wimbledon Stadium. Following discussions at the Primary Care Committee, bids to the Estates &	

	Technology Transformation Fund (ETTF) were submitted on the 30th June for Colliers Wood; Patrick Doody; Central Medical; Wideway; Alexander Road and Vineyard Hill. On the assumption that the bids meet the criteria of the ETTF, those successful bids will be announced in September/October 2016. There followed questions from the Governing Body. AM asked about the process for actually making decisions regarding individual locations and proposals. CC replied that the investment criteria could be found at paragraph 7.2 of the Strategy. In the absence of Clare Gummett (CG), AD raised two question submitted in writing on her behalf. (i) how does the CCG intend to gather the views of patients and the public on this Plan? (ii) on page 33 of the Plan it places "proactive engagement with the public" under the heading "Political". This rather make engagement sound like something the CCG has to do rather than wants to. CC responded: (i) that Practices' Patient participation Groups would be involved; (ii) that she acknowledged that this wording was potentially misleading and would be amended.	**CC**
	DZ said it was very encouraging to see estates being considered "in the round" and that every option regarding public estates in Merton needed to be considered. She added that a bid had already been made to 1 Public Estate Fund. On the issue of public engagement, Lynn Street (LS) welcomed the involvement of Patient Participation Groups but that there were a number of other options and these should be considered. She saw the engagement of the Plan as a huge and very important piece of work. The need for a clear programme of engagement was vital to challenge public perception of services. PD was happy with the Plan in principle but that specific projects would need to be considered thoroughly to ensure they fitted in with the Primary Care Strategy. CC agreed with this and that, although some bids had already been made to the EFFT, this was only to ensure that deadlines for bids were met and the CCG could withdraw its bids if appropriate. SP welcomed the mitigations built into the plan but felt strongly that one should be added regarding any loss of collective control over Estates in Merton.	**CC**
	The Governing Body **AGREED** a draft Locality and Neighbourhood structure, to enable further consultation with GP members and key partners. The Governing Body **NOTED** the priority order of Estates submissions under ETTF. The Governing Body **APPROVED**, subject to ETTF funding, the timescales highlighted in section 9 of the Plan. AM then asked AD for his overall comments on the "Strategic" section of the agenda. AD stated that primary care was vital to the CCG achieving its aims, and links to Community Services was a key part of this, as were links with the Local Authority and Mental Health Trust.	

	The Executive Team would now be driving forward the overall Strategic Plan in more detail and at an operational and commissioning level. For the September Governing Body meeting an overall implementation plan for this would be presented for consideration	
7.	**Quality and Performance Governance**	
7.1	Minutes of Clinical Quality Committee: 04.05.16; 15.06.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	In the absence of Clare Gummett (CG), Chair of the Clinical Quality Committee, LS provided the summary on her behalf. <u>Referral to Treatment</u> A key measure of the 2016-17 CCG Improvement and Assessment Framework is for patients to be waiting 18 weeks or less from referral to hospital treatment for elective care. The target for this is 92% target and, historically, the CCG has narrowly failed to meet this. A key factor in this has been a significant underperformance at St George's Hospital. The Trust is committed to turning this around in 2016-17 and the Clinical Quality Committee will be monitoring its progress. On a broader scale, Merton will be working closely with neighbouring CCGs, NHSE and NHSI to reduce the demand for planned care to a more sustainable level. One of the main concerns was how patients on the waiting lists are being supported, and, of course, many are re-presenting to their GPs, resulting in some cases being admitted as emergencies. <u>Southwest London & St George's Mental Health Trust (SWLSTG) – Care Quality Committee (CQC) inspection</u> The overall findings of this inspection were that the Trust "Required Improvement", but it was judged to be "Good" in some areas, particularly "Caring" and "Well Led". As Merton is the lead CCG for this Trust, the Clinical Quality Committee sought and was given assurance that the new Director of Nursing and Deputy Director of Nursing were now in post and some improvements have been made. The areas of particular concern to Merton patients in this report include Community Home Services, Crocus (the Older People's) Ward and Jupiter Ward. An action plan has been reviewed and is being monitored. <u>IAPT Recovery Rate</u> Clinical Quality Committee is concerned that the recovery rate has dropped to below 50%. This is being investigated and will be considered again at the next Committee meeting. <u>Safeguarding Children</u> One area of concern is SWLSTG rate of Level 3 training is currently 68% against a target of 90%. An action plan to improve performance is in place. <u>Safeguarding Adults</u> In February the new Pan London Adult Safeguarding Policy and Procedure document was launched and a Merton Safeguarding Policy incorporate the pan-London policy has now been developed.	

	An area of concern was noted over safeguarding issues in the CCG's Intermediate Care Bed provision, resulting in not currently being able to offer the full provision commissioned. However, the Care Quality Committee has been assured that patients are safe within the reduced provision and a new service has been commissioned wef 1st October 2016. <u>Continuing Healthcare</u> The Committee continues to receive monthly updates on the situation over the transfer of services for continuing healthcare – and they continue to be a cause of considerable concern. The Committee is assured that robust action is being taken at a number of levels and will continue to monitor it closely. The Governing Body **NOTED** the minutes of the Clinical Quality Committee.	
7.2	CCG Assurance Report Month 1 (April 2016)	
	LS explained that the Assurance Report provided an April 2016 update to the Governing Body on CCG achievement against national and local performance, finance and quality standards. Where available, more recent performance information has also been included in the report. The report covers the four main domains as defined by the NHS England CCG Improvement and Assessment Framework 2016-17. These are: Better Health, Better Care; Leadership and Sustainability. Scorecards showing areas of risks for the Better Health and Better Care domains – along with key local indicators – are included, along with exception reports. A scorecard showing financial performance, with key risks and mitigations are shown. The Sustainability and Leadership sections will be included as further information and guidance is released by NHS England. The activity performance section will be developed following the first meeting of the new Performance Delivery Group later in July 2016. AD commented on the new format of the report and its rationale. Page 3 showed the key performance messages: areas of good performance and chief risks to the CCG: Cancer (2 week wait); cancer Breast symptoms (2 weeks wait); RTT (52 weeks wait); Diagnostics (6 weeks wait). Also, the financial impact, whether performance is above or below target and, if below, what actions are being taken to address. Page 4 showed the Quality Indicator Scorecard. In domain one (Better Care) there were significant challenges facing the CCG. The main driver of these was issues over St George's performance and AD had requested a full rectification report from the Trust. For mental health, IAPT recovery rate had deteriorated; this was being investigated with a rectification report to follow. Page 9 showed Finance and Audit data. This was particularly important for the Governing Body to enable it to question capacity issues and how these would be addressed.	

	There followed questions from the Governing Body. SP felt that the concerns regarding data quality with St George's should be reflected in the report. The Governing Body agreed with this. MJ reflected that the CCG was in an unusual position as it commissioned from three acute trusts but was host commissioner to none of these. He enquired whether there was any difference between how Merton patients fared compared to those from Wandsworth and Sutton. AD responded that Merton was disproportionately affected by St George's performance. Nevertheless, the CCG was a "strong, critical friend" to the host commissioners and they tended to respond in a positive manner. The Governing Body **APPROVED** the Assurance Report Month 1 (April 2016)	**CCl**
7.3	Complaints and PALS Annual Report 2015/16	
	LS explained that this was the year-end report for NHS Merton CCG complaints and PALS service, covering the time period of 1 April 2015 to 31 March 2016. The complaints and PALS service was managed on behalf of NHS Merton Clinical Commissioning Group by NHS South East Commissioning Support Unit (SECSU). LS then highlighted some of the key performance indicators. • Acknowledgement rates had improved • 69% of responses were sent within the target 25 days. This performance was due mainly to a number of complex complaints which required additional time to provide a full and satisfactory response. However, in such cases complainants were regularly updated on progress. The overall number of complaints received had also risen and Continuing Healthcare was the main reason for this. Due to this, and themes arising from such complaints, action was taken "in year" and these were also a significant factor in the CCG procuring a new provider of Continuing Healthcare. The report also contained details of lessons learned from complaints. The Governing Body **APPROVED** Complaints and PALS Annual Report 2015/16.	
7.4	Safeguarding Children Q4 Report	
	LS stated that the Q4 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; a statutory obligation of the CCG. All actions identified in the Q3 2015/16 report have been achieved in Q4. An area of outstanding work is to appoint a named doctor however, as an interim arrangement the Designate Nurse has covered key functions of this role.	

	AM commented that the appointment of a named doctor was an ongoing problem. The post had gone to advert, but without success. Other options are being explored, such as the Clinical Leads becoming involved or making a joint appointment with Sutton CCG, which was also experiencing similar difficulties. AM congratulated LS on the good work done on completing the other actions. The Governing Body **APPROVED** the Safeguarding Children Q4 Report.	
7.5	Safeguarding Adults Q4 Report	
	LS stated that this report set out the CCG's safeguarding arrangements and activity within commissioning and provider services across the whole health economy of Merton for Q4. It provided the Governing Body with assurance that MCCG was meeting its statutory duties and requirements for safeguarding adults at risk by operating within the parameters of the Care Act 2014 and the Pan London Policy and Practice guidance 2015. The report focussed on progress made in priority areas identified within the Safeguarding Adults Annual Report: • Assurance • Training • Prevent • Mental Capacity Act and Deprivation of Liberty Safeguards LS highlighted that the rate of staff training in adult safeguarding in quarter 4 had dropped to 52.17%. She explained that this was mainly due to the significant number of interim staff taken on during that quarter and that this was now being addressed. JH asked whether there had been any recommendations from the NHSE Safeguarding Adults and Children Deep Dive. LS confirmed that there had the CCG had been given an overall rating of "Good" but work had been undertaken to ensure that safeguarding processes were aligned with policies. The Governing Body **APPROVED** the Safeguarding Adults Q4 Report.	
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	
	PD (chair of the Finance Committee) provided the following summary. The CCG's budget deficit had continued to dominate Finance Committee discussions: that the CCG had forecasted a deficit of £6m for 2016/18 but NHSE had imposed a 0.6% deficit figure. Accordingly, the CCG's budget now reflected NHSE's request but the Governing Body should be aware that this may not be credible and that the actual deficit was likely to be £3.5m. PD raised the question of whether the CCG should give NHSE prior warning of this.	

	PD also stated that there were concerns over the quality of data reporting by both St George's and St Helier's. AD commented that a full review of St George's data was being undertaken and he had also discussed with the Chief Officer of Sutton CCG (host commissioner for St Helier's) if they could be taking any further action with St Helier's. AD added that, in August, he wanted to be able to define the CCG's actual position. The Governing Body **NOTED** the minutes of the Finance Committee.	
8.2	Financial Recovery Plan (FRP)	
	AH stated that the CCG was now officially in the process of financial recovery. This had three distinct stages: 1. Diagnostic – what is the position, why has it arisen and what can be learned from this. 2. Developing a plan – what is needed to resolve the position. 3. Delivery – how to get back to financial sustainability Assistance on drafting a Financial Recovery Plan (FRP) was commissioned from RSM and their representative, Paul Brown was present today to answer questions as necessary. Today, AH said he would be focussing on developing a Plan. Page 13 of the FRP explains that the CCG originally submitted a planned deficit position of £6m. However, following discussions, NHSE imposed a deficit target of £0.6m. The CCG has now identified further actions which would reduce the expected deficit position to £3.3M. These actions, totalling in savings of £2.7m involve the removal of the RTT Reserve and the release of savings, provisionally in pace to mitigate the risk of not securing acute contracts. However, it was unlikely that this revised figure would be accepted by NHSE. The CCG's original submission to NHSE included the requirement to deliver a £7.3m QIPP in 2016/17. As part of the FRP, a further £2m of savings have been identified. The schemes for these are all supported by detailed PIDS; some involve "stretching" existing schemes and other are completely new schemes. However, only seven months of 2016/17 remain in which to accomplish these extra savings. AH emphasised that to undertake its commissioning agenda the CCG had to regain financial balance – getting as close to the NHSE specified deficit of £0.6M, as soon as possible. Accordingly, there was still the need to look for further savings. There were two areas being considered: • Acute over-performance: the CCG to take a greater leadership role with the commissioning hosts of the three acute trusts it commissions services from. • Continuing Healthcare: that, with a new provider in place, it may be possible to have a greater control over expenditure. There would also be a review of all commissioned services to ensure the CCG is getting the best possible value for money and carefully evaluating patient benefit and effectiveness.	

	There followed questions from the Governing Body. SP asked whether the time remaining in 2016/17 would be sufficient for the CCG to achieve the savings required. AH accepted this and that was why it was now being viewed as a two year plan including 2017/18. SP asked further, if decommissioning of services became necessary, would two years be sufficient, bearing in mind the contracting round for 2017/18 would commence in September 2016. AD commented that coming to the Governing Body meeting in September would be a plan for 2017/18 commissioning and, hopefully, 2018/19. PD asked whether, if the plan was for commissioning over two years, would there also be an assurance of resources over the same period. AD said that he hoped this would be given but acknowledged that it was unlikely. DZ asked how short term (two years) planning needs be balanced against longer terms aims (transformation of services). In short, a clear vision of what the CCG could afford to do now, such as preventative health, was needed. AD acknowledged this and reminded the Governing Body of the CCG's statutory duty for performance and improving health outcome, and achieving financial balance. The CCG, and Governing Body, needs to challenge itself to think innovatively to come up with the right solutions. The Governing Body **APPROVED** the Financial Recovery Plan.	
8.3	The Evaluation of our Commissioned Services	
	In the absence of Sue Hillyard (SH) Karen Parsons (KP) presented this item and explained that with the CCG's challenging financial position it was necessary to review all services commissioned in relation to the benefits for the population of Merton. Accordingly, It is proposed that decisions about the future commissioning arrangements of services are put through a governance process (appendix 1) in which the decision is risk assessed by Clinicians, Quality and Equality experts, Commissioning experts as well as patient representatives. A steering group called the Evaluation of Commissioned Services Group (ECSG) was set up to oversee the processes. This group consists of Quality, Patient Representation, Healthwatch, Clinical Lead (GP), Public Health, Commissioning, Contracting and Finance along with external management consultants RSM. However, with the size and depth of the number of services and procedures commissioned this will be done in stages. • Phase 1: individual services and contracts reviewed along with Procedure of Limited Clinical Value. • Phase 2: a longer list of services and procedures provided by the Acute Contracts will be reviewed through this process. If the Governing Body approves this process the timetable will be as follows: Governing Body September 2016 – A presentation of the long list of services that could be potentially	

	reviewed, provided in a different way or no longer commissioned - The Governing Body will be asked to do approve that the team do a wide engagement piece on these key services - The Governing Body will also be asked to give permission for the providers of these services to be notified that are being considered and that the CCG we will be confirming its commissioning position with them later in the year. Governing Body January 2017 - The Governing Body will be given the feedback form the public and members on the services and the executive team will also recommend what services we should be changing at that point - The Governing Body will be asked to confirm this in January AM confirmed that the proposed process had already been considered by the Clinical Review Group and stressed that decisions taken regarding the future of services would be taken "in the round" and it may that improvement to a service may be proposed rather than full decommissioning. TH emphasised the need for the population of Merton to be made aware of the financial reasons for considering decommissioning. DZ welcomed the "re-framing" of the CCG's approach and the focus should be on using funding for the best purpose. She added that it would be very helpful to get the backing of other organisations too. AD agreed with the collective approach and that such discussions are ongoing. The Governing Body **APPROVED** the current processes and governance that is in place. The Governing Body **APPROVED** Procedures of Limited Clinical Value The Governing Body **NOTED** that the Clinical Review Group/Clinical Panel will review recommendations and agree which services could be prior approval.	
9.	**Governance**	
9.1	Minutes of Audit and Governance Committee: 17.03.16; 20.05.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	PD, Chair of the Audit and Governance Committee, stated that there were three main issues discussed at the March and May meetings: • Board Assurance Framework – good progress had been made with risks regarding the 2016/17 objectives. • Financial Governance Review (RSM) – the Committee had endorsed the recommendations resulting from this and these had been included in the joint action plan (with the review carried out by Capsticks). • Procurement of Local Audit Arrangements - PD noted that there was a paper regarding this later on the agenda that was seeking approval for the CCG to enter into a collaborative procurement process for external audit arrangements. This would entail the establishment of a Procurement Working Group (to be led by Andrew Hyslop (AH))	

	comprising the six South West London CCGs and, for the practical work, an Audit Panel again across the South West London CCGs. The proposal was that Merton CCG be represented by the non-conflicted attendees of the Audit and Governance Committee. Specifically, himself, SP, CG, AH and LS. AH commented that PD had explained the requirements of the later item (Item 9.4 Procurement of Local Audit Arrangements) and would the Governing be content to approve this item now. The Governing Body was happy to do so. The Governing Body **NOTED** the minutes of the Audit and Governance Committee. The Governing Body **APPROVED** the nomination of the stated attendees of the Audit and Governance Committees to act as the Audit Panel.	
9.2	Board Assurance Framework	
	LS explained that a revised 2016/17 Board Assurance Framework had been produced, in order that it reflected the revised corporate objectives for the year. A significant number of the risks remained the same in nature, and there had been additions to the BAF cover GP ICT, the Transformation Programme and Primary Care Commissioning. Amendments have also been made to reflect the current financial position of the CCG. It should be remembered that the BAF is a live document, meaning that updates are made on a regular ongoing basis and the document reported to committees does not reflect a static position. The Governing Body **APPROVED** the Board Assurance Framework.	
9.3	NHS Merton Clinical Commissioning Group (CCG) Governance Review: Financial Governance Action Plan	
	LS explained that the CCG commissioned Capsticks Governance Consultancy Service to undertake a Governance Review of the Governing Body and associated Committees. The findings from the review were presented to the Governing Body in April 2016. The CCG also commissioned a Financial Governance Review, undertaken by RSM, to establish the causes of recent financial challenges. A combined action plan has been developed to address the recommendations from both of these reviews. The plan has been shared virtually with the Audit and Governance Committee and progress will also be monitored by that Committee. LS noted that a number of recommendations were implemented immediately and these are reflected as “Complete” on the Action Plan. AM added that the action to appoint a third lay member to the Governing Body underway with interviews being held. The Governing Body **APPROVED** the Financial Governance Action Plan.	

9.4	Procurement of Local Audit Arrangements	
	See minute of item 9.1.	
10.	**Key Actions to Communicate with the Organisation**	
	AM identified the key actions as: • The Chair's and Chief Officer's Updates • The Primary Care Strategy • That the IMT Strategy had been approved • That the Estates Development Plan had been approved • Update on the CCG's financial position	
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**	
	29th September 2016 2.00-5.00 Venue: Chaucer Centre, Morden	