Agenda item: 20 **Paper no: 16**

Title of Report:	**Minutes from G&W Governing Body Committees- Part I**	
Status:	**TO NOTE**	
Committee:	**G&W Governing Body**	**Date**: 18/12/19
Venue:	Martineau Hall, Dorking Halls	

The following minutes are presented at this meeting for noting.

Meeting Name	Date of Meeting/s
Local Clinical Commissioning Committee	20 August 2019; 17 September 2019; 15 October 2019.

In addition, the following minutes are currently in draft, pending approval at the next committees meeting. These will be presented at the next Governing Bodies in Common meeting on 25/03/20.

Meeting Name	Date of Meeting/s
Local Clinical Commissioning Committee/ ICP Assurance Group	19 November 2019

GUILDFORD AND WAVERLEY CCG

LOCAL CLINICAL COMMISSIONING COMMITTEE- PART I

MINUTES

Date	20/08/19	**Time**	13:00- 14:40
Venue	Board Room, 3rd Floor, Dominion House, Guildford		

Members/ Attendees

Name (initials)	Title	Attendance (✓)/ Apologies (A)
Voting Members		
Dr Darren Watts (DW)	**(Committee Chair)** GP Member, Guildford and Waverley CCG	A
Phelim Brady (PB)	**(Committee Vice Chair)** Lay Member Patient and Public Engagement , Guildford and Waverley CCG	✓
Dr Justine Hall (JH) *From item 2*	GP Member, Guildford and Waverley CCG	✓
Dr Seun Akande (SA)	GP Member, Guildford and Waverley CCG	A
Matthew Tait (MT) *From item 9*	ICS Chief Officer	✓
Karen McDowell (KMc)	ICS Director of Finance	A
Vicki Taylor (VT) *On behalf of KMc*	Deputy Chief Finance Officer, Guildford and Waverley CCG	✓
Vicky Stobbart (VS)	ICP Director, Guildford and Waverley CCG (shared role)	A
Giles Mahoney (GM)		✓
Sumona Chatterjee (SC)	ICS Director for Surrey Wide Services	A
Clare Stone (CS)	ICS Director of Quality and CCG Chief Nurse	A
Jackie Moody (JM) *On behalf of CS*	Head of Quality (Acute), Surrey Heartlands CCGs	A
Dr Sian Jones (SJ) *From item 9*	Clinical Chair, Guildford and Waverley CCG	✓
Julie George (JG)	Public Health Consultant, Surrey County Council	✓

Reviewed by: GM (11/09/19); PB (11/09/19)

Name (initials)	Title	Attendance (✓)/ Apologies (A)
In Attendance		
Jane Williams (JW)	Deputy Managing Director, G&W CCG	✓
Neil Manrai (NMa) *For item 6*	Mental Health and Learning Disabilities Commissioner	✓
Natasha Moore (NM)	(Minute taker) Governance Manager for the Surrey Heartlands CCGs	✓
Debo Sokoya (DS)	(Minute taker) Corporate Committees Administrator	✓

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** The Chair welcomed members and attendees; apologies were received as detailed above. He reminded all that confidential papers should be handed in to NM after the meeting for secure disposal; that the meeting would be recorded for administration purposes only; and the recording would be deleted once the minutes had been approved.		
2	**Declarations of Interest** The Chair noted the register of members' and attendees' interests included in the meeting papers. No additional interests had been received since the previous meeting. The Chair invited members and attendees to report any new declarations/ amendments to the register; and to report any declarations pertinent to items on this agenda. It was agreed that the mitigating action for GM's interest would be reviewed and 'interest noted' would be considered. **ACTION: NM to review and amend.** *JH joined the meeting.*	**NM**	**30/08/19**
3	**Quorum** It was noted that the meeting was not quorate until SJ arrived. Consequently, some items would be taken out of order to ensure the Committee was quorate for items requiring a decision.		
4	**Minutes from last meeting on 16/07/19** The Chair presented the minutes from the previous meeting. **The Local Clinical Commissioning Committee:** • **APPROVED the minutes of the last meeting.**		
5	**Action Log** The Chair presented the action log with actions shaded having been marked as closed. The following open actions were discussed:		

Item No.	Discussions and New Actions	Who	When
	2. Declarations of Interests; NM to ensure that JG's additional interest/s on register. JG would provide the additional information for insertion in the register. 8. Performance Report – Month 2; Examine a potential correlation between cancer waits and complaints. A further update would be received once additional information was received from the CQRM meeting to be held in October. The Chair stated his concerns about Echocardiology and asked if there were adequate staffing levels. GM noted that this continued to be challenged. Detailed assurance would be sourced. JW to obtain an update from the Quality team for the next meeting.		
8	**Strategic planning update & note development of the plan** GM reported that the ICS was responding to the NHSE Long-Term Plan. As part of this, the ICS was required to develop a 5-year Plan. SC was coordinating this programme with ICPs and the ICS. GM gave assurances that he and JW were working on this programme, along with inclusion of financial models. JG asked if this was being aligned to Surrey County Council's Health and Wellbeing Strategy (submission for this was December 2019). GM responded stating that the plan was being developed together to flow into the December timeline. This he felt will bring clarity and a better understanding for all involved in the programme. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.** • **AGREED to the next steps as per the report.** • **AGREED for final report to be presented in September 2019 (and at the G&W ICP Board). DS to add to the forward plan.**	**DS**	**30/08/19**
9	**Performance Report – June 2019** GM presented the report highlighting the following: • A&E 4hr performance position had improved to 90.1% in May. June's performance is estimated at 88.5% and above the National Position of 86.4%. This was in line with trajectories, noting pressures within the system. • RTT (incomplete) performance remains 87.7% and below the 92.0% target. The total waiting list size is above year-end target and above plan. • 52+ week wait- the numbers were slightly above the planned level with three breaches in May 2019. Reviews of these patients were underway.		

Item No.	Discussions and New Actions	Who	When
	SJ and MT joined the meeting. The Committee was now quorate.		
	• Diagnostic waiting times performance has slightly improved and above the planned trajectory, however some specialities remain challenged, e.g. Echocardiology and Urodynamics. Just over 50% of patients on Urodynamics patient list breached target due to capacity. A recovery plan is being developed to address the backlog and compliance is scheduled to return in June. **GM to pick up with the Quality Team for an update on this area.**	**GM**	**30/08/19**
	o JG queried how much of the delay in diagnostics contributes to 18-week performance and whether any analysis had been done on this correlation. SJ noted that GPs can direct access to these specialities outside of the pathway. **GM to include some additional information on this area in future reports.**	**GM**	**30/08/19**
	o JH highlighted a concern regarding echocardiology referrals when being 'managed' by a GP. JW noted that the option of specialist RSS cardiology support was being examined. SJ also noted that there were plans for a new CT scanner to be purchased and **agreed to obtain an update from the next Cancer Board meeting.**	**SJ**	**30/08/19**
	• Cancer 2-week wait for breast symptoms performance had improved to 84.5% although below the planned trajectory, with additional recruitment underway. 62 Day Urgent GP Referral position was still a concern. The Trust had improved with the reallocation formula but had further deteriorated, although still above the NHSE/I trajectory.		
	o SJ noted that the performance deteriorated could have been due to the loss of working days over Easter and May.		
	o GM outlined the directive towards a new 28-day standard. At present, the three biggest specialities were being focused on.		
	• IAPT (Roll Out) performance has improved significantly since quarter 3 and performance target was met for April 2019 of 1.5%.		
	• Dementia Diagnosis had improved with the latest rate at 62%.		
	• Learning Disabilities (Health Checks) performance has improved but year-end performance below target at 52.2% and below the national ambition of 75%. A recovery plan is being formulated to address key areas of improvement.		
	• Emergency Ambulance Indicators- response times had improved although yet to make the 90th percentile. The Trust continues to progress towards to achievement of the milestones agreed through the Remedial Action Plan (RAP). MT noted that the provider had made improvements on some of the key areas of transformation.		
	• Healthcare Associated Infections (HCAI)- noted 6 cases in May for G&W, which included 2 cdiff cases for the Trust. **GM to obtain detail as to which provider the remaining 4 cases came under.**	**GM**	**30/08/19**
	PB queried the wording regarding page 9 of the report regarding RTT waits. **GM confirmed to obtain clarity on this area.**	**GM**	**30/08/19**

Item No.	Discussions and New Actions	Who	When
	GM noted a system pressure with regards to patients with mental health and learning disability needs presenting at A&E and where these individuals are placed into residential units out of the local area. Discussions were underway at the Local A&E Delivery Board. **GM Agreed to provide an update at the next meeting.** Alongside this, JW noted that a piece of work had been undertaken regarding High-Frequency Users which found that the patient number were small. The Trust's main concern was with regards to challenging behaviour and a potential Outreach Support Model was being examined. Discussions were also ongoing with a working group scheduled for September. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report with focus on the exceptions. **The Local Clinical Commissioning Committee:** • **NOTED the report.** *SJ and JH left the meeting. The Committee was no longer quorate.*	**GM**	**30/08/19**
10	**Finance Report - Month 4** VT presented the report highlighting across the Heartlands' CCGs, noting the £3.1m deficit control total but that the CCGs had the ability to 'earn' additional funding through Commissioner Sustainability Funding, which was £310,000 for quarter 1. As the CCGs reported on plan for quarter 1, phased funding had been received. It was noted that the CCG plan assumed delivery of £2.2m savings against the unidentified QIPP and the joint recovery plan. She explained as previously reported, the risk of non-delivery against these plans has been included within the reported net risk. VT noted that if the Trust reported a favourable position to offset the commissioner deficit, then this would be accepted. VT noted that at present, the Trust's position was slightly favourable, however this was driven by 2018/19 benefits that were 'one off' benefits. *JH re-joined the meeting.* VT noted that discussions with the Trust were ongoing to triangulate financial positions. *SJ re-joined the meeting. The Committee was now quorate.* MT asked how confident the CCG was in terms of transparency of the Trust's financial position. VT stated she was confident that there was increased level of transparency between the two organisations with her attending Trust finance meetings and vice versa.		

Item No.	Discussions and New Actions	Who	When
	MT asked what was the resulting performance against activity levels and how sighted ICP partners were on activity versus. VT confirmed that this data was available **and agreed to include in future reports for LCCC and G&W ICP Board**. GM also noted he had asked for a series of scenario plans to be developed, for example if activity for quarters 1 and 2 show any trends, how the system responds to this. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report, with additional information on activity for the next report.**	**VT**	**30/08/19**
6	**Reducing age of access into Surrey IAPT Services** NMa presented this report, highlighting the planned pilot scheme from October 2019- January 2020 to reduce the age for those accessing IAPT services to 17 years for G&W. He noted that at present, there were cases where those awaiting a referral, turn 18 and therefore can no longer be referred to childrens' services. He advised that there are currently 6 providers for the service, acknowledging that these providers work well together, and the plan was to replicate the same model as used by Kent CCGs. NMa advised that referrals will be through GPs and self-referrals only and would not apply to CAMHS. SJ asked if the Haven was considered as a 'sign-posting' option. **NMa agreed to consider this.** JG asked how the pilot scheme would be evaluated. NMa responded that the safeguarding level 3 valuation process would be implemented as used by Kent CCGs and that there would be discussion with Quality colleagues as to how best evaluate. JG also asked for clarity as to whether this would apply to group sessions. NMa confirmed that this extension of the service would not apply to group sessions for 17 year-olds. SJ confirmed whether this would be communicated to GPs. NMa confirmed that it would. SJ also asked whether this would be extended to schools and counsellors. NMa noted that at this stage, the extension would not apply to referrals from schools and counsellors. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO APPROVE** a 14-week pilot project reducing the age of access to IAPT Services to 17 years.		

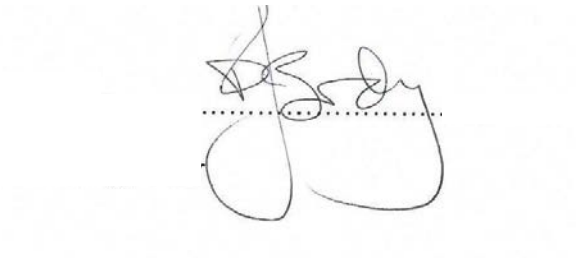
Item No.	Discussions and New Actions	Who	When
	The Local Clinical Commissioning Committee: • **APPROVED a 14-week pilot project reducing the age of access to IAPT Services to 17 years.** • **AGREED the next steps as per the report.** • **AGREED for progress report of the pilot to be presented at the March 2020 meeting. DS to add to the workplan.**	**DS**	**30/08/19**
7	**Tariff for non-face-to-face activity** JW presented this report, noting that this was part of the Transformation Programme across G&W spanning 15 specialties, with 26 different clinic types, either already in place or being planned. Following examination within the ICS space, it is estimated that this would result in converting around 100 face to face appointments to telephone contacts per month, however noting that further modelling is planned. The Chair stated that the paper provided a lot more information than previously provided and a clear explanation of the process. MT suggested that the system needed to understand the cost differential of face to face as opposed to non-face to face provisions. Following discussion, members agreed that non-face-to-face activity can continue but that non-face-to-face tariffs needed to be costed. **JW to undertake cost modelling** **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO APPROVE** the proposed approach to further modelling the impact of the identified 'trials' and to better understand the actual cost to the system for delivering the different types of activity. **The Local Clinical Commissioning Committee:** • **NOTED the approach used by the other ICPs within the ICS, considering the complexities in adopting non-face-to-face tariffs and the steps taken to engage with the relevant national programmes to seek advice and guidance.** • **NOTED the current plans and what is understood about the impact of these plans at this stage.** • **APPROVED the proposed approach to further modelling the impact of the identified 'trials' and to better understand the actual cost to the system for delivering the different types of activity.** • **NOTED the principles for agreeing locally determined prices, as described in the National Tariff Guidance.**	**JW**	**30/08/19**

Item No.	Discussions and New Actions	Who	When
11	**System Finance Report Month 3** VT presented the report and noted that as this report was now out of date, section 5 was noting the risk as per the point at which plans were submitted to NHSE. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
12	**2019/20 Financial Recovery Plan (FRP) and Summary Financial Recovery plan document** VT highlighted that the plans were now a few months old and had been reviewed by the LCCC previously and submitted to NHSE. She noted that a Joint Finance Group meets weekly to review the commissioner and provider financial positions and to review all schemes. **VT agreed to circulate the latest document summarising these positions,** which would be updated monthly. She noted that this highlighted a control total gap of £7m; although this was an improvement in position, the full level of risk was still applicable. On a positive note, GM flagged that this latest report reflected a different way of working and a more positive relationship between partners. MT queried the reporting mechanism to note this latest financial position for FRP reports and initiatives. VT responded by explaining that this report, which she would circulate, reported the financial positions, net position, system risk and updates against each of the schemes. Members discussed how FRPs and QIPP (and the Cost Improvement Programme (CIP) position for the Trust) should be reported. GM explained that at present, there were 3 categories of reporting as noted but that this would be reviewed with work planned to review and streamline. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.** • **AGREED the next steps as per the report.**	**VT**	**30/08/19**
13	**QIPP Delivery Report – Month 3** JW presented the report and outlined the challenge of aligning the QIPP, FRPs and the Trust's CIP reporting. She noted that some		

Item No.	Discussions and New Actions	Who	When
	teams were now integrated across, with PMO Team integration in progress. Noted some of the schemes were not delivering. She noted in some cases, this was down to methodology, which was being addressed; or noted that some elements of the schemes may have been overly-ambitious. JW noted that she had reviewed in to two groups: mitigation of QIPP schemes with a focus on transformation schemes, some of which where it is difficult to 'measure' QIPP against these; and other schemes within the FRPs, e.g. some transactional schemes. SJ advised that at the CCG/ Trust Board-to-Board meeting approximately a year ago, there was an interest to align the Trust's CIP with QIPP. JW acknowledged that further work needed to be done to align this. GM said in principle this was run as one system control total but that this needed to be clearly reported. MT outlined that for some CIP programmes, these won't align to QIPP programmes but that alignment should take place where appropriate. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED that at Month 4 the CCG has delivered savings of £985k, which is 23% of the year-to-date target of £4.3m. This figure includes both identified and unidentified QIPP. Delivery of identified QIPP was 55% year to date.** • **NOTED that the CCG is forecast to deliver 51% of the total 2019/20 QIPP requirement of £14.8m. Identified QIPP schemes are forecast to deliver 93% being £5.0m of the £5.3m total.** • **NOTED the contractual mechanisms in place to manage the £3.6m QIPP agreed as part of the RSCH contract.** • **NOTED the Financial Recovery Plan elsewhere on the agenda as the key mechanism for maximising in year delivery and closing the forecast gap of £6.8m.**		
14	**Sub-Committee minutes:** • **Better Care Fund Local Joint Commissioning Group: 16/07/19;** • **MOG: 16/07/19;** • **Clinical Forum: 18/06/19.** The Chair noted minutes of the above meetings. **Recommendations: The Committee is asked:** • **TO NOTE** the sub-committee minutes as above. **The Committee:** • **NOTED the sub-committee minutes.**		

Item No.	Discussions and New Actions	Who	When
15	**AOB** No other business was raised.		
16	**Top risks identified** The Committee raised the following risks following this meeting: • Financial position; and • Echocardiology and Urodynamics performance.		
17	**Overall review of papers submitted to the meeting and decision making** Members and attendees agreed the papers were clear and of a high quality.		
18	**Meeting close** Meeting closed at 14:40.		

Signed and agreed by:



Phelim Brady, Lay Member PPE, Guildford and Waverley CCG (Committee Vice-Chair)

Minutes agreed for publication by:

Date: 17/09/19
Giles Mahoney, G&W ICP Director (Exec Lead)

Future Meeting dates (Tuesdays)	Deadline for agenda items/ papers (Fridays)
17 September 2019	06 September 2019
15 October 2019	04 October 2019
19 November 2019	08 November 2019
17 December 2019	06 December 2019

GUILDFORD AND WAVERLEY CCG

LOCAL CLINICAL COMMISSIONING COMMITTEE- PART I

MINUTES

Date	17/09/19	**Time**	13:00- 14:05
Venue	Board Room, 3rd Floor, Dominion House, Guildford		

Members/ Attendees

Name (initials)	Title	Attendance (✓)/ Apologies (A)
Voting Members		
Dr Darren Watts (DW)	**(Committee Chair)** GP Member, Guildford and Waverley CCG	✓
Phelim Brady (PB)	**(Committee Vice Chair)** Lay Member Patient and Public Engagement , Guildford and Waverley CCG	✓
Dr Justine Hall (JH) *From item 2*	GP Member, Guildford and Waverley CCG	✓
Dr Seun Akande (SA) *From item 9*	GP Member, Guildford and Waverley CCG	✓
Matthew Tait (MT)	ICS Chief Officer	A
Karen McDowell (KMc)	ICS Director of Finance	✓
Vicky Stobbart (VS)	ICP Director, Guildford and Waverley CCG (shared role)	✓
Giles Mahoney (GM)		✓
Sumona Chatterjee (SC)	ICS Director for Surrey Wide Services	✓
Clare Stone (CS)	ICS Director of Quality and CCG Chief Nurse	A
Jane Lovatt (JL) *On behalf of CS*	Head of Quality, Surrey Heartlands CCGs	✓
Dr Sian Jones (SJ) *From item 8*	Clinical Chair, Guildford and Waverley CCG	✓
Julie George (JG)	Public Health Consultant, Surrey County Council	✓
In Attendance		
Jane Williams (JW)	Deputy Managing Director, G&W CCG	✓
Vicki Taylor (VT)	Deputy Chief Finance Officer, G&W CCG	A

Name (initials)	Title	Attendance (✓)/ Apologies (A)
Zak Comler (ZC) *Observer with JW*	NHS Graduate Trainee	✓
Natasha Moore (NM)	(Minute taker) Governance Manager for the Surrey Heartlands CCGs	✓
Debo Sokoya (DS)	(Minute taker) Corporate Committees Administrator	✓

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** The Chair welcomed members and attendees; apologies were received as detailed above. He reminded all that confidential papers should be handed in to NM after the meeting for secure disposal; that the meeting would be recorded for administration purposes only; and the recording would be deleted once the minutes had been approved.		
2	**Declarations of Interest** The Chair noted the register of members' and attendees' interests included in the meeting papers. No additional interests had been received since the previous meeting. The Chair invited members and attendees to report any new declarations/ amendments to the register; and to report any declarations pertinent to items on this agenda. None were received. *JH joined the meeting.*		
3	**Quorum** It was noted that the meeting was quorate.		
4	**Minutes from last meeting on 20/08/19** The Chair presented the minutes from the previous meeting. **The Local Clinical Commissioning Committee:** • **APPROVED the minutes of the last meeting.**		
5	**Action Log** The Chair presented the action log with actions shaded having been marked as closed. The following open actions were discussed: 14.Top risks identified; DMc to raise poor LD health check performance as a risk on the risk register. It was confirmed this risk has now been inserted in the risk register. Mark as closed. 2. Declarations of Interest; NM to review the mitigating action for GM. NM confirmed that this had been reviewed. Mark as closed		

Item No.	Discussions and New Actions	Who	When
	9. Performance Report; GM to include updates in the following areas: Echocardiology and Urodynamics; correlation regarding diagnostic and 18-week performance; update from Cancer Board regarding new CT scanner (with SJ); data on HCAIs; and system pressure regarding those with LD/ MH being placed out of area. GW provided an update on the following: • Echocardiogram performance had significantly improved with 1.06% of patients breaching 6 weeks in July compared to 23.6% in May and 9.60% in June. The improvement was driven by the provision of additional capacity and locum support. The development of a business case to increase staffing resource on a permanent basis to ensure consistent achievement of the standard are underway. • Urodynamics had 10 breaches in July of 41.67%. Capacity continues to be a challenge, although a small volume of patients and each pathway is tracked through PTL management. There are plans in place to train clinical fellows to undertake the diagnostic test which would provide additional capacity. The training consists of a formal course followed by onsite training, it is likely the impact of this would not be felt until Q4 due to the next course not being held until October. JG queried the potential correlation between diagnostic and 18-week referral to treatment. JW and GM noted that this is difficult to quantify, although noted numbers for the above two areas were small. Mark as closed. 10. Finance report; VT agreed to include performance against activity levels data in future reports. KMc confirmed the report is not yet available for this month as future reports would be separate reports for performance and finance. Mark as closed. 7. Tariff for non-face-to-face activity; JW to undertake cost modelling JW to undertake cost modelling. Continued work is in progress, an update to be given in November. 12. 2019/20 Financial Recovery Plan (FRP) and Summary Financial Recovery plan document; VT agreed to circulate the latest document summarising the commissioner and provider financial positions. KMc confirmed she will circulate the Month 5 document. She noted that from Month 6, the document would be an appendix to the System Finance Report.		
6	**Performance Report – July 2019** VS outlined the report noting the following: • A&E 4hour performance position remained challenged at 89.5% in June and below the NHSE/I trajectory target. July's performance is estimated at 91% and above the National Position of 87.8%. Advised there had been two assurance visits to Emergency Department (ED) regarding quality and that NHSE/I colleagues		

Item No.	Discussions and New Actions	Who	When
	were due to observe the next Local A&E Delivery Board (LAEDB). Noted that some changes had been made to the daily system calls and that the completion of phase 3 ED capital refurbishment programme would help capacity and enhance the patients experience. • RTT performance had slightly dropped to 89% and although stable, was below plan. The total wait list time was above year-end target. However, some challenges in Trauma & Orthopaedics, Ophthalmology, Oral & General Surgery and Cardiology were noted with recovery plan at specialist levels and compliance by October 2019. • 52+ week wait: The numbers were slightly above the planned levels with two breaches in June both in Queen Victoria Hospital in East Grinstead. Clinical Harm Reviews of the patients were underway. • Diagnostic waiting times overall performance continues to improve. There were significant challenges in Echocardiogram of 48 breaches and 10 breaches in Urodynamics. Recovery plans are being implemented with compliance expected from July. SJ is involved in the recovery plans. • Cancer waits, 2 week wait breast symptoms performance had dropped to 75.8%, although a joint recovery plan is being developed with the CCG for a direct access diagnostic for breast pain patients. • 62 days urgent GP referral performance compared to previous month improved to 79.2% in June although below the planned trajectory. The Trust continues work with the National Cancer Team on a revised improvement plan with compliance in place by November 2019. • Dementia Diagnosis continues to improve at 62.4% in June and above the planned trajectory. • Learning Disabilities Health Check performance for Q4 had improved over previous quarters to give a year end performance of 52.2%, although below 70% national trajectory. VS highlighted that a recovery plan with the Primary Care Team is being developed to address areas such as data coding issues, training and GP engagement. • Mixed sex accommodation – none to report i for the Trust but 12 reported year to date for G&W. There were 5 in June across the system, with four being at Frimley and one at Ashford and St Peters. It was suggested that the four at Frimley could be attributed towards the day surgery refurbishment works. The Chair asked if there was any data on Community service. JL advised that the first cut of draft data had been received and progress was positive. She advised that a review was in place to obtain the data. JG requested clarity on the declining 62 day urgent GP referral performance.GM explained that the number of breaches were low, which results in a higher percentage. KMc asked if the Quality Premium data could be included going forward. VS said she would query this **and agreed to include in**	**VS**	**24/09/19**

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	future reports. JL advised that some of the data was yet to be received. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report with focus on the exceptions. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
7	**Finance Report Month 5** KMc presented the summarised financial position as follows: • At month 5, there is a year to date deficit of £3.0m, a £2m adverse variance to plan and a forecast deficit of £2.8m in line with plan. The adverse variance represents unidentified QIPP and acute pressures across a number of providers. • The forecast outturn position assumes that £5.4m of unidentified QIPP savings can be delivered in order to meet the forecast deficit. This is reliant upon the delivery of the financial recovery plan programs. The committee is to note that this represents a high risk to delivering. • Net risks are £9.1m, which includes the unidentified QIPP savings, the joint financial recovery plans, acute performance and other risks. • Noted that the CCGs had released all contingency and other reserves also into the YTD position. • She also noted that the main acute provider was due to present at the G&W Practice Council meeting tomorrow on the system financial recovery plan. PB asked for additional clarity regarding the status of any unmaterialised accruals. KMc further explained that this is being managed and mitigated and by Month 5, a judgement is made whether they will materialise, this represents a small value released into the position. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
8	**System Finance Report Month 4** KMc presented the report, advising that it included all partners, including SaSH and East Surrey CCG. She explained that future reports would include the Financial Recovery Plans (FRPs) across the four Systems and also include risks, actions and mitigations taken. *SJ joined the meeting*		

Item No.	Discussions and New Actions	Who	When
	PB raised a concern regarding the increase in A&E activity in NWS, particularly an increase in admissions for the age range 17-65 years. KMc noted that additional capacity had been provided and a review is taking place. The Committee discussed whether some patients might be attending both A&E and the Urgent Care Treatment Centre (located at the same site) and then being 'sign posted' accordingly; this may be creating a 'double count' in activities. KMc suggested more narrative might be needed to explain the increased activity. **ACTION: KMc to ensure the appropriate narratives and actions are provided in the report.** **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**	**KMc**	**24/09/19**
9	**QIPP Report Month 5** JW highlighted the following: • Report consisted of reviews of the QIPP programs, those that were working well and those areas needing improvement. • Some 'historical' QIPP teams were now working on the FRPs, with a workshop having taken place to improve patient experience and identify 'extra' areas where savings could be made. • A '60 day challenge' had started where schemes with 0% delivery are reviewed and scrutinised. This includes: o POLCE, which was now over delivering; o The new RSS model is being reviewed with some different triage models being proposed; o Ensuring projects align to the Transformation Plan; o Enhanced Health in Care Homes scheme was being reviewed with the aim to prevent unnecessary A&E attendances; and o Some 'quick wins' in terms of transactional savings, for example challenging on some PBR contracts. • Next month, a 'Mitigation to QIPP' data set report will be reviewed. • ICP focus going forward will be on how to support this area of work. KMc advised that a South East system group had been set up with Directors of Finance to share better practice to help to delivery FRPs and QIPP. The NHSE regional team had also asked what support is needed in the System to deliver. This had been passed to the ICP Directors and Directors of finance and will be discussed at SOAG. **KMc to share outputs from this meeting.** *SA joined the meeting.* GM mentioned some potential opportunities for savings with regards to Medicines Management Schemes, e.g. move towards generic branded drugs. The Chair explained that there had been a successful project	**KMc**	**24/09/19**

Item No.	Discussions and New Actions	Who	When
	with regards to this area with growth in branded drug prescribing now stabilised. He outlined that MOG were reviewing this data with a view to expanding this project, examining how to incentives practices and understanding the differences in prescribing patterns. PB queried the Integrated Urgent Care Scheme and why this had not had an impact. JW explained that the emergency ambulance provider had just launched a new electronic patient records system and the crucial aspect of this programme was how to utilise the connection between the emergency ambulance provider and111 services and also how to maximise extended access and referrals into specialists. JW also acknowledged that there are various debates regarding whether availability of a robust 11 service reduces urgent care attendances or not. SC clarified that with the current service model, the impact may be slightly longer-term. She also commented that return on investment is difficult to quantify, e.g. quantifying how many A&E attendances a 111 service has prevented. However, she noted there are KPIs within the contract and the team are holding the provider to account. SC noted that proxy measures are in place but that these were not reliability indicators of effectiveness. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
10	**Sub-Committee minutes:** • **Better Care Fund Local Joint Commissioning Group: 20/08/19;** • **Clinical Forum: 16/07/19;** • **MOG: 13/08/19.** The Chair noted minutes of the above meetings. **Recommendations: The Committee is asked:** • **TO NOTE** the sub-committee minutes as above. **The Committee:** • **NOTED the sub-committee minutes.**		
11	**AOB** <u>Clinical Cardiology specialist for RSS</u> JW raised as part of QIPP savings, there was appetite for an additional GP in RSS with a speciality in cardiology. Funding for this would be £3,300 until March 2020. This role would be to advise and provide guidance to improve and streamline the system, as well as filtering 'inappropriate' referrals. A similar post in the Surrey Downs RSS had resulted in a 20% reduction in Cardiology referrals by filtering 'inappropriate' referrals and undertaking 'quick win's where advice and		

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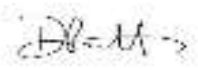
	guidance can be given. At present, at G&W, there were generalist GPs in place but no specialists. JW noted that a Transformation Programme was underway with work also underway across the system regarding streamlining and redesigning pathways. She advised that positive work was underway with the community heart failure team with consultants being actively engaged. SJ queried whether there was additional review needed regarding ECGs within primary care or community clinics, noting that this was currently an LCS. JW confirmed that work was underway to align new LCSs across G&W, NWS and SD CCGs. JW requested approval from the committee for the above. Following discussions, members agreed. She also raised that a review of the RSS was due and planning was underway for this. **The Local Clinical Commissioning Committee:** • **APPROVED the additional funding for the RSS Cardiology Specialist until 31/03/20.** No other business was raised.		
12	**Top risks identified** The Committee raised the following risks following this meeting: • Financial position.		
13	**Overall review of papers submitted to the meeting and decision making** Members and attendees agreed the papers were clear and of a high quality.		
14	**Meeting close** Meeting closed at 14:05.		

Signed and agreed by:



Date: 15/10/19
Dr Darren Watts, GP Member, Guildford and Waverley CCG (Committee Chair)

Minutes agreed for publication by:

Date: 15/10/19
Vicky Stobbart, ICP Director, Guildford and Waverley (Exec Lead)

Future Meeting dates (Tuesdays)	Deadline for agenda items/ papers (Fridays)
15 October 2019	04 October 2019
19 November 2019	08 November 2019
17 December 2019	06 December 2019

GUILDFORD AND WAVERLEY CCG

LOCAL CLINICAL COMMISSIONING COMMITTEE- PART I

MINUTES- DRAFT

Date	15/10/19	**Time**	14:10- 15:40
Venue	Board Room, 3rd Floor, Dominion House, Guildford		

Members/ Attendees

Name (initials)	Title	Attendance (✓)/ Apologies (A)
Voting Members		
Dr Darren Watts (DW)	**(Committee Chair)** GP Member, Guildford and Waverley CCG	✓
Phelim Brady (PB)	**(Committee Vice Chair)** Lay Member Patient and Public Engagement , Guildford and Waverley CCG	✓
Dr Justine Hall (JH)	GP Member, Guildford and Waverley CCG	A
Vacant	GP Member, Guildford and Waverley CCG	-
Matthew Tait (MT) *Until Item 7*	ICS Chief Officer	✓
Karen McDowell (KMc)	ICS Director of Finance	✓
Vicky Stobbart (VS)	ICP Director, Guildford and Waverley CCG (shared role)	✓
Giles Mahoney (GM)		✓
Sumona Chatterjee (SC)	ICS Director for Surrey Wide Services	✓
Clare Stone (CS)	ICS Director of Quality and CCG Chief Nurse	A
Jackie Moody (JM) *On behalf of CS*	Head of Quality (Acute), Surrey Heartlands CCGs	A
Dr Sian Jones (SJ)	Clinical Chair, Guildford and Waverley CCG	✓
Julie George (JG)	Public Health Consultant, Surrey County Council	✓
In Attendance		
Jane Williams (JW)	Deputy Managing Director, G&W CCG	A
Vicki Taylor (VT)	Deputy Chief Finance Officer, G&W CCG	A

Reviewed by: VS (11/11/19); DW (12/11/19)

Name (initials)	Title	Attendance (✓)/ Apologies (A)
Rachel Mackay (RM) *For item 6*	Associate Director of Medicines Management	✓
Niki Baier (NB) *Until Item 7*	Deputy Director of Acute & Collaborative Contracts Surrey Heartlands CCGs	✓
Adam Binnie (AB) *For Item 7&11*	Planned Care Service Redesign Manager	✓
Ben Hill (BH) *For Item 13a*	Surrey Heartlands Head of Urgent Integrated Care	✓
Sarah Taylor Smith (STS) *For Item 13a*	Clinical Lead for Integrated Care, G&W CCG	✓
Michelle Hayman-Joyce (MHJ) *For Item 13a*	Head of Urgent Integrated Care, G&W CCG	✓
Natasha Moore (NM)	(Minute taker) Governance Manager for the Surrey Heartlands CCGs	✓
Debo Sokoya (DS)	(Minute taker) Corporate Committees Administrator	✓

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** The Chair welcomed members and attendees; apologies were received as detailed above. He reminded all that confidential papers should be handed in to NM after the meeting for secure disposal; that the meeting would be recorded for administration purposes only; and the recording would be deleted once the minutes had been approved.		
2	**Declarations of Interest** The Chair noted the register of members' and attendees' interests included in the meeting papers. No additional interests had been received since the previous meeting. The Chair invited members and attendees to report any new declarations/ amendments to the register; and to report any declarations pertinent to items on this agenda. The following was noted: • Item 6- GP Members noted a conflict for this item. GP members to remain in the room for the discussion but not to participate in the decision for this item.		
3	**Quorum** As the required quorum was met, the Chair declared the meeting open.		
4	**Minutes from last meeting on 17/09/19** The Chair presented the minutes from the previous meeting. **The Local Clinical Commissioning Committee:** • **APPROVED the minutes of the last meeting.**		

Item No.	Discussions and New Actions	Who	When
5	**Action Log** The Chair presented the action log with actions shaded having been marked as closed.		
6	**Accelerated System Efficiency – Medicines Management led scheme to implement the preferred blood glucose test strip (BGTS) meter and accompanying test strips across G&W CCG to align with the updated BGTS formulary** RM presented the paper highlighting that the purpose was to support GP practices to implement the agreed blood glucose test strip (BGTS) formulary. The project forms part of the accelerated QIPP. The proposal was to fund a meeting with a nominated GP at the practice and a representative from Interface Clinical services (ICS) (the third party provider undertaking the work on behalf of GlucoRX).GlucoRX is the manufacturer of the preferred meter and test strips. The meeting will be funded to discuss how ICS will implement to support the practice in informing patients of the transition to the new meter. The meeting would be funded for 1 hour of GP time for each practice. SJ ask for some clarity on if these included all adult patients and/ or all Type 1 and Type 2 patients. RM clarified that the proposal was for the majority of Type 2 patients unless there is a clinical reason for an alternative meter. Currently there are 31 different test stripes being used across the CCG; however there has been a significant move towards previous formulary choices since the introduction of a BGTS formulary in 2015. The Chair advised that there were robust elements on how the preferred providers had been chosen to achieve in year savings. SJ asked if the Diabetes GP Leads were aware of the proposal. RM responded and gave assurance that they had been communicated with to comment on the proposed updated formulary during the consultation phase. PB noted that he was assured that a thorough process had been followed. Members agreed to support. **Recommendations: The Local Clinical Commissioning Committee is asked** • **TO APPROVE** this in year project – supporting the up-front investment of £2100 which will enable the delivery of the overall savings in the region of £75-100k. The minimum anticipated return on investment, over a 12-month period, would be £72,900, with the potential to deliver up to 50% i.e. £35-£50k, within the 2019/20 financial year. **The Local Clinical Commissioning Committee:** • **Could not approve this in year project as due to a conflict of interest for GPs (see above item 2) therefore the Committee was not quorate. However, under the Scheme of Reservation**		

Item No.	Discussions and New Actions	Who	When
	and Delegation and the specified financial thresholds, the required Executive Directors were present for this decision to be APPROVED. • **NOTED the next steps as follows: Medicines Management team to provide GPs with a summary of rationale and process; and team to work with Commercial Companies governance process and achieve sign off before any work is undertaken** *RM left the meeting.*		
7	*AB joined the meeting.* **Telephone Advice and Guidance** AB presented the business case for a 12-month pilot to implement a telephone Advice and Guidance (A&G) platform, Consultant Connect, through a network of consultants at the Trust who would be available to answer queries via telephone. Calls would forward on to a national team if not answered within a certain length of time. He noted that the average response time was 39 seconds. Implementation of this system could result in a reduction in attendances at A&E and secondary care referrals. If answered by the Trust, the A&G tariff would be paid directly to them. The Chair asked if the Trust has 'bought into' the use of Consultant Connect. AB confirmed that consultants were aware and that their preferred option would be option 3, using local consultants only. The Chair highlighted the fast 'pick-up' time of 39 seconds compared to similar systems used previously. NB further highlighted that the recommendation was supplementary to the existing A&G service with a 12-month pilot, rather than as a replacement. NB also noted that a neighbouring Trust had successfully implemented this service **and agreed to obtain some detail on learning on implementing this service.** The Chair asked if there were other ways to access this service, e.g. facilitate to e-mail test results, ECGs etc., for review. **AB to investigate.** JG highlighted the advantage that using local consultants may help to form and solidify relationships between local consultants and GPs. Members agreed this would be an advantage. KMc challenged why this was not being funded from the Outpatient transformation funds; whether this should be looked at as part of outpatient workstream across the system; and asked if this was value for money. MT noted that if the pilot scheme would reduce the total cost in the System, it was worth exploring the pilot. **VS agreed to explore other options for funding.** Members agreed.	**NB** **AB** **VS**	**30/10/19** **30/10/19** **30/10/19**

Item No.	Discussions and New Actions	Who	When
	SJ challenged the logistical implementation to ensure that consultants had access to the right equipment to use this A&G. VS confirmed that ensuring provision of technology was being implemented but **agreed to obtain and update in the context of this service.**	**VS**	**30/10/19**
	The Chair also asked, given imminent winter pressures, whether this could too be implemented for urgent care and moved into 'phase 1'. AB confirmed that he had received confirmation that this could be implemented within four weeks. **AB agreed to prioritise this area.**	**AB**	**30/10/19**
	After discussion, the committee agreed option four, to use Consultant Connect with access to national network. The committee noted that the paper was very easy to read and helpful and asked that their thanks be passed onto the paper author.		
	VS noted that the metrics of the pilot scheme would be monitored through the Outpatients Transformation Board via the ICP Board. **VS agreed for this to be reported to LCCC too**. **The project approval is subject to it not being funded from operational transformation project**. In terms of communication, it was suggested that this was presented at the next Practise Council meeting in November.	**VS**	**30/10/19**
	Recommendations: The Local Clinical Commissioning Committee is asked: • **TO APPROVE** the project, supporting the investment of £60k per annum, which will enable the delivery of the overall savings of £376k. **The Local Clinical Commissioning Committee:** • **APPROVED the project – supporting the investment of £60k per annum, which will enable the delivery of the overall savings of £376k.** • **APRROVED the project subject to it not being funded from operational transformation project funds.** • **NOTED the next steps - to progress contractual arrangement with Consultant Connect and they will then take forward implementation steps (once IG Team has signed off).** *AB, MT and NB left the meeting*		
8	**Performance Report- Month 4** VS outlined the report and highlighted the following by exception: • Learning Disabilities Health Check performance for Q4 had improved over previous quarters to give a year end performance of 52.2%, although below the 75% national trajectory. She highlighted that although there has been an improvement in the last two months, there has been a lack of data included in the reports, despite having had a deep dive. With this in mind, PB highlighted the need to flag any absent information in a performance report going forward as an area to		

Item No.	Discussions and New Actions	Who	When
	highlight. **VS to request that the next performance report provide at least two quarters of the required data and includes additional narrative in this area**. VS explained that there were some issues with coding which were being addressed by providing EMIS/ CQRS training to practices. • Dementia Diagnosis continues to improve at 62.6% in July and above the planned trajectory. • Cancer 62 days urgent GP referral performance improved compared to previous months to 82.3% in July which is above the national trajectory. Noted this was the first time that this metric was above target since 2015 and passed on her congratulations to all involved. VS advised on some actions being taken: o Ongoing work to develop 28-day faster diagnosis pathways, focusing initially on Colorectal, Lung and Prostate pathways. o The development of Breast recovery plan and resourcing of staff o Urology's innovative new prostate pathway went live at the beginning of July with the streamlined Lung cancer pathway. o Pathway Navigators now in post for Urology and Breast. o Screening recorded 2.5 breaches in July due to the lack of oncology capacity, complexity of diagnosis and patients needing more time. • Cancer waits: 2 week wait breast symptoms performance had dropped to 74.7%, although a joint recovery plan is being developed with the CCG for a direct access diagnostic for breast pain patients PB requested for some clarity on how the RAG rating is composed, as he felt that 'amber' ratings when not above target might be misleading. VS explained how the RAG rating was composed, although acknowledged there might be a need to review this method. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report with focus on the exceptions. **The Local Clinical Commissioning Committee:** • **NOTED the report.**	**VS**	
9	**Finance Report Month 6** KMc presented the summarised financial position as follows: • At month 6, there is a year to date deficit of £3.5m, a £2.2m adverse variance to plan and a forecast deficit of £2.8m in line with plan. The adverse variance represents unidentified QIPP and acute pressures across a number of providers. • The forecast outturn position assumes that £5.8m of unidentified QIPP savings can be delivered in order to meet the forecast deficit. This is reliant upon the delivery of the financial recovery plan programs, which represents a high risk to delivering.		

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	• The CCG and the Trust are working in partnership and have produced a local ICP financial recovery plan. The focus has been to identify the steps that the Trust can take in order to reduce cost and transform care to deliver the required efficiencies in 2019/20. • Net risks are £9.2m, which includes the unidentified QIPP savings, the joint financial recovery plans, acute performance and other risks. • Noted that the CCGs had released all contingency and other reserves into the YTD position. • KMc advised that there have been some discussions on how to manage the run rate and over performance at some acute providers. She said there was a need to do some checks and validating in other areas. KMc explained regulators are aware of the CCGs position. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
10	**System Finance Report Month 5** KMc presented the report, advising that it included all partners across the four Systems, including ES CCG, SaSH and FCH. KMc explained that the report also included an appendix which shows ICP levels of risk mitigations and FRP actions. The report also contains FRP narrative. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.**		
11	*AB and MHJ joined the meeting.* **QIPP Report Month 6** VS highlighted the following: • At month 6, the CCG had delivered savings of £3.32m, which is 48% of the year-to-date target of £6.96m. This figure includes both the identified and unidentified QIPP. Delivery of identified QIPP is 92% year to date. • The forecast to deliver 54% (£8.04m) of the total 2019/20 QIPP requirement which is £14.79m. Identified QIPP schemes are forecast to deliver 102% (£5.44m) of the £5.35m total. • There are a number of schemes where savings have not been delivered as planned and unlikely these will recover in time to deliver the year end forecast although required adjustments are being made to reflect these. She advice that there are mitigations to		

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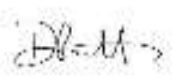
	QIPP schemes in place and are currently being modelled and mobilized PB stated that it was encouraging to see the position improving for very high intensity users. PB highlighted that the challenge was to discover if there were areas where there is a better place of provision. MHJ advised that the model has now moved into the wards and the challenging issue is the capacity with mental health beds. SG asked who were the high risk patients and not getting the care. She suggested there was a need to frequently review patients that are within these categories. SJ explained that there were a number of patients not being seen at the GP surgeries although some were often seen, therefore PCNs would need to review this area. MHJ agreed that this was an issue and advised that some work was been considered by PCN's. KMc highlighted the use of digital technology for wellness management as diabetic spend was being reviewed. SC challenged the content of the report that it did not capture correctly the needful data. MHJ explained that the relevant information had been captured and further reviews were in place. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO NOTE** the report. **The Local Clinical Commissioning Committee:** • **NOTED the report.** *AB left the meeting.*		
12	**Sub-Committee minutes:** • **Better Care Fund Local Joint Commissioning Group: 18/09/19;** • **Clinical Forum: 20/08/19;** • **MOG: 10/09/19.** The Chair noted minutes of the above meetings. **Recommendations: The Committee is asked:** • **TO NOTE** the sub-committee minutes as above. **The Committee:** • **NOTED the sub-committee minutes.** *STS, MHJ and BH joined the meeting*		

Item No.	Discussions and New Actions	Who	When
13	*BH and STS joined the meeting.* **AOB** <u>G&W ICP Community Assessment Pathway</u> BH presented the report advising that long-term care in the acute setting has a significant impact on an individual's outcome of direct placement into a Nursing Home. He explained that during last Winter, the pathway was reviewed with the aim to reduce the length of stay from 23 days to 7 days from point of positive checklist once medically optimised and this has saved 160 beds per month which equated to 5 bed days per day. Funding for this pathway expired in March 2019 and was further extended by the CCG. As at 09/10/19 when the pathway was suspended, a total of 67% of patients had been through the pathway. Majority were assessed as being self-funded or had Adult Social Care (ASC) funding with FNC funding. This has been a challenging pathway to agree due to both the CHC legal framework and ASC Legal Framework which prohibits them funding patient care until their eligibility had been confirmed by the panel. The committee noted the monthly cost per patient of a nursing home bed of £2,200 and a total cost of £132,000 per month for 10 patients. The proposal was for each partner in the system to invest £33,000 each month to continue the new pathway until April 2020. The Chair asked if the CCG can continue to afford the funds for this pathway and why the funding stopped. VS explained that the CCG was endeavouring to meet the demands of the pathway with all the partners and putting it forward for transformational money. STS advised that the impact in the hospital was quite high due to inadequate funding. It seemed that the funding structure was not properly developed to administer the pathway and the additional capacity created did not result in system efficiencies or reduction in escalation beds within the Acute Provider. BH advised that available funding with CHC and ASC and the two available options stated in the paper were the recommendations. He highlighted that the future recommendation was a Community Assessment Pathway model that also includes Mental Health patients with positive checklists including section 117 agreements. This would support reducing delays in mental health beds given the current challenges this would be a significant system benefit. SJ asked if there was an agreement with other parties to pay into the pathway. VS clarified that the LCCC was the first committee that has had the paper presented so formal agreement from ASC and the Trust had not yet been received. After some discussion, the Committee agreed to the positive impact the model would have on reducing length of stay and the current pressures		

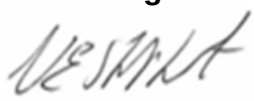
Item No.	Discussions and New Actions	Who	When
	on mental health beds and to ensure robust evaluation of the pathway including qualitative and quantitative data to support a business case to ensure this is business as usual from April 2020. **Recommendations: The Local Clinical Commissioning Committee is asked:** • **TO APPROVE** CCG and CHC investment of £33,000 each, for a total of £66,000 to support this pathway. **The Local Clinical Commissioning Committee:** • **APPROVED investment of £66,000 to support the proposed pathway. Agreements to be obtained from ASC and the Trust for their share in this investment.** • **NOTED the next steps before April 2020: to ensure a robust evaluation of the pathway including qualitative and quantitative data to support a business case to ensure this is business as usual from April 2020** *STS, BH and MHJ left the meeting.* No other business was raised. *VS and SC left the meeting.*		
14	**Top risks identified** No other risks were identified not already logged on the risk registers.		
15	**Overall review of papers submitted to the meeting and decision making** Members and attendees agreed the papers were clear and of a high quality.		
14	**Meeting close** Meeting closed at 15:40.		

Signed and agreed by:



Date: 19/11/19
Dr Darren Watts, GP Member, Guildford and Waverley CCG (Committee Chair)

Minutes agreed for publication by:



Date: 19/11/19
Vicky Stobbart, ICP Director, Guildford and Waverley (Exec Lead)

Future Meeting dates (Tuesdays)	Deadline for agenda items/ papers (Fridays)
19 November 2019	08 November 2019
17 December 2019	06 December 2019
21 January 2020	10 January 2020
18 February 2020	7 February 2020
17 March 2020	6 March 2020
21 April 2020	10 April 2020
19 May 2020	7 May 2020 (Thursday due to Bank Holiday)
16 June 2020	5 June 2020
21 July 2020	10 July 2020
15 September 2020	4 September 2020
20 October 2020	9 October 2020
17 November 2020	6 November 2020
15 December 2020	4 December 2020