right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MINUTES

MERTON CLINICAL COMMISIONING GROUP

GOVERNING BODY PART 1

26th January 2017
Time: 10.30am – 1.30pm
120 The Broadway, Wimbledon SW19 1RH

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
CM	Chris Moreton	Chief Finance Officer (Interim)
AM	Dr Andrew Murray	Clinical Chair
SP	Prof. Stephen Powis	Secondary Care Consultant
KP	Karen Parsons	Chief Officer (Interim)
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM

Non-Voting Members

CCl	Chris Clark	Director of Performance, Planning &Informatics (Interim)
JM	Dr M Jarzembowski	Chiar, Local Medical Committee
AMo	Andrew Moore	Programme Director of Financial Recovery
LW	Liam Williams	Director of Commissioning Operations (Interim)

Other Officers in Attendance

MW	Michelle Wallington	Principal Assoc. Communications & Engagement - SECSU
EB	Eileen Bryant	Interim Executive Lead for Safeguarding, Wandsworth & Merton CCGs (items 9.3 & 9.4 only)
TF	Tony Foote	Note Taker - SECSU

Members of the Public in Attendance

David Ash	KOSHH
Sandra Ash	KOSHH
Graham Barker	Patient Engagement Group Member
Chris Bittell	Abbvie
C Jackson	KOSHH
Julian Keens	Ipsen Ltd
Logie Lohendran	Patient Engagement Group (Vice Chair)
Tom Pollak	

Apologies:

Dr Tim Hodgson	GP Member

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	Dr Andrew Murray (AM) welcomed all to the meeting. AM then said that, in light of the issue of recording Governing Body meetings being raised at the last meeting, he thought it would be helpful to clarify this matter. The Governing Body of Merton CCG is committed to openness and transparency, and conducts as much of its business as possible in a session that members of the public are welcome to attend and observe, subject to available space. The meeting, although held in public, is not a public meeting and as such there is no opportunity provided for the public to ask questions in that arena other than that offered at the discretion of the Chair. The Governing Body meeting is audio recorded as part of our commitment to make information as accessible as possible. The recording is added to our website a few days after the date of the Governing Body meeting. The CCG accepts that the recording of public meetings can improve transparency and record keeping which is why the CCG has to date provided an audio recording of the meeting. From the 1st April 2017 we will also produce a video recording of the meeting. This will be uploaded to our "youtube" channel and a link made available via our website and social media channels. Once this arrangement is in place the CCG will not normally permit other filming of the Governing Body meeting unless expressly agreed by the Chair in advance of the meeting. Until the 1st April the CCG will accommodate members of the public who wish to record CCG meetings if advance notice is given and in so far as it does not disrupt business and is respectful of the rights of individuals who may not wish to be filmed. To be clear, the use of any recording devices at any time – including mobile phones – is not permitted without the prior agreement of the Chair and all members of the public present. Anyone found using such a device without prior agreement will be asked to cease recording and may be asked to leave the meeting. The CCG has also considered more generally how it should proceed in regards to allowing members of the public to participate in Governing Body meetings held in public. As a result we have agreed a policy which can be found on our website. At this time I would draw your attention to the section on recording of the meeting and the requirement for the request to be made in advance to the CCG and for all members of the public in attendance to be given the opportunity to give their consent. I have not received any such requests. Therefore, anyone found recording will be asked to leave.	
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 the meetings of the Merton Clinical Commissioning Group Governing Body of the 24th November 2016 and 15th December 2016.	
	The Governing Body **APPROVED** the minutes as a full and accurate record of the meetings.	
4.	**Matters Arising and Action Log**	
4.1	Actions arising from meeting of the Merton Clinical Commissioning Group Governing Body of the 24th November 2016.	
	AM noted that the action had been superseded by recent developments.	
5.	**Chair's Update and Chief Officer's Report**	
5.1	Chair's Update	
	AM highlighted the following areas: <u>Organisational Changes</u> Work continued to consolidate the CCG's senior management resources with partner CCGs, to enable stronger accountability and leadership on a more collaborative basis. There was an agreement that each of the five South West London CCGs (NHS Kingston, Merton, Richmond, Sutton and Wandsworth CCGs) will share the Accountable Officer and be led locally by a Managing Director (MD). This role will be different to the current remit of the Chief Officer role. There will also be one Chief Finance Officer, with statutory financial responsibilities for the five CCGs (excluding Croydon). Sarah Blow, Chief Officer for Bexley CCG was announced on 19 December as the new Accountable Officer for NHS Kingston, Merton, Richmond and Wandsworth CCGs from 2017/18 and NHS Sutton CCG from April 2018. We are also proposing changes to the senior management arrangements across the CCGs, including Merton and Wandsworth CCGs working together as one local delivery unit, with the intention to operate under one Managing Director. In light of this, there are a number of planned senior leadership changes. Karen Parsons, our Interim Chief Officer and Liam Williams, Interim Director of Commissioning Operations are leaving the CCG today. Andrew Moore, currently Director of Financial Recovery, will take on the role of Director of Commissioning and will also act as Chief Officer for February until Graham MacKenzie (Chief Officer for Wandsworth) returns from leave to cover Wandsworth and Merton until the end of March. In addition I would like to welcome Chris Moreton to the Governing Body as he takes on the role of acting Director of Finance following the departure of Andrew Hyslop, who left on 13 January. These arrangements will enable the CCG to fulfil its statutory responsibilities and also to ensure its QIPP programmes are further developed and ready for delivery in 2017/18. The CCG will continue to work closely with Wandsworth CCG to ensure transitional arrangements are in place. AM thanked Karen Parsons, Andrew Hyslop and Liam Williams for their work, and also Andrew Moore for agreeing to take on the additional role. AM also recognised the contribution of Lynn Street, the CCG Director of Quality and	

	Governance who left at the end of December. Sustainable Transformation Plan A series of local public events are being arranged for the next two months as part of on-going local engagement. Forums will be held in each of the six local boroughs and these will be repeated approximately every six months. The NHS will also be carrying out an online survey to gather people's views on what matters to them about their NHS. The Collaborative Leadership Group met and had further discussions about better collaborative working, an update on acute configuration and joint prevention campaigns across south west London. There was also a discussions of the plans with the south west London JHSOC. GP Forward View The five year forward view template was submitted to NHSE on 23 December 2016. The plan covers specific areas of work for Merton to undertake over the next year, including plans around the new IT funding the CCG has secured to improve the sharing of patient records and reduce GP workload. It also outlines next steps in plans to help redevelop GP premises, provider and workforce development and extended access. Feedback on this is expected from NHSE and the CCG will then undertake further refinement. Further Services on the Wilson Site AM would be chairing a meeting with local people on 31 January at the Wilson Hospital to talk about the practice closure, the walk-in closure and the future plans for the Wilson site. The local MP will also attend. Other meetings AM met with Stephen Hammond MP in December for a general discussion of work the CCG is undertaking. Additionally, Karen Parsons and Liam Williams met with the Chief Office of Merton Council and the Chair of the OSC to discuss the CCG's forthcoming plans in relation to the Wilson site and commissioning plans in general. The Governing Body **NOTED** the Chair's Update.	
5.2	Chief Officer's Report	
	Karen Parsons (KP) highlighted the following areas: 16/17 and 17/18 QIPP KP stated that the CCG remained on target to achieve its 2016/17 control total of £0.6m but this was heavily mitigated and dependant on delivery of the QIPP plans. The CCG's 2017/18 QIPP plans currently forecast the need to achieve gross total of £13.4m which is, and will remain challenging, over the next 5 years. There is, however, no option to do nothing. The CCG will continue to work across SWL STP in partnership with key stakeholders to transform services now and in the future. As part of the planning round the CCG is required, over the next 2 months, to have its QIPP plans agreed and embedded within the acute provider contracts. Epsom Health and Care Daniel Elkeles (Chief Officer, Epsom and St Helier NHS Trust) kindly invited Merton and Sutton CCGs and other partners to visit Epsom Hospital to see the new integrated service they have in place to support early and effective discharge planning, hospital to home support and community assessment and	

	diagnosis service (CADU). The CADU is GP led on hospital site. It is for people with an acute exacerbation or diagnostic uncertainty; urgent assessment and access to diagnostics; enhanced care package to support the return home; and providing certainty help to prevent admission. The integrated team come together twice daily in a 'huddle' where they discuss and plan for the care of their patients on their wards, on CADU and at home. The Epsom Community Hub provides community based coordinated health and social care for people with complex conditions; short term intense care and care planning; multidisciplinary care & care coordination; and allows people to stay at home, regain independence and prevent admission. <u>Sustainable Transformation Plan</u> KP commented that AM had already covered this issue in his update. <u>120 Broadway</u> The CCG is responsible for void costs for all NHS buildings in its area. This is particularly pertinent to 120 Broadway in Wimbledon which is currently the office base for Merton CCG staff. In discussion with NHS Property Services and Chief Officers across SWL, the CCG is currently considering the future use of 120 Broadway. This could mean some changes over the next year but we will ensure than any decision taken will factor in minimum disruption for our staff. <u>Personal thanks</u> KP said that whilst she had only been with Merton CCG for a short time she continued to be impressed with the leadership and dedication of the Chair, Clinicians, Executives and staff of the CCG. Regardless of staff being interim or substantive there is a commitment and passion to transform local health and care across system that provides our patients with the best and most affordable outcomes. KP said she appreciated the support given to her by the CCG and wanted to take this opportunity to wish all staff the very best for the future and will follow their progress with interest. The Governing Body **NOTED** the Chief Officer's Report.	
6.	**Strategy**	
6.1	Devolution for London - Memorandum of Understanding	
	AM explained that in December 2015, all 32 Clinical Commissioning Groups (CCGs), London Councils on behalf of the 32 London boroughs and the City of London, the Mayor of London, NHS England and Public Health England came together as 'London Partners', and signed the London Health and Care Collaboration Agreement. Through this, the Partners committed 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. A draft of the London health and care devolution Memorandum of Understanding (MoU) was circulated in December 2016 for comment. A number of CCGs requested clarification on the implications of commitments within the MoU for non-pilot relative to pilot areas. The paper now presented aimed to summarise these implications. AM added that he had already discussed this issue with the Chief Executive of Merton Council who had no significant reservations. Peter Derrick (PD) acknowledged that more detail had now been provided but he remained unclear as to what significant difference the planned devolution	

	would make. He felt there was still a lack of clarity over decision making and how the pilot areas had been selected. AM accepted that details were still being worked on and what was presented now represented a high level view. With regards to decision making, AM stated that this should be devolved from a national level to London. PD repeated that he was not yet clear what the benefits of this would be. KP commented that some things would be better on a London-wide scale, particularly as certain issues single CCGs, or even individual sectors, might struggle to cope with. Dr Marek Jarzembowski (MJ) asked whether any of the South West London CCGs were taking part in the pilot scheme; AM confirmed that they were not. Dr Dagmar Zeuner (DZ) asked was there a timeframe for the implementation of the MoU. AM confirmed there was and would ensure the latest version of this was circulated to members. The Governing Body **NOTED** the update on the Devolution for London - Memorandum of Understanding.	**AM**
7.	**Finance**	
7.1	Minutes of the Finance Committee: 20.01.16; 23.11.16; 07.12.16 – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations.	
	PD highlighted the following areas: • There were significant risks relating to NHS Property Services and the issues mentioned in the Chief Officer's Report. This required close monitoring and the Finance Committee would continue to do this. • PD noted that contracts had been agreed with St George's and ESH with work ongoing on risk sharing. This was very welcome. • The CCG remained on target for its year end position, but this was dependent on a number of things and could change, for better or worse. • The Team will be working very hard on the 2016/17 QIPP programme for the rest of the financial year. • The figure of £13m QIPP for 2017/18 was noted but PD added that the Finance Committee was not entirely convinced that this was achievable. PD added that he felt that NHS England was carrying out a de facto abolition of CCGs but that this was not on any statutory basis. There was now a South West London Region although each CCG remained an independent body and this could lead to a confusion of responsibilities. The Governing Body **NOTED** the Finance Committee minutes.	
7.2	Finance Report Month 9	
	CM stated that the CCG continued to report that the control total of a £0.6m deficit would be achieved. However, the CCG incurred additional and material pressure on its acute position in November and work had been undertaken to establish whether the spike in activity was a "one off" or the start of a seasonal trend. There was an argument that the established methodology could overstate the position to be in the region of £750k. For the year to date position, the CCG's pro-rata target is a £450k deficit and there has been slippage relative to this: posting an overspend of £777k, producing an adverse variance of £327k. This was principally due to bank interventions required to achieve the year-end target not being prorated in to the year to date position. The CCG chose this approach on the basis that the	

interventions once completed and achieved will be binary in nature and as such have been phased in to M12.

Key Variances

- Acute – the full year forecast acute position shows an adverse variance to plan of £2,327k. Adjusting for the £750k reduces this variance to plan to £1,577k but this is still £714k worse than last month's FYF.
- Primary Care & Prescribing – Overall, the FYF favourable variance has improved by £404k to £1,435k. £29k of this is due to prescribing improvement but the bulk of the improvement is in Primary Care.
- Corporate and Estates - the FYF adverse variance is £1,123k. The position has deteriorated this month by £210k, due mainly to Nelson IT costs.
- Reserves – the FYF indicates an improvement of £1,322k to a favourable variance of £2,748k.

Revue Resource Limit

There has been an increase of £1,649k in the RRL in M9 to £272,157k. NHSE have applied this adjustment to compensate the CCG for 2015/16 costs in primary care.

Non-Acute

Overall, the FYF position has deteriorated very slightly to £732k adverse compared to plan. This is £51k worse than the M8 FYF. Excluding CHC, there is a net movement of just £15k. £36k relates to CHC. Compared to the sizeable changes in the FYF experienced previously, we are growing in confidence that the CHC FYF looks reasonable and robust.

Primary Care & Prescribing

Overall, the FYF position shows a £1,435k underspend at M9 which is an improvement of £404k over M8. Prescribing shows a £116k underspend after the impact of QIPP of £1,235k. This is £29k better than M8.

The prescribing forecast has performed well this year, achieving a stretched QIPP target in addition to the favourable variance explained in this report. Again, we have increase optimism that this figure looks robust for the full year.

There is an improvement in the primary care FYF at M9, £216k relates to a prior year benefit. The remainder of the £404k relates to some over budgeting.

Corporate and Estates

The Corporate and Estates FYF position has worsened in M9 by £210k to a full year forecast adverse variance of £1,123k. £165k relates to the CCG's view that IT printer costs at the Nelson will not be recovered. £43k relates to CHP voids at the Nelson that were previously unaccounted for.

The CCG continues to forecast to break its running cost allocation. The forecast disclosed in the accounts is net of a movement of £119k (M8:£171k) which has been moved from running costs and placed in transformational costs. We have left the NHS Property Services related property costs forecast unchanged. Some further information has come in since month end which may signal an improvement in this area but it is too early to say at what level this will be.

Reserves

The reserves position is made up of four elements: unallocated savings, finance policy & procedure QIPP, Systemwide Programmes, Non-recurrent fund.

Much of the reported improvement relates to the position taken on unallocated savings. These savings must be achieved for the CCG to hit its control target of

	a £0.6m deficit. There are broadly offsetting, minor changes to the Finance Policy and Procedure QIPP element and system wide programmes. **Risks and Mitigations** The major risk to the position is in the judgement on the future performance of the acute. All other risks can be assumed to be included in the position. Given that we have already mitigated the position as much as is possible, any further deterioration would result in the CCG forecasting that its control total cannot be met. We have advised NHSE of this view and estimate the down side to be £1m in a final deficit of £1.6m in this scenario. There followed questions and comments from the Governing Body. Clare Gummett (CG) asked for further details about primary care and prescribing. CM replied that primary care was now the CCG's responsibility. When this transferred from NHSE to CCGs it was considered to be underfunded and the CCG made a pessimistic prediction for it. However, it had been more positive than initially thought. The Finance Committee **APPROVED** the Finance Report Month 9.	
8.	**Commissioning**	
8.1	Update on Clinical Thresholds and Policy Changes	
	Andrew Moore (AMo) presented this item and began by providing some context to the decisions the Governing Body was being asked to make. It was, AMo stressed, important to recognise that the CCG was in a position of Financial Recovery: that it was currently spending more than its funding allowed and that next year would be even more challenging. This meant that the need to make difficult decisions was unavoidable but that if Merton CCG could do this together with the other South West London CCGs there would be advantages of scale and continuity. Also very important was the need to engage with the public about the need to make such decisions and assure them of the fair and transparent processes used to reach decisions. The Governing Body then considered the three sections of the paper. **IVF** AMo informed the Governing Body of progress being made in this area by other South West London CCGs: • Croydon CCG commenced an 8-week public consultation on moving IVF to an exceptions only basis on 4 January, concluding on 1 March 2017. • Richmond CCG launched engagement on tightening access to IVF. On 17th January Richmond CCG decided to commence formal consultation on applying tighter access criteria for IVF. Between now and March 2017, Merton would be undertaking considerable public engagement and will discuss the prospect of any changes with the Overview and Scrutiny Committee, and will seek to understand how to reach some stakeholder groups that will help us to draw together a full equalities assessment. AMo said that the CCG already had a comprehensive list of stakeholders groups that it wished to engage but asked the Governing Body if it had any further suggestions. Dr Carrie Chill (CChi) suggested Patient Participation Groups and AMo agreed to include these. CG acknowledged that the list was very comprehensive but stressed the need for stakeholders from East Merton to be well represented, as the most deprived were likely to be most	**AMo**

affected by changes. In light of this, Julie Hall (JH) asked whether it was possible to plot IVF referrals geographically but AMo said it was difficult to get such data.

DZ stated that there were currently 193 applications for IVF in Merton: she asked what effect would a tightening of thresholds have on this total and what would be the savings. AMo replied that the answers to both questions would depend upon what the Governing Body decided, but savings could be as much as £700k a year.

AMo observed that a period of consultation and formalities that may follow may take as long as six months. It was possible, that once people became aware of a possibility of change in eligibility for IVF treatment there would be a "surge" of people wanting apply to before changes took effect. With this in mind, an option for the CCG would be to inform all IVF providers that there should be a "pause" for entrance to waiting lists whilst consultation was ongoing. This could result in a significant saving for the CCG but, AMo conceded, any delays to treatment caused by such a pause could have a clinical effect.

KP asked about people already in the IVF program and AMo stated he would not expect a pause in access to IVF treatment to impact upon those already in the program. JH enquired whether a pause would have a detrimental effect upon providers; AMo thought this unlikely. Professor Stephen Powis (SP) asked about what mechanism would be in place for individual cases to seek treatment on an exceptional basis; AMo assured him that the Individual Funding Request process was still in place for such circumstances.

DZ said that if there was to be a pause changes to the eligibility criteria were inevitable, so what was the point of having a consultation. She added, if the CCG could not afford to provide certain services it should be open and say so. AM acknowledged this and accepted that the CCG would not be going through a period of consultation if it was not planning to reduce access to IVF. AMo commented that the Governing Body needed to consider the local population when making its decision. His recommendation - moving to a very restrictive policy – did carry a risk of being challenged and so it was vital that the public were informed of the rationale for taking such a decision.

CChi was concerned about the effect of a pause on patients already on the waiting list who had been considered eligible under the current criteria. AM agreed and that he would support a pause only for those not already admitted to the waiting list. MJ commented that IVF was a very emotive issue and any decision had to be clearly explained to both patients and GPs.

LW advised that there was a significant risk of a legal challenge if patients were currently referred or accepted for treatment under the current CCG policy, and whose treatment was delayed or excluded due to changes being agreed that further restricted the access criteria. SP said that he felt uncomfortable with being asked to make a decision without greater detailed data. He suggested that it might be more appropriate to proceed with the consultation but not pause the service and then make a decision to align with the start of the 2017/18. However, AM said the Governing Body had to make a decision today and asked how long a pause would need to be cover the period of consultation. AMo considered that it may be necessary to maintain a pause until August 2017.

DZ was also concerned that the Governing Body was being asked to decide without all the data available and she did not feel that clear case for tightening of the IVF threshold had been in in light of the possible effect this may have upon patients.

	At this point, AM declared that there would be a vote to ascertain the Governing Body's intentions. <u>The first issue for vote was</u>: (i) There should be pause in the provision of the IVF service with immediate effect or; (ii) There should there be no pause in the provision of the IVF pending a decision made at the March Governing Body meeting The Governing Body voted as follows; (i) 5 votes in favour (ii) 4 votes in favour The Governing Body **APPROVED** that a pause in the provision of the IVF service should commence with immediate effect <u>The second issue for vote was</u>: (i) That such a pause should come into effect for patients not yet on the waiting list or; (ii) That such a pause should come into effect for patients not yet referred into a secondary care provider. The Governing Body voted as follows; (i) 1 vote in favour (ii) 8 votes in favour The Governing Body **APPROVED** that such a pause should come into effect for patients not yet referred into a secondary care provider. AM thanked all Governing Body members for their contributions to a very challenging discussion. He added that AMo would email all members to provide further assurance regarding safeguards during the review period. **<u>Surgery Readiness Guidance</u>** AMo reminded the Governing Body that at its December meeting a paper regarding this matter had been approved. The paper suggested options for helping patients to be more ready for elective care and discussed whether the CCG should strictly enforce stop smoking and BMI pathways for the majority of elective care or make the policy for guidance only. AMo stated that it was now being proposed to not pursue a threshold policy that would require patients to undertake, or successfully complete stop smoking or weight loss before being referred to elective care in all but the most urgent cases. Instead, whilst the CCG will issue guidance to all clinicians showing the benefits of helping patients to be more ready for surgery, there will not be any new policy which directly prevents a patient gaining access to treatment. The CCG's position will be strong encouragement for patients to agree to improve their fitness and to consider, if necessary, choosing not to be referred until their fitness improves, or to undertake fitness improvement actions in the period between referral and treatment. AM welcomed this approach as did DZ, commenting that it was in line with the principles of proactive and preventative care. The Governing Body **APPROVED** the guidance for clinicians to help patients be more ready for surgery.	**AMo**

	Changes to Clinical Thresholds AMo explained that at the December Governing Body a paper "Evidence Based Commissioning" was approved. Since that meeting, the proposed policy changes had been drafted into the form of a marked up new version of the policies which had been made available as part of today's papers. Richmond CCG adopted the new version of the policies without amendment on 17th January 2017 with the same qualification of a delegation of authority to the Chair and Accountable Officer to approve minor amendments to the policies as they are finalised and readied for implementation with other CCGs in SWL. AMo added that, should any future changes be needed the CCG would firstly get the consideration of its Clinical Reference Group (CRG). AM asked if any changes to were requested by the CRG how would these be confirmed; by the full Governing Body or by Chair's action. AMo replied that it should be the full Governing Body. AM then suggested that the changes now before the meeting could be considered at the next CRG meeting and then be approved at the extraordinary Governing Body meeting in February. AMo agreed that, if the Governing Body was not content with all the changes made these would be considered by the CRG and return for Governing Body consideration in February. CG commented that she did not feel she had any authority over these issues and would need assurance from a clinician. DZ acknowledged this concern and commented that all the Governing Body could reasonably do was assure that a robust process was in place. However, she felt that this was not apparent from the evidence provided. AMo responded that there had been a very thorough review process, including the involvement of the CCG's Clinical Directors, but that if the Governing Body wanted further assurance this could be arranged. LW commented that it would be useful for the CRG to suggest any necessary "tweaks" and the Governing Body would then have greater assurance. JH said that she was assured by the process and SP agreed but emphasised the importance of a route for exceptional cases, and AMo acknowledged this. CG also felt more assured now, particularly with the involvement of the Clinical Directors. However, CChi said she would welcome the views of the CRG on these changes. The Governing Body **AGREED** that it was content with the process in place and **APPROVED IN PRINCIPLE** the changes to the policies pending consideration by the Clinical Reference Group at its meeting on 8th February 2017.	
8.2	The Wilson Health Centre List Dispersal – Support Payment	
	LW explained that the decision to disperse The Wilson Health Centre practice was agreed in principle at the Executive Management Team (EMT) meeting on 14th September 2016, and approved, subject to an appropriate resource package provided to practices receiving the dispersed patients, at the Primary Care Commissioning Committee on 29th September 2016. The Wilson Health Centre practice will close on the 31st March 2017. The Governing Body was now being asked to approve practices receiving a payment of £20 per patient one month in arrears for practices registering 51 or more new patients over a period of six months. The proposal also confirms payment for practices receiving any of the identified vulnerable patients, regardless of the total number received. To facilitate this, the Governing Body was requested to also approve the delegation of authority to the Accountable Officer to implement a contract between the CCG and the practices receiving	

	patients as a result of the practice closure. Further work is required to agree this contract with NHS England and the Merton LMC as it will be used to set out scope and eligibility for those applying to the scheme over the coming weeks. AM commented that this matter had received extensive consideration by both the EMT and Finance Committee. There had also been involvement of the Local Medical Committee and MJ confirmed that he supported the recommendations. CG raised a concern that, with the list being dispersed, patients might "fall between the gaps". LW responded that all patients had been provided with information to support them in deciding with whom to register and a helpline had also been established. Furthermore, LW assured, all dispersed patients would be tracked to ensure that none were left with a GP. The Governing Body: (i) **APPROVED** practices receiving an additional payment of £20 per newly registered patient as pre the criteria set. (ii) **APPROVED** the procurement of South East CSU to provide patient record transfer support. (iii) **APPROVED** the delegation of authority to the Accountable Officer to approve the contract required to enable additional support to practices.	
9.	**Quality and Performance**	
9.1	Minutes of Clinical Quality Committee: 01.11.16; 07.12.16 TBC – inc. verbal summary from Committee Chair regarding key issues, risks and mitigations	
	Due to the extended discussion on item 8.1 (Update on Clinical Thresholds and Policy Changes) this item was **DEFERRED** to the March meeting.	
9.2	Public Sector Duty Annual Report January-December 2016	
	KP presented this item and explained that the report highlighted progress made in respect of Equality and Diversity responsibilities. The report, once approved by the Governing Body, will be published on the CCG's website by January 31, 2017. This is one of the specific duties under the Equality Act 2010, which states that public bodies must publish information by January 31 of each year showing how they are meeting the general equality duty. AM commended a very comprehensive report and CG thought it a very good reflection of work carried out. The Governing Body **APPROVED** the Public Sector Duty Annual Report January-December 2016.	
9.3	Q2 Children's Safeguarding Report	
	Eileen Bryant (EB) joined the meeting for this and the following item. She highlighted safeguarding training as an issue although rates of this were improving across all providers. In general EB was confident that the Governing Body could be assured that Merton Clinical Commissioning Group, as a commissioner of healthcare services, had effective arrangements in place to safeguard children and young people. CG added that the Quality Committee had already considered the report and was assured.	

	The Governing Body **APPROVED** the Q2 Children's Safeguarding Report. JH left the meeting at this point to attend another meeting.	
9.4	Q2 Adult Safeguarding Report	
	EB explained that Local Authorities, as lead agencies, are required to report safeguarding data to NHS Digital (formerly HSCIC), but reporting protocols are still being developed and some variation in data quality remains. Figures for Quarter 2 provided by the Local Authority do not represent a complete account of the status for all the referrals. Following discussions at Director and Senior Manager level, the Local Authority agrees that the data as presented did not reflect the overall status of safeguarding activity. The discrepancy arises because there are a number of cases in the system awaiting an outcome or authorisation. In future, the Local Authority has advised that this information will be recorded and will be included in the statistics provided to the CCG. EB added that there were similar concerns regarding data provided for Mental Capacity Act and Deprivation of Liberty activity. Aside from these data concerns, EB was confident that the Governing Body could be assured that Merton Clinical Commissioning Group, as a commissioner of healthcare services, had effective arrangements in place to safeguard adults. CG said that she was also concerned about the data issues and the impact these may have upon vulnerable adults. EB said she would be pursuing this matter further with the LA's Director of Housing and Community. CChl echoed this concern and DZ added, from a LA perspective, that she agreed clarity was needed and would raise the issue at the next One Merton Committee meeting. KP said she had already written formally to the LA expressing the CCG's concerns. The Governing Body **APPROVED** the Q2 Adult's Safeguarding Report. EB then left the meeting.	
9.5	CCG Governing Body Assurance Report & Scorecards: Month 7 2016/17	
	Due to the extended discussion on item 8.1 (Update on Clinical Thresholds and Policy Changes) this item was **DEFERRED** to the next meeting.	
10.	**Governance**	
10.1	Board Assurance Framework	
	Due to the extended discussion on item 8.1 (Update on Clinical Thresholds and Policy Changes) this item was **DEFERRED** to the next meeting.	
11.	**Public Health**	
11.1	Annual Public Health Report on Childhood Obesity and Merton's Child Healthy Weight Action Plan	
	DZ presented this item and explained that the report presents the Director of Public Health's Annual Public Health Report (APHR) 2016/17 on Childhood Obesity and the Child Healthy Weight Action Plan 2016-2018. Childhood obesity is an epidemic and the World Health Organisation regards it	

	as one of the most serious global public health challenges. Merton CCG has a leadership role with its partners in tackling childhood obesity and reducing health inequalities locally and the chair of the Merton CCG has pledged support for this priority through the Merton Health and Wellbeing Board. AM commented that the Health and Wellbeing Board had made childhood obesity as its top priority. He welcomed DZ's report and weight plan, noting the specific actions for the CCG. CChi agreed with this and stressed the importance of tackling this vital issue. • The Governing Body **RECEIVED** the independent Annual Public Health Report (APHR) 2016-17, **CONSIDERED** consider the key messages and **ENDORSED** publication. • The Governing Body **ENDORSED** and **CHAMPIONED** delivery of the Child Healthy Weight Action Plan 2016 – 2018.	
12.	**Key Actions to Communicate with the Organisation**	
	Due to the extended discussion on item 8.1 (Update on Clinical Thresholds and Policy Changes) this item was deferred to the next meeting.	
13.	**Any Other Business**	
	There was no additional business to discuss.	
14.	**Meeting Close**	
	Part 1 of the Governing Body meeting closed at 1.10pm.	
14.	**Date of Next Meeting**	
	23rd February 2017 – time and venue to be confirmed.	

Signed as a full and true record of Part 1 of the Merton Clinical Commissioning Group Governing Body Meeting on the 26th January 2017.

---------- ----------

Andrew Murray - Clinic Chair Date

right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MINUTES

MERTON CLINICAL COMMISIONING GROUP
GOVERNING BODY PART 1

23rd February 2017
Time: 1.00pm – 2.00pm
120 The Broadway, Wimbledon SW19 1RH

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
AMo	Andrew Moore	Chief Officer (Acting)
CM	Chris Moreton	Chief Finance Officer (Interim)
AM	Dr Andrew Murray	Clinical Chair
SP	Prof. Stephen Powis	Secondary Care Consultant (joined meeting at 1.45pm)
KP	Karen Parsons	Chief Officer (Interim)
DZ	Dr Dagmar Zeuner	Director of Public Health, LBM

Non-Voting Members

CCl	Chris Clark	Director of Performance, Planning &Informatics (Interim)
JM	Dr M Jarzembowski	Chair, Local Medical Committee

Other Officers in Attendance

MW	Michelle Wallington	Principal Assoc. Communications & Engagement - SECSU
ZZ	Zoli Zambo	QIPP Lead
TF	Tony Foote	Note Taker - SECSU

Members of the Public in Attendance

David Ash	KOSHH
Sandra Ash	KOSHH
Sue Clark	Merton Residents Healthcare Forum

No.	AGENDA ITEM	WHO
1.	**Welcome and Introductions**	
	Dr Andrew Murray (AM) welcomed all to the meeting. AM stated that the Governing Body of Merton CCG was committed to openness and transparency, and conducted as much of its business as possible in a session that members of the public were welcome to attend and observe, subject to available space. The meeting, although held in public, was not a public meeting and as such there was no opportunity	

	provided for the public to ask questions in that arena other than that offered at the discretion of the Chair. The Governing Body meeting was audio recorded as part of the CCG's commitment to make information as accessible as possible. The recording would be added to the CCG's website a few days after the Governing Body meeting. The CCG was now also live streaming Governing Body meetings, following a practice already used by other CCGs including its neighbour Wandsworth CCG. As stated at the January meeting, now this arrangement was in place the CCG would not permit other filming or audio recording of the Governing Body meeting unless expressly agreed by the Chair in advance of the meeting. Anyone found using such a device without prior agreement would be asked to cease recording and may be asked to leave the meeting. AM added that the CCG had also considered more generally how it should proceed with regard to allowing members of the public to participate in Governing Body meetings held in public. As a result of this there was now an agreed approach which could be found on the CCG's website. AM drew the meeting's attention to the section of this on recording of the meeting and the requirement for the request to be made in advance to the CCG and for all members of the public in attendance to be given the opportunity to give their consent. AM added that he had not received any such requests and, therefore, anyone found recording would be asked to leave. Dr Marek Jarzembowski (MJ) noted that the agenda stated *"Questions from the public are welcome and will be received at the discretion of the Chair"* and should this wording now be revised. AM agreed to consider this.	
2.	**Declarations of Interest**	
	The Governing Body **APPROVED** the Register of Interests as a full and accurate record.	
3.	**For Approval**	
3.1	Effective Commissioning Initiative – Changes to Clinical Thresholds	
	Andrew Moore (AMo) explained that this issue had been considered at the January Governing Body meeting with a decision made that the Clinical Reference Group (CRG) should review the proposals to provide assurance to the Governing Body. The CRG met on the 8th February and a comprehensive review was undertaken. The paper now presented contained the CRG's comments: the majority of the original proposals were supported but there were some suggested changes, as follows: <u>Pain Management</u> <u>Therapeutic Facet Joint Injections/Medial Branch Blocks</u> The CRG recommended that until the CCG provided a distinct pain management service this proposed changes should not go ahead. <u>Limited cataract surgery provision for second eye operations and update criteria.</u> The CRG recommended that this proposal not proceed until further discussions were held.	

	Reversal of Female and Male Sterilisation The CRG recommended that a policy was not required as funding would not be provided for such a procedure. Minor Skin Lesions The CRG supported the proposal that treatment alternative to surgery should always be considered and added that such minor surgery should not take place in either a hospital or primary care setting. AMo added that Croydon and Richmond CCGs had already approved all proposals without amendment. AM noted that members of the CRG were present in their Governing Body roles and asked for their views. Dr Carrie Chill (CCHi) said that she was satisfied that the proposals were evidence based. Dr Tim Hodgson (TH) commented that he was fully confident of the proposals as amended by the CRG. Dagmar Zeuner (DZ) agreed with this. There followed questions and comments from the Governing Body as a whole. Julie Hall (JH) asked for further clarification of the definition "minor skin lesions". AM responded that such lesions would be both minor and asymptomatic. Both Peter Derrick (PD) and Clare Gummett (CG) stated that they felt much more assured of the proposals following the CRG's review. However, PD did raise two issues for further consideration: (i) how can the CCG be confident the new policies would be implemented; (ii) in light of the raising of the threshold in the policies, and the likely increase in applications being made on the grounds of exceptional circumstances, would the Individual Funding Request (IFR) system need to be reviewed. AMo said that he would try to address both these points in the more general update he would presently provide. Dr Marek Jarzembowski (MJ) queried the recommendation that no policy for the reversal of sterilisations was required as it was possible that in certain circumstances such a procedure could be helpful. It was suggested that the IFR system could accommodate such eventualities. MJ acknowledged this but added that GPs would require additional support if such requests increased. The Governing Body **APPROVED** the proposed changes to the ECI policies and delegated to the Chair and Accountable Officer the ability to approve minor amendments and clarifications to the policies as they are finalised and readied for implementation with other CCGs in South West London. AMo then presented a more general verbal update on progress in this area. He stated that there were a wide variety of people who needed to be made aware of, and understand, the revised policies. Zoli Zambo has been appointed the South West London Project Lead with responsibility for this. The aim was also to ensure that before referrals were made the policies were observed or, if this was not possible, that hospitals applied them upon receipt of referrals. With regard to the IFR process, the CCG had commissioned the Commissioning Support Unit, the current providers of the IFR service, to assist with the CCG's "prior approval" programme. Overall, AMO stated, there was a commitment across South West London to have	

	all the revised policies in place by 1st April 2017. At this point a member of the public said that the live streaming of the meeting was not working. AM apologised for this, said it would be looked into but gave the assurance that there was also an audio recording of the meeting being made and this would be made available via the CCG's website. Returning to the matter in question, DZ said when the policies were being implemented it was vital to stress that this was being done for the benefit of patients. MJ agreed strongly with this. AMo also informed the meeting that a comprehensive programme of public engagement was underway with fifteen events scheduled and, eventually, forty-one different groups will have had the opportunity to engage and contribute. CG added that she had been very impressed by the level and variety of engagement so far. AMo stated that events so far had been well attended and as part of an update to the March Governing Body meeting he would provide a summary of feedback so far received. The Governing Body **RECEIVED** the verbal update on the Choose Wisely campaign in Merton and the progress of the South West London shared ECI process improvements.	**AMo**
3.2	London Health and Care Devolution Programme - Memorandum of Understanding	
	AM informed the meeting that Merton was the only London CCG to not yet sign off the Memorandum of Understanding (MoU) and that to sign it off now would only enable exploratory work to be carried out on potential options. PD stated that he remained very sceptical about this matter and that it appeared that the devolution programme would involve a large increase in structures and governance arrangements. Indeed, he added, previous efforts at devolution had brought an increase in centralisation. PD was not convinced that the cost of devolution would be offset by the promised benefits and his preference would be to use existing structures rather than imposing new ones. One particular area of concern for PD was the plans for NHS property, and the role of the London Capital Estates Board. He urged caution and highlighted the risk of a resource in one area being deployed in another. Finally, PD said that he found the listed principles of the programme admirable but struggled to see these reflected in the actual contents. DZ commented that she understood and welcomed PD's scepticism. However, she added that signing off the MoU would not be permanently binding and it was important for Merton CCG to have a role in the on-going discussions. JH asked what would happen if the CCG did not sign the MoU and AM replied that he expected that things would proceed as planned. Whilst noting the concerns raised, the Governing Body **APPROVED** the London Health and Social Care Devolution Memorandum of Understanding.	
4.	**For Discussion/Review**	
4.1	Assurance Report and Scorecards: Month 7 2016/17	
	CCl informed the Governing Body that this item had been deferred from the	

	January meeting and that a fully updated version would be considered at the March Governing Body meeting. He then provided a brief summary of the report's salient points: • Over the winter period, providers had shown good resilience • Generally positive A&E performances • A mixed performance with planned care • Certain issues regarding St George's remain There followed questions from the Governing Body. CG stated (as Chair of the Clinical Quality Committee) that her main concern was for patients waiting over 100 days for cancer care. CChi commented that much of the delays in treatment were due to day-to-day factors such as staff shortages and that it had been stressed to Trusts that they must develop greater resilience to overcome these. With regard to A&E performances, CG noted that whilst these were generally encouraging Trusts were still failing to meet national targets. TH stated that there were still significant difficulties in getting a patient access to diagnostic services at St George's and that it was often quicker to re-refer to another Trust. He felt strongly that this was not good enough and it would be worthwhile to have a representative of St George's at a future Committee meeting. CG confirmed that St George's had been invited to attend the June meeting. MJ noted that Epsom & St Helier's had achieved better results compared to St George's and Kingston: what was the reason for this and could it be duplicated by the other Trusts? CChi replied that EStH's improved performance was due to a high level of commitment throughout the Trust and talks were on-going with the other Trusts to see what learnt from this. The Governing Body **DISCUSSED** the Assurance Report and Scorecards: Month 7 2016/17.	
4.2	Board Assurance Framework	
	AMo informed the Governing Body that this item had also been deferred from the January meeting. There were no questions from the Governing Body. The Governing Body **REVIEWED** the Board Assurance Framework.	
5.	**Questions from the Public**	
	<u>Question</u> In light of the CCG's aim to align with other NHS organisations, how did the decision to pause IVF treatment tally with Epsom and St Helier's opening a new IVF clinic and welcoming referrals. AM acknowledged that this may appear to be a case of conflicting aims but that the CCG was not asking GPs to cease making referrals for couples with fertility problems. He added that any decision limiting access to services was not one that clinicians felt comfortable making. However, this had to be balanced against the pressing need to make difficult decisions at a very challenging time for the NHS.	

	The questioner responded that some services – including hip and knee replacements – would be restricted to private patients. AM replied that the CCG was not putting a stop on hip and knee operations and it was not comparable to the actions taken relating to IVF.	
6.	**Any Other Business**	
	There was no additional business for discussion.	
7.	**Meeting Close**	
	The Meeting closed at 2.10pm.	
8.	**Date of Next Meeting**	
	23rd March 2017	

Signed as a full and accurate record of the Merton Clinical Commissioning Group Governing Body Meeting (Part 1), 23rd February 2017.

---------- ----------

Andrew Murray - Clinic Chair Date