Agenda item: 23 **Paper no: 19**

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

The following minutes are presented at this meeting for noting.

Please note that confidential items within these minutes have been redacted.

Meeting Name	Date of Meeting/s
Clinical Cabinet	4 July 2019; 1 August 2019; 5 September 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 25/03/19.

Meeting Name	Date of Meeting/s
Surrey Downs ICP Board	14 November 2019

Surrey Downs CCG Clinical Cabinet

Minutes

Guildford and Waverley CCG	
North West Surrey CCG	
Surrey Downs CCG	ü

Date	4th July 2019	**Time**	9.00 – 12.00
Venue	Cedar Room, Cedar Court		

Members/ Attendees

Name (initials)	Title	Attendance (ü)/ Apologies (A)
Core Members		
Dr Russell Hills	Clinical Chair	A
Dr Jill Evans	Locality Chair – East Elmbridge	ü
Dr Robin Gupta	Locality Chair - Dorking	ü
Dr Niki Kirby	Locality Chair - Epsom	ü
Dr Simon Williams	GP Urgent Care and Integration Care Lead	A
Dr Natalie Moore	GP Planned Care Lead	ü
Dr Sarah Gledhill	GP Mental Health Lead	A
Dr Andreas Pitsiaeli	GP Prescribing Clinical Director and Chair of LMC	ü
Dr Suzanne Moore	GP Paediatric and Maternity Lead	ü
Colin Thompson	Integrated Care Partnership (ICP) Director	ü
Karen McDowell	Integrated Care System (ICS) Director of Finance	ü
Sumona Chatterjee	ICS Director of Surrey Wide Services	ü
Clare Stone	ICS Director of Quality and NHS Surrey Heartlands CCGs Chief Nurse	A
Jane Lovatt *On behalf of CS*	Head of Quality - Community	ü
Dr Liz Saunders	Consultant in Public Health, Surrey County Council	ü

Name (initials)	Title	Attendance (ü)/ Apologies (A)
Matthew Tait	ICS Chief Officer	ü
In Attendance		
Lorna Hart	Deputy Managing Director, Surrey Downs CCG	ü
Victoria Griffiths	Epsom and St Helier Hospitals	ü
Thirza Satell	Epsom and St Helier Hospitals	ü
Hilary Floyd	Derby Medical Centre	ü
Rachael Graham	Deputy Director of Contracts – Non Acute and Primary Care	ü
Dr Judith Eling	Specialist Registrar (ST4) in Public Health, Surrey County Council	ü
Edwin Addis	Governance and Risk Manager (minutes)	ü

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** CT welcomed everyone to the meeting at 9.03am. Apologies: Dr Russell Hills, Clare Stone, Dr Simon Williams		
2	**Declarations of Interest** The Clinical Cabinet received confirmation from all members and attendees that their entry in the Register of Interests was up-to-date, accurate and complete. Jill Evans has a new role (GP Lead for Adult Community Services/SD Health and Care Partnership) and has declared interest for item 10 (Community Contract Gateway 3).		
3	**Quorum** As the required quorum was met, CT declared the meeting open.		
4	**Minutes from Last Meeting on 6th June 2019** The minutes from the previous meeting were agreed as an accurate record of the meeting after correcting a sentence on page 8 (SM said only GPs need to do 8 hours training).		
5	**Matters Arising and Action log**		
5.1 5.2 5.3	**Action Log**: 02/05/2019 Item 6 – Revised CC ToR have been approved at the GBiC meeting held on 26/06/2019. (close) 06/06/2019 Item 7 – CT circulated the FRP as agreed. (close) 06/06/2019 Item 8 – CT circulated information (dashboard) about care homes as agreed. (close)		

Item No.	Discussions and New Actions	Who	When
5.4	06/06/2019 Item 11 – SC and NM to discuss and provide update at the next meeting about IRIS training and providing a liaison officer GPs can call. (leave open)		
5.5	02/05/2019 Item 15 – Transformation Board update. Invite Paul Clements to the August meeting to provide an update on digital technology and capital schemes. (item added to August agenda – close)		
6	**The Integrated Care System (ICS) Update**		
6.1	MT highlighted: SOAG meeting held on 3rd July went through the financial recovery plans (FRP) across the system. FRP teams should be commended; we have mitigated a good proportion of risk in the system but the expectation to close the financial gap was still very challenging.		
6.2	Transformation funding - £6m of flexibility. Half of this funding has been committed to Enhanced Access and Primary Care development agenda. RG said Dorking locality had a lot of project ideas and asked how bids will be submitted. MT said this would be decided over the next two weeks by the partners within ICPs. Options include submitting bids to the ICS or it could be decided this is transformation funding for ICPs.		
6.3	Quality agenda – ratings of the trusts. Quality Surveillance Group will decide whether trusts should be under regular or enhanced surveillance.		
6.4	National outpatients project - next steps on devolution. Property is owned by NHS Property Services, not by CCGs and the question is whether we will be able to change that as part of the devolution. We will be going back to NHSE on this issue.		
6.5	CCG Configuration – all four member councils have been visited to discuss the future arrangements. East Surrey are keen to colaborate but there are a number of questions that need to be answered: What will be the operating model? Is it right for the development of ICPs? There are also complex issues around HR and ICP architecture that need to be resolved.		
7	**The Integrated Care Partnership (ICP) Update** CT highlighted:		
7.1	Reorganisation of clinical support and pathways; NM agreed to be Senior Officer for Planned Care. Clinical directors and Primary Care clinicians leading on 6 areas (colorectal, MSK, Ophthalmology, Dermatology, Gynaecology) have been appointed.		

Item No.	Discussions and New Actions	Who	When
7.2	Urgent care – work on the three main strands to align the teams. The pace of change is significant to address admissions in SASH.		
7.3	Support to PCNs – see update under Primary Care item		
7.4	The aim is to avoid duplication so transition from CC to ICP Board should take place in Sept/Oct. MT added that not everything will be resolved by September so the agreed principle is, unless there is clarity, contracts will be extended till March 2020. RG said we need funding released to PCNs, with technical solutions needed for how we move funding around the system.		
7.5	JL asked whether any discussions had taken place about the Quality and Performance Board. CT said Claire Fuller is coming to the next ICP meeting to discuss Performance.		
8	**2019/20 Month 2 Finance Report** KMc presented the report and highlighted:		
8.1	Surplus control total Is £300k with QIPP programme of £30m. Reported risk of £24m.		
8.2	FRP – mitigating risk, shift in the risk position. Challenge in the system. SASH contract is outstanding with issues. Over performance in St George's and Kingston (non-elective at St George's).		
8.3	Section 13 of the report – risks. The biggest risk is the unidentified QIPP and FRP. In addition, £10m via programmes.		
8.4	It's early days in this financial year so far; our forecast is to break even. Further discussions with regulators are taking place with regards to month 3 position.		
8.5	Discussion: RG asked about the amount of unidentified QIPP. KMc answered that it was £30m. SM asked how this would be achieved. CT said FRPs are the vehicles for finance recovery plans and added that we have expensive PTS and that opportunities for savings exist in the transition between acute care and primary care. On the elective side the referrals are above what they were 2 years ago. Significant work is done through private providers but they are unwilling to establish caps on contracts.		
8.6	SM asked about fixed term contracts. CT said that, on the UC side, Epsom was £3m adrift in the forecast outturn. Deep dive on SASH is planned (admissions 20% up). MT added that a bigger debate is ongoing with SH providers about moving off		

Item No.	Discussions and New Actions	Who	When
	the PbR. SASH has yet to come to a point where it is willing to move away from PbR contract.		
8.7	AP talked about medicines management; Surrey has one of the lowest spends in the UK and it would be interesting to consider the possibility of culture change with the introduction of ICPs – we don't have insight into the spend. SM added we must not forget about quality.		
8.8	JE asked whether this was only a ESHT issue and added that we need to know about finance issues in Kingston too (on block contract).		
8.9	SM had a query about St George's patients movements. CT said sometimes they tend to get stranded and are often moved to London providers. JE said consultant referrals have been an ongoing issue for a a long time. CT said we tried to deal with this in the past as commissioners but with very little ifluence. SM said stroke patients admitted by St Georges sometimes stay there for a long time. The aim is is to reduce this by 40% by end of the year. JE added there were issues with such patients at Kingston too; weekly meetings with senior clinicians have been introduced to discuss these patients and get them discharged. **The Clinical Cabinet NOTED the 2019/20 Month 2 Finance Report**		
9	**2019/20 Month 2 Performance Report** CT presented the report and highlighted:		
9.1	Emergencies are going up, and there are significant performance issues in relation to A&E . A deep dive on SASH will be done soon. JE said we have enhanced access now so difficult to understand why emergencies are going up. CT said we need to work on this at practice level and with the new Community services. JE said we need information and analyse it so we can start addressing issues. CT said we get hospital information 2 months later from the clearing house. NK added that Alamac provides more real time information for the local SRG (system resilience group) to provide a better picture about how patients are moved through the system.		
9.3	AP said there is a lot of information but it not always easy to understand what it means clinically. We need to know at what level it's at. Which processes are going wrong? It's often not very clear. AP suggested going on a walk around to see what the issues are.		
9.4	RTT position – some variation in Kingston and Epsom (IAPT, cancer) but holding very well. Services for these patients perform well with areas of variation.		

Item No.	Discussions and New Actions	Who	When
	The Clinical Cabinet NOTED the 2019/20 Month 2 Performance Report.		
10	**Community Contract Gateway 3 presentation**		
10.1	LH introduced the item and said Gateway 3 is about the transformation plan and that SD needs to go to GB in September.		
10.2	TS delivered the presentation and highlighted: ESTH is the host (holds contracts and the CQC registration). Discussions about community services have commenced with the CQC at the last ESTH Relationship Meeting;		
10.3	All 3rd party contracts are operational and finalisation of contracts is underway;		
10.4	SDHC integrated governance framework shows a governance flowchart including local governance, SDHC governance, SDHC executive governance, partner governance and lead contract governance;		
10.5	SDHC risk management framework ensures robust governance is in place to support management and oversight of all risks within the partnership.		
10.6	The new management structure supports PCN as the foundation of the model. Fully recruited except for ICP Lead Clinician.		
10.7	Engagement - PCN Welcome Events have been held across the localities to welcome staff to SDHC.		
10.8	SDHC have developed an ambitious Transformation programme which aims to redesign how care is delivered to residents across Surrey Downs. Key risks: financial gap, vacancy rates, inherited long waiting lists.		
10.9	What is next in our journey - shaping new culture and identity and bringing people together as a single team.		
10.10	Discussion: SM said this is significant investment but there are some challenges (e.g. 25% financial impact of the vacancy rates).		
10.11	JE said there is a lot more focus. A lot of bank staff trying to reverse the trend. Really strong local focus and different implementation dynamic; it feels positive despite the financial issues. LH mentioned a recent 3 hour meeting to find workforce solutions (how to recruit staff).		

Item No.	Discussions and New Actions	Who	When
10.12	MT asked about outcomes and measurable metrics within the transformation plan (e.g. two hour window described nationally) Questions about signing off:		
10.13	HF said SDHC want to be measured on outcomes rather than numbers and that KPIs will be outcome based. We would like to report on both staff and patients. TS added that SDHC introduced EMIS and that the Operations Manager is keen to know what the outcomes will be. HF said there should be a balance between quantitative and qualitative outcomes and that there is a draft schedule in the contract to give a flavour before clinical systems are in place (schedule 6: significant milestones).		
10.14	Challenge around 2 hours target - MT said this is an investment in community services and NK added we need to improve the communication to do with the 2 hour service, but targeting the right patients is a challenge.		
10.15	Context: there was a legal challenge at the end of 2018 which resulted in further due diligence. Gatweay 1 came to CC in January 2019 when the original bid was re-assessed. Gateway 2 was presented to the CC in April and gateway 3 will go to GBCiC in September.		
10.16	AP asked what is meant by district nurse modernisation. TS said SDHC want to use technology better – via EMIS and secure apps. The structure of the service was not good enough in the past and the plan is to use technology and staff more effectively through training and upslkilling. AP said part of modernisation means ongoing referral arrangements and asked whether interpretation of results would be part of the process. TS said yes but there would be local nuances in each PCN. JE added that they are planning to get administrators to ring patients to see how they are.		
10.17	SM said Children's procurement had similar difficulties in mobilising that contract, for example vacancy factor.		
10.18	AP said the diary is not always clear and that we need to co-design what it will look like in SystmOne.		
10.19	SC asked whther SDHC, as part of the triumvirate model, are considering integration of mental health. TS confirmed they (mental health staff) are a part of the team.		
10.20	CT asked whether any further clarification is needed before CC decide whether to approve Community Contract Gateway 3.		

Item No.	Discussions and New Actions	Who	When
10.21	LH went through Appendix 1 Gateway to explain the RAG rating. NK asked whether patient records would be kept in the same way. LH answered yes they would and that this would be monitored via CQRM. **CC APPROVED Community Contract Gateway 3**. Next step: closure report will be presented to GBiC in September.		
11	**Findings of Long-acting reversible Contraception (LARC) Review in Surrey** JuE presented and highlighted:		
11.1	The amount of LARC provided by GPs in the time period from 2016 to 2018 has increased by 14% for IUD and IUS procedures, and by 5% for implants. There is variation across Surrey and we don't have comparative data (data incomplete due to coding differences between primary care and sexual health clinics).		
11.2	Commissioning review undertaken April-May 2019 and current provider's contract extended for 2 years (to end of March 2022).		
11.3	Survey findings: GPs almost unanimously felt that LARC provision should be in primary care in principle (regardless of the quality of, and access to, provision in specialist clinics). The most frequently cited reason was that patients feel less anxious, know the provider, don't perceive attending the GP surgery as stigmatising and can get more holistic care and better follow up.		
11.4	GPs have been having to compensate for difficulties patients have experienced in making appointments for LARC in sexual health clinics, with a 13% increase in the LARC workload for GPs in the county which has a knock-on effect on other primary care services.		
11.5	There are 7 proposed actions shown on the last slide – any feedback would be welcome.		
11.6	Discussion: RG said this LARC review was discussed at PCOG, the main issue being that we don't have a hub in Surrey Downs; patients have to go to Guildford or other hubs.		
11.7	SM said a refresh of the buddy system is needed as well as a spoke service and added that premium emergency LARC service has to be incentivised in some way. NM said specialist nurses do come into practices and RG added signposting is a problem - CNWL clinics should but don't always provide appointments within 5 days.		

Item No.	Discussions and New Actions	Who	When
11.8	AP asked whether unplanned pregnancy rates are tracked. JuE said we can look into that. **The Clinical Cabinet NOTED the LARC Review Report**		
12	**Urgent Care and Integration Highlight Report** **The Clinical Cabinet NOTED the Urgent Care and Integration Highlight Report.**		
13 13.1 13.2 Discussion: 13.3 13.4 13.5	**Planned Care Programme Monthly Highlight Report** NM presented the report and highlighted: Format of Joint Planned Care Board between ESTH and SDCCG - it will include clinical directors and other members from the trust (Dermatology and MSK). Further stretch areas have been identified such as Rheumatology and Pain management . RG asked whether launch dates are known for other programmes. CT said not yet and added there will be a 6 weeks warning before programmes start. The next step is to arrange the meetings, some of them will be with Sutton. RG said he attended a workshop for Epsom and Dorking about bringing patients into tier two services, the rest will be community driven. East Elmbrdige and Dorking need to be involved and JE said they will always work together with Kingston. CT said the process for agreeing pathways is led by Primary Care and Secondary Care clinicians and JE added she attended a pre-meeting. **The Clinical Cabinet NOTED the Planned Care Programme Monthly Highlight Report**		
14 14.1 14.2	**Paediatrics, Maternity and Children's Services Highlight Report** SM highlighted: Safeguarding – GPs need to see email with new Adult and Child safeguarding Policies (in accordance with new Intercollegiate Guidance) to be uploaded on practice systems and populated with practice specific information. **Action:** Communicate via Start the Week. Transformation Funding Business Cases 19/20 Bids were analysed by the Board and the following bids were shortlisted for funding: Children Services Academy – this is still being reviewed.	EA	

Item No.	Discussions and New Actions	Who	When
14.3	Weight Management in Pregnancy - Early intervention and prevention pilot to improve weight management during pregnancy and post pregnancy for mothers >BMI 30. Focus on gestational diabetes. The aim is to reduce levels of maternal and childhood obesity		
14.4	SEMH - setting up 4 accelerator sites in cluster schools to test new approach to supporting children with mental health needs in school.		
14.5	Breastfeeding – accreditation scheme aimed at training 100 GPs to champion this issue, focusing on more vulnerable families. David Holden, Children Lead ?? so needs to be revisited. Some practices not doing ante natal care.		
14.6	School exclusions and children that are not in education. SM asked for any feedback on children with complex needs and in the context of SEND/EHCP. There is a bigger piece of work to be done, to find out where the gaps are and provide help via the transformation budget.		
14.7	Clinical leads and SABP will be undertaking the CAMHS SPA audit. The aim of the audit is to understand more about the many referrals to CAMHS which don't proceed to a service (c2,000 per year. **Action**: SM to bring back SPA development plan to the next meeting (Spa development Plan). SC said it would be helpful to link this Audit with the transformation plan. GPs need to have something they can print from the system that gives some local provison while waiting for the appointment. NK said some patients see referral somewhere else as a rejection. JE added we are still getting upset patients who feel powerless when rejected. SM said we are identifying the themes. SC said that one of the things SABT is working on to ensure there is a better clinical input, but cognisant of the fact it is not right, the model needs to change. One of the solutions - integrating with SCC services. We need to test those and question whether these referrals should have been made in the first place. Self-referral reduces demand. NK said GPs used to be able to refer to SPA. One patient was rejected recently and told to access support via school but what if a young person does not attend school. SM said we need help from both GPs and schools. **CC NOTED the Children's Services Highlighted Report.**		

Item No.	Discussions and New Actions	Who	When
15	**Mental Health Services Highlight Report** SG highlighted:		
15.1	Surrey wide IAPT review, useful observations will be shared when available. There is a small scale pilot project to lower the age range to 17; In Kent they already do it. AP asked how do you tell a 17 year old to self-refer. SM said there needs to be an overlap provision and SC added there is a gap in the service.		
15.2	Single point of access for children (SPOA). SG to investigate further. SPOA manager will be contacted to find out more;		
15.3	SC added she will bring a paper to CC next month, about the IAPT contract and review of IAPT services led by Kent Medway. **ACTION** item for next meeting.		
15.4	Expending our MH PCN hub model, we have not been able to bring it to CC. It has had input from clinicians in the bid. Currently 3 are live and will expand to 11.		
15.5	AP asked about the timeframe. SG answered contact within 3 days and first assessment/therapy within 28 days. SM said a lot of change is happening, it needs a refresh via Start of the Week. No fixed pathways for enduring MH issues (when to refer to Spa, clarity needed on psychosis too). AP added we are getting confused about thresholds. SM said once you get into Spa, the level of intervention is not always suitable. **The Mental Health Services Highlight Report was NOTED**		
16	**Primary Care Highlight Report** SE highlighted:		
16.1	PCOG – there was a robust discussion about LCS harmonisation that looked at micro suction and spirometry. ECGs for SD, how we look at 12 week ECG reporting. Prostate next month at PCOG, diabetes finishes next year. SM said clarity is needed on spirometry diagnosis. RG added it was not fit for purpose.		
16.2	Good attendance at the recent away day chaired by AP. Members worked on identifying actions that will be done at the SH level and which ones will be more local. After the summary, the following points were noted:		
16.3	At the away day some members said they were not happy with having just one product available. NK said if GPS are given a product they don't like, they will not use it. **Action**: MT/CT to meet to discuss feedback from the pilot to inform our specification.		

Item No.	Discussions and New Actions	Who	When
	AP added that PCNs should decide but that he was informed that there is only going to be one. 16.4 RG provided some feedback about the questionnaire and said there was no room for specific feedback on products. GPs should have been able to put our thoughts and suggestions. 16.5 Interpreting and Translation – the contract is coming to an end and scoring is currently being done as part of the procurement. IT will be a stand still situation, new provider will be announced soon. PCCC Part 1 held in Epsom recently - a practice submitted application to close down but, after discussions, it was agreed for application to be withdrawn. **Clinical Cabinet NOTED The Primary Care Highlight Report**		
17	**Medicines Management Update – Medicines Optimisation Group (MOG)** AP presented and highlighted: · Cannabis-based products for medicinal use (medicinal cannabis), implementation of national guidance has potential to increase costs; · Freestyle Libre – implementation of NHS England guidance will need careful monitoring to ensure prescribing spend is in line with allocated funding from NHS England; · Primary care rebate schemes for Leuprorelin estimated to save £6,900 per year; · Vitamin B compound strong tablets for malabsorption due to chronic alcohol consumption; · Serious shortage protocols will allow community pharmacist to change the prescription to a drug with a similar therapeutic effect. The protocols will be carefully defined and will rarely happen. Discussion: · Transfer of care - if medicines reconciliation is not done, community pharmacists can address discrepancies. · IT systems to be developed for DOAC. Costings to be done, LMC is included in that. · Increase in significant reporting in relation to DOAC and warfarin. GI bleed – root cause analysis · Current stock shortages – shortage of HRT and LS. JE commented that shortages are getting more pronounced. · Community pharmacies need to develop better communication with practices;		

Item No.	Discussions and New Actions	Who	When
	· LPC – has a form to advise of alternatives when there are shortages; · Meeting about medicines workforce strategy is coming up. · Antibiotics – data shows all CCGs spend within targets on antibiotics. Trusts are more variable – above national target for antibiotic prescribing. **Action** AP to send email about this to CT . · JE said GPs will have a PCN pharmacist in the practice which will be a part of the team – integration of community pharmacies will be very important. **The Clinical Cabinet ADOPTED these recommendations.**	AP	
18	**Surrey Priorities Committee (SPC) Update** LS highlighted: At the last SPC meeting which was held in May it was discussed whether thresholds for injections and back pain need to be altered. The SPC is reluctant to decide to change the thresholds. We need to have a clinical dialogue first about the impact of changing thresholds. A meeting is being planned with clinicians in the next week or so to sense check the implications. James Brian will be attending. CT added we will discuss evidence based topics (high volume/ high cost) with James Brian and colleagues.		
19	**Any Other Business - None** Meeting finished at 11.47am		
20	**Dates for Future Meetings:** Thursday, 1st August 2019, 9am-12noon		

Minutes agreed for publication by:

Date: 01/08/2019
Colin Thompson, ICP Director

Surrey Downs CCG Clinical Cabinet

Minutes

Guildford and Waverley CCG	
North West Surrey CCG	
Surrey Downs CCG	ü

Date	1st August 2019	**Time**	9.00 – 12.00
Venue	Cedar Room, Cedar Court		

Members/ Attendees

Name (initials)	Title	Attendance (ü)/ Apologies (A)
Core Members		
Dr Russell Hills	Clinical Chair	A
Dr Jill Evans	Locality Chair – East Elmbridge	ü
Dr Robin Gupta	Locality Chair - Dorking	ü
Dr Niki Kirby	Locality Chair - Epsom	ü
Dr Simon Williams	GP Urgent Care and Integration Care Lead	A
Dr Natalie Moore	GP Planned Care Lead	ü
Dr Sarah Gledhill	GP Mental Health Lead	A
Dr Andreas Pitsiaeli	GP Prescribing Clinical Director and Chair of LMC	ü
Dr Suzanne Moore	GP Paediatric and Maternity Lead	ü
Colin Thompson	Integrated Care Partnership (ICP) Director	ü
Karen McDowell	Integrated Care System (ICS) Director of Finance	ü
Sumona Chatterjee	ICS Director of Surrey Wide Services	ü
Clare Stone	ICS Director of Quality and NHS Surrey Heartlands CCGs Chief Nurse	A
Jane Lovatt *On behalf of CS*	Head of Quality - Community	ü
Dr Liz Saunders	Consultant in Public Health, Surrey County Council	ü

Name (initials)	Title	Attendance (ü)/ Apologies (A)
Matthew Tait	ICS Chief Officer	ü
In Attendance		
Sarah Watkin (SaW)	Deputy Director of Contracts – Non Acute and Primary Care	ü
Martin Munroe	Specialist Registrar (ST4) in Public Health, Surrey County Council	ü
Edwin Addis	Governance and Risk Manager (minutes)	ü

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** CT welcomed everyone to the meeting at 9.01am. Apologies: Dr Russell Hills, Dr Simon Williams, Matthew Tait, Clare Stone.		
2	**Declarations of Interest** The Clinical Cabinet received confirmation from all members and attendees that their entry in the Register of Interests was up-to-date, accurate and complete.		
3	**Quorum** As the required quorum was met, CT declared the meeting open.		
4	**Minutes from Last Meeting on 4th July 2019** The minutes from the previous meeting were agreed as an accurate record of the meeting after making minor amendments to paragraphs 10.18;14.1;14.5 and 15.5.		
5	**Matters Arising and Action log**		
	Action Log: **06/06/2019, Item 11** SM spoke with SC and will link with Charisse Monero to work out a plan on DA and IRIS training and take it to Clare Stone. Bring back an update later (close).		
6	**The Integrated Care System (ICS) Update**		
	CT highlighted: · The formal merger application will be submitted to the NHSE by end of September 2019. An engagement event for the membership about the merger was timetabled for 8th August. Lunch and learn sessions for staff will be announced soon. · As part of the proposal, we are discussing the new operating model for the merged CCG, ICP development and what will happen to the Clinical Cabinet in the new environment. An update will be discussed in September. AP asked about the timing of move to new meetings – the proposal is October for the new arrangements but this had not been confirmed yet. · The Surrey Heartlands' meeting with Simon Stevens has been re-arranged. We have an ambitious target over 5 years on		

Item No.	Discussions and New Actions	Who	When
	outpatient F2F reductions and want to dissuss options around a different model for estates. · Surrey Hearlands transformation funding - £6.2m has not been committed yet; the proposal will be going to SOAG to decide how this would be apportioned. · IHT – pre consultation business case has gone to the Clinical Senate and has been supported. The aim is to now send the pre-consultation business case to NHSE/I. Discussion: · SM asked how MPs reacted when they were briefed about IHT plans. CT explained that last time it was rejected. This time the document is better but the issue is the capital. Deprivation index scoring for Sutton is high. The regulators will take 3-4 months to decide and during this period an assessment on how much capital is available and the likelihood of us getting it will be produced. If they say yes, the hope will be to proceed to consultation. SM said Sutton might get a new hospital. CT added that a cancer diagnostic centre would be based on the Sutton site. **The Clinical Cabinet NOTED the ICS Update**		
7	**The Integrated Care Partnership (ICP) Update** CT highlighted: · Focus on FRP and a proposal around forming a committees in common, details sent to all organsations that are part of the ICP. · Work on developing services at the PCN level in planned care. · Community contracts will be linked to PCNs. Discussion: · AP said that in the next 2-3 months we will know more about how medicines management will fit in with the PCNs. (SaW joined the meeting at 9.30) · JE asked how much authority PCNs will have. CT said allocations of money will be known in the next 6 months. JE added that East Elmbridge would like to know who they need to talk to as they want to move quickly. CT said SC will come with a proposal and JE added they want to move rapidly as part of co-design. East Elmbridge would like to be quite autonomous as a PCN. Decisions about funding need to be made differently from where they are made currently.		
8	**2019/20 Month 3 Finance Report** KMc presented the report and highlighted: · It is still early in the financial year and a number of assumptions have been made which are contained within the report.		

Item No.	Discussions and New Actions	Who	When
	· She noted that this position has also been discussed at the Strategic Finance Committee and that she was still concerned that we have significant gaps in 2 of the CCGs plans which need to be closed through the ICP recovery plan processes and gaps have not been fully closed at this stage. These gaps are not reported at M3 which were discussed at the SOAG last month. · There still remains a gap within the Surrey Downs plans including the FRP actions; she also recommended the financial recovery plan updates and progress against delivery are presented alongside this report at the meetings. · The system FRP summary which includes risk, opportunities and FRP actions that went to the regional finance director is to be shared with this committee. · KMc highlighted that we are starting to experience a number of pressures at this early stage in the year, especially against the SASH contract, and noted that the report requires further narrative regarding the pressures in SASH included going forward. · KMc raised that SASH, East Surrey and First Community now attend the system finance meetings so hopefully this will help to build the relationships and close down key issues. Discussion: · Queries were raised with regards the scale of the financial problem in the East Surrey system. KMc highlighted that, although ES have a deficit plan, SASH have a surplus plan, unlike the SD system where both commissioner and provider are in deficit. · Another question was regarding ESH and further over-performance at the end of the year. It was highlighted that both Kingston and ESH are both on a block contract therefore this will not materialise. · It was noted that Daniel Elkeles is the Financial Recovery Plan (FRP) lead for the Surrey Downs ICP. **The Clinical Cabinet NOTED the 2019/20 Month 3 Finance Report**		
9	**2019/20 Month 3 Performance Report** CT presented the report. **The Clinical Cabinet NOTED the 2019/20 Month 3 Performance Report.**		
10 10.1	**Locally Commissioned Service (LCS):** **On demand availability of drugs for palliative care** SaW introduced the item and highlighted: This LCS has been developed because specialist palliative drugs cannot always be provided by a patient's usual community		

Item No.	Discussions and New Actions	Who	When
	pharmacy when required urgently. This system has been in place a number of years to allow designated pharmacies in Surrey to supply in a timely manner. The LSC has been updated with minor amendments – specifically the drugs that need to be available.		
10.2	Payment has remained the same and there continues to be 3 pharmacies that provide the service within Surrey Downs. PCOG have approved the LCS and asked for CC sign off too. AP said this is very positive from the quality of end of life care point of view. It is crucial to publicise to GPs – including weekend and 24hour providers.		
10.3	JE asked whether this information will be circulated to all primary care prescribers, including matrons, the hub, the community hospitals need to know too. **Action:** SaW to action.	SaW	
10.4	SM asked about out of hours providers and if these pharmacies deliver. It was confirmed that out of hours providers hold stock and that the pharmacies do not deliver.		
10.5	JE asked if the service also covers out of hours. It was confirmed that this service would only be available within the opening hours of the designated pharmacies.		
10.6	Discussion: JE said that we need to make it easier for GPs to prescribe palliative care drugs. We need to be able to do it electronically, via pre-populated forms. It would be good to have a template in EMIS like in Kingston.		
10.7	**CC APPROVED the Palliative Care Locally Commissioned Service.**		
11	**Urgent Care and Integration Highlight Report** **The Clinical Cabinet NOTED the Urgent Care and Integration Highlight Report**		
12	**Planned Care Programme Monthly Highlight Report** NM presented the report and highlighted:		
12.1	Dermatology – PCN pilot starting in East Elmbridge in August to trial a new way of triaging dermatology referals.		
12.2	End of August – a new joint programme board (comprising both commissioners and providers) for the Planned Care workstream will commence.		
12.3	In September task and finish groups on MSK, Gynecology, Neurology etc. (8 in total) will commence. Once dates are finalised CT will circulate.		

Item No.	Discussions and New Actions	Who	When
12.4	Discussion: SM said meetings were being planned to review pathways with different GP leads for each area. CT explained about the geography and 3 different providers. NB asked about the process and CT explained it will be clearer after the second and third workshops. The aim is to revise pathways added AP and identify eficiencies. NM said that digital solutions need to be explored and JE mentioned an example (heart failing services) and added that Epsom still do not want to do it.		
12.5	CT mentioned the prescribing workstream. During the first workshop initial ideas were discussed; AP added we can offer a lot in terms of how things are done, for example in relation to repeat prescribing. Environmental efficiencies can be made too.		
12.6	PCOG – there is a proposal from the Cancer Alliance for the prostate stratified pathway; we are optimistic about getting funding for that.		
12.7	JE asked whether biopsy was covered too. NM said that it was. AP suggested looking at expenditure relating to benign lesion cases going to secondary care. **The Clinical Cabinet NOTED the Planned Care Programme Monthly Highlight Report**		
13	**Paediatrics, Maternity and Children's Services Highlight Report** SM highlighted:		
13.1	Audit of CAMHS referrals - for the first time, SABP took over the Single Point of Access (SPA) service and decided to provide investment. It was found that admin team could improve the process if referral forms were pre-populated. SABP use complex algorythms when referrals come in to come up with solutions and decide how the child moves through the system.		
13.2	Pre-referral information - A4 sheet about CAMHS was produced with key information to enable young people to decide who to contact.		
13.3	First 1000 Days event generated a lot of interest. There is evidence that if we invest in the first 1000 days it helps the population and the economy. Everything, from how a child does at school to how much they earn as adults, and from mental health wellbeing to life expectancy, can be shaped by the first three years of a person's life and even before they are born. Alison Baum OBE, set up a charity Best Beginnings, creator of Baby Buddy app which provides really useful, evidence based information about pregnancy, feeding etc. The app is responsive to the user and tailored to how you as a user want to look after the child.		

Item No.	Discussions and New Actions	Who	When
13.4 13.5 13.6	Crisis messaging service - the uptake is really good in Epsom and Ewell. Translations for speakers of other languages are not yet available. Discussion: JE asked how do we know advice provided by baby buddy app is correct. SM explained a lot of work went into this but SM to bring back assurance before GPs can start using and recommending it. RG asked whether the NHS App group had approved it. SM said it was endorsed by NHS but not approved yet. **Action**: SM to bring back an update to a future meeting. Gypsy, Roma and Traveller (GRT) project to be rolled out in Surrey, engaging with GRT communities to register them with GPs, access antenatal care etc. **Clinical Cabinet NOTED the Children's Services Highlight Report.**	SM	
14	**Mental Health Services Highlight Report** **ITEM REDACTED- Commercial in Confidence**		
15	**The Primary Care Highlight Report** SE highlighted: Surrey Heartlands have made a financial offer to PCNs to support them (the difference in the 70% funding for practice pharmacist, giving additional monies to Clinical Directors to support them in attending meetings and funding towards administrative costs). In addition to this offer, Surrey Heartlands also has additional monies to help PCN development and are currently working this through with the PCNs. SE confirmed that the laptops will come out to all practices and she will send out a list to practices to inform them of how many each will be getting SE has a meeting with the Associate Director for Communications in Surrey Heartlands to discuss the intranet as discussed at previous Clinical Cabinets and locality meetings. LCS Review – Read codes will be sent to practices for the new LCS which are being introduced as part of the harmonisation of LCS across Surrey Heartlands. SE confirmed that phlebotomy and ABPM financial uplifts will be made as part of the Quarter 2 payments. NK said that at the last PCOG it was agreed that service specifications would be reviewed and this would be communicated to all Practice Managers. There are still ongoing discussions about a LCS for PSA and the Care Homes LCS as part of the new GP Contract. It was also acknowledged that the LCS' would be sent		

Item No.	Discussions and New Actions	Who	When
	out to Practices whilst a review process is being initiated. AP sought clarification over the Buddying service which SE said she would check Estates – all PCNs have now received an Estates pack which details information on GP estates within the PCNs such as room size etc and details any information the CCG has on new builds in the area – Heads of Primary Care have will be offering to go through the estates plan with the CDs. Resilience monies have been released to Surrey Heartlands. This is a small sum of money from NHSE to support practices who need help. A criteria will be drawn up and discussed at PCOG. SE reminded members of the two meetings coming up: 8th August for the meeting at Silvermere to discuss the merger of CCGs and Council of Members on the 12th September. **Clinical Cabinet NOTED The Primary Care Highlight Report**		
16	**Medicines Management Update – Medicines Optimisation Group (MOG)** AP presented and highlighted: · Continuous glucose monitoring approved by Surrey APC (up to £3,000 per patient per year, but some costs are off-set by use of Freestyle Libre).Cost pressure to the CCG will be more apparent in October. · June MCG - Primary care rebate schemes for Clenil Modulite estimated to save £33,000 per year. · The primary care prescribing of liothyronine (T3) is not supported. Initiation for patients with hypothyroidism should only be undertaken by consultant NHS endocrinologists. Discussion: SM asked about connectivity with the acutes and AP said they are represented and discussed at committees. Guidance on Osteoporosis is complex - Strontium has a red status with increased CVD risk. Specialists to do this for now. Zolendronate patients should have infusions up to 3 times. AP to highlight to GPs, from the cost point of view and appropriateness point of view. Some patients lost to follow up. Dementia guidance – behavioural and psychological aspects. DOAC choice/ADHD - a lot of opportunity for working more closely together. Same with catheters and other equipment. SM commented that prescribing habits need to change. AP agreed and said the pharmacists in Epsom and St Helier are spending too		

Item No.	Discussions and New Actions	Who	When
	much time on admin. 80% of their work should be face to face ideally; but in reality they spend only 40% face to face. **The Clinical Cabinet ADOPTED these recommendations.**		
17	**Surrey Priorities Committee (SPC) Update** LS highlighted: Next meeting in September to review PRP for MSK conditions. ICPs are invited to provide a shortlist of interventions where they would like a policy reviewed by public health. The shortlist will then be turned into a workplan.		
18	**Strategic Planning Update and Development of Plan** CT said three is nothing new to report except to highlight the timeline for implementiion of the Long Term Plan.		
19	**Substance Misuse Update** MM highlighted: · Public Health Surrey County Council (PH SCC) propose a contract with Surrey and Borders Partnership (SABP) Trust for the delivery of adult Integrated Substance Misuse Treatment Service under Regulation 12(7) of the Public Contract Regulations 2015; which may be entered into directly between the two or more public organisations involved. · This proposal is scheduled to be submitted to the Committee in Common (CiC) on 25th September 2019. The proposal is for PH SCC to enter into a cooperative agreement under s.11, driving the change in substance misuse treatment. It would give us a stronger focus on clinical management. · In 2018/19 there were 3,000 people in treatment, 130 more than in 2017/18 (individuals with alcohol and non-opiate addictions) . · We ensured that, from referral to start of treatment, it took on average 14 days. Single referral sigle point by email or telephone. Three centres (in Redhill, Chertsey and Guildford). · Increased collaboration with hospitals, increased engagement through ambulatory programme. Discussion: CT asked clinicians for their opinions about the service. JE said it is better now and GP agreed. SM asked if home detox is better for people. MM said vast majority is ambulatory detox. Some are taken by taxi to Guidlford or Redhill for detox. How visible is this among GPs. Needs a little bit more promotion. MM to promote via Start the Week. MM said initially there was no appetite but gradually starting receiving positive feedback about ambulatory detox. SM asked about patients that do not act on referral, people who refuse treatment. MM said there needs to be a strong desire from		

Item No.	Discussions and New Actions	Who	When
	them to engage and motivation to make that journey. Sometimes we work via Skype with people who do not want to engage. If they drop out, we try to reconnect as we don't want to lose them. AP asked about communication with GPs. MM answered that any review or change is communicated to GPs. AP asked about GP referral vs. self-referral? MM said a level of motivation is already there if they self-refer. SM asked about mental health support as there is overlap with social issues, where best to place them. MM explained 56% of service users have mental health (MH) needs. Working with Community MH services and SABP CQRM to enrich that relationship. We don't refuse anyone because of their MH status. SM asked whether any phsychotherapy training is provided for staff. MM said the IAPT service also operates out of the clinic. LS asked whether they are able to gain access to CBT. Previously there was resistance. LS – have we got evaluation built in the service. We are getting positive feedback. Any plans to evaluate this change? LS could provide some help. MM said the new ambulatory detox model has been evaluated and the report will be availalble in quarter 3. SM said it was an impressive relationship; less so with the sexual health service. **Action:** StM to communicate via Start the Week.	StM	
20	**Any Other Business - None** Meeting finished at 11.47am		
21	**Dates for Future Meetings:** Thursday, 5th September 2019, 9am-12noon		

Minutes agreed for publication by:

Date: 05/09/2019

Colin Thompson, ICP Director

Surrey Downs CCG Clinical Cabinet

Minutes

Guildford and Waverley CCG	
North West Surrey CCG	
Surrey Downs CCG	✓

Date	5th September 2019	**Time**	9.00 – 12.00
Venue	Cedar Room, NHS Surrey Downs CCG, First Floor, Cedar Court, Guildford Road, Leatherhead, Surrey, KT22 9AE		

Members/ Attendees

Name (initials)	Title	Attendance (✓) or Apologies received (A)		
		Guildford and Waverley	North West Surrey	Surrey Downs
Core Members				
Dr Russell Hills	Clinical Chair			✓
Dr Jill Evans	Locality Chair – East Elmbridge			✓
Dr Robin Gupta	Locality Chair - Dorking			✓
Dr Niki Kirby	Locality Chair - Epsom			✓
Dr Simon Williams	GP Urgent Care and Integration Care Lead			✓
Dr Natalie Moore	GP Planned Care Lead			✓
Dr Sarah Gledhill	GP Mental Health Lead			✓
Dr Andreas Pitsiaeli	GP Prescribing Clinical Director and Chair of LMC			A
Dr Suzanne Moore	GP Paediatric and Maternity Lead			✓
Colin Thompson	Integrated Care Partnership (ICP) Director			✓
Karen McDowell	Integrated Care System (ICS) Director of Finance	✓		

Name (initials)	Title	Attendance (□) or Apologies received (A)		
		Guildford and Waverley	North West Surrey	Surrey Downs
Sumona Chatterjee	ICS Director of Surrey Wide Services	A		
Jane Lovatt for Clare Stone	Head of Quality - Community ICS Director of Quality and NHS Surrey Heartlands CCGs Chief Nurse	✓ A		
Dr Liz Saunders	Consultant in Public Health, Surrey County Council	✓		
Matthew Tait	ICS Chief Officer	✓		
In Attendance				
Kevin Solomons	Associate Director of Medicines Management, SD CCG	✓		
Roshni Shah	GP Trainee (Epsom)	✓		
Edwin Addis	Governance and Risk Manager (minutes)	✓		

Item No.	Discussions and New Actions	Who	When
1	**Welcome, Introductions and Apologies** RH welcomed everyone to the meeting at 9.01am. Apologies: Dr Andreas Pitsiaeli		
2	**Declarations of Interest** The Clinical Cabinet received confirmation from all members and attendees that their entry in the Register of Interests was up-to-date, accurate and complete.		
3	**Quorum** As the required quorum was met, RH declared the meeting open at 9:05am.		
4	**Minutes from Last Meeting on 1st August 2019** The minutes from the previous meeting were agreed as an accurate record of the meeting.		
5	**Matters Arising and Action log**		
	Action Log: **01/08/2019, Item 15** CT gave an update about Digital and said further detail will be available from the ICP Board (close). **06/06/2019, Item 11** SM spoke with SC and will link with Charisse Monero to work out a plan on DA and IRIS training and take		

Item No.	Discussions and New Actions	Who	When
	it to Clare Stone. Bring back an update later (close). **01/08/2019, Item 10** Action completed (close). **01/08/2019, Item 10** Bring Back an update about baby buddy app to a future meeting, date to be confirmed (close). **01/08/2019, Item 19** StM waiting to hear back from the drug and alcohol services commissioner. Add update to a future agenda (close). **Matters Arising:** RH said that the delegated responsibility for this committee was signed off by the Governing Bodies in June to bring it into line with other two CCGs. RH also had conversations with partners about having a committees in common arrangement going forward. It will be a three-part meeting: 1) business of the ICP first, 2) clinically led section around transformation, 3) Clinical Cabinet if decision was needed about finance etc. Next steps towards establishing the ICB Board include confirming the membership and agreeing dates for meetings (2nd Thursday every month?). The first official meeting will take place in November and, once the merger happens after the vote, the structure of governing bodies would change. There is clinical majority on the ICP Board. RH thanked the three locality chairs for their contributions to the Clinical Cabinet and added that locality voice will continue to be present on the ICP Board. CT will chair the ICP Board and minutes of meetings will be presented to the Governing Bodies and the general public. CT added it will be the first time we have a Board with CEOs of the trust and other providers. A question was asked about the vote. RH said if one CCG votes against, the merger cannot take place. We organised two engagement events – analysed feedback from the first event and tested it again until we felt we had the right collaborative arrangements and structure. Threre was a discussion about the merger: • CCG mergers are part of national policy - direction of travel towards integration. • Feedback from the second engagement event – members did feel listened to but there were concerns around finance and how it would work logistically after the merger. SW added ES CCG are leaders in urgent care so the merger could deliver many benefits. • Some areas have little GP engagement, concerns exist about GPs losing influence and becoming more remote from the big organisation. RH explained localities will be represented and decision making clarified: what will be decided by ICPs and what at System level.		

Item No.	Discussions and New Actions	Who	When
6	**The Integrated Care System (ICS) Update**		
	MT highlighted: • Membership vote about the merger will take place in the next 2 weeks. • Staff consultations on how to organise functions in the merged CGG and ICS (ICP, PCNs) are taking place across the organisation (e.g. what to delegate to ICPs and what to Surrey wide). • Explicit commitment to take over ES CCG from 1st November 2019. • SOAG approved local transformation funding allocations - £1m to each geography. • A&E performance in RSFT and more pressure to deliver 26 week choice, one option is to find alternative provider to achieve the target. • EU exit – we are in a major incident mode looking at medicines (preventing stockpiling), workforce, fuel shortages, transport delays, on call rotas. • Winter escalation issue, how we manage incidents. **The Clinical Cabinet NOTED the ICS Update**		
7	**The Integrated Care Partnership (ICP) Update** CT highlighted: • Financial pressure at Sutton and Epsom hospitals, a lot of it linked with pace of change. CT sent email to NHSE describing the issues. • Big drive on planned care, SD CCG is the outlier by £15m because of private providers, dermatology etc. • The strategy going forward is focused on PCNs. The second pilot is about to start and we are looking for GPs interested in leading on dermatology. If this model is successful, we will be dealing with more patients at PCN level. Discussion: • As part of our work on FRP, we are working with clinicians on how waste could be reduced and quality improved. We need to replicate lessons learnt during the 6 weeks' pilot (task and finish group) in East Elmbridge. • GP education about cardiology needed – the national recommendation is to have the same model that East Elmbridge will have (local commissioning service, Level 3, with GP champions). RH added that clinical leadership at SD is good. Each place has a different set of skills and our referral rates are going down. • Financial situation in ES CCG is challenging and we are currently discussing how best to work with partners taking into account all 6 pillars of population health management. **The Clinical Cabinet NOTED the The Integrated Care Partnership (ICP) Update**		

Item No.	Discussions and New Actions	Who	When
8	**2019/20 Month 4 SH ICS Finance Report** KMc presented the report and highlighted: • Section 6 shows the YTD and forecast outturn of all system partners. Although reported on plan, a number of organisations are reporting pressures within the financial position. • Surrey Downs are reporting a number of financial pressures within acute, slippage on QIPP and private providers. All risks are reported in the finance report including mitigations. • SASH, First Community and East Surrey will be presented in the month 5 report, also the report will include ICP risk, mitigations and FRP actions. • A deep dive review will take place with the financial positions and discussion will be required with NHSE/I with regards to any potential movement in plans. Discussion: • CT added that A&E activity has increased and SM suggested that a breakdown would be helpful as visibility is needed. RH explained local positions are reported via ICPs. • SM raised about coding, the best way to improve is by encouraging conversation between GPs and secondary care clinicians (reducing follow ups). **The Clinical Cabinet NOTED the 2019/20 Month 4 Finance Report**		
9	**2019/20 Month 4 Performance Report** CT said this report provides the Clinical Cabinet with an update on June's performance position of the Surrey Downs CCG, including risks and actions to address, and highlighted: • RTT (incomplete): both CCG and Trust level performance remained stable in June 2019 at around 88.0% but below the planned trajectory (-0.3%). The total wait list size is above year end target (+5.6%) and tracking above planned levels. • A&E 4hr performance was missed for two of the three local providers in June 2019 (EpSH 88.4%, KHFT 90.5%, SASH 96.4%). • Mental health performance is good with on-going compliance since April 2019. The Alzheimer Dementia Navigation Service is in place and new services are being developed with Dementia Connect**.** • Issues around RTT - we are working with colleagues on a new specification for enhanced care in care homes. We are moving from organisational care towards integrated care. There was discussion about complexities linked with providing holistic, individualised care. Hotspots have been identified and PCN footprints created to bring about integration. We are going through quantum change to create population-based as opposed to organisation-based care. **The Clinical Cabinet NOTED the 2019/20 Month 4 Performance Report.**		

Item No.	Discussions and New Actions	Who	When
	SW left at 10.20am to attend another meeting.		
10	**Urgent Care and Integration Highlight Report** RH introduced the item and said this monthly highlight report from the Urgent and Integrated Care Team summarises the key actions that have and will take place and asked if there were any questions. Discussion: There was a discussion about social prescribing. All PCNs are actively pursuing plans to set up social prescribing services. East Elmbridge, with Elmbridge BC, are piloting siting existing link worker in Littleton Surgery to inform how the service evolves and to drive awareness of service by GPs. Vaccinations - last year there were issues with availability of vaccinations and take up among housebound patients. This year we need to work on improving take up (for example, community nurses could get involved) and communications about flu jabs. NK mentioned "This is Me" passport at Ashford and St Peter's Hospital which is completed jointly with patient's families to help staff understand more about the patient's support needs and identify ways of providing more personalised care. We need to replicate this approach across the system. Catheters - identified as a QIPP project for 19/20. This project is currently waiting for the UIC programme to confirm who the ICP lead is. There was a discussion about how to upskill staff about catheters as there is an opportunity to consolidate this work by working with PCNs. **CC NOTED the Urgent Care and Integration Highlight Report**		
11	**Planned Care Programme Monthly Highlight Report** NM presented the report and highlighted: • Dermatology pilots – we had a good meeting with the trust. We are now monitoring both pilots (East Elmbridge and ICP PCN) to review impact on referrals to secondary care. • FRP Planned Care Team Launch meeting was held recently to start the process of bringing planned care teams together across the ICP. Discussion: There was a question about pathway redesign and the remit of people who attended the workshops. CT explained the workshops were organised to discuss the pathways with clinical colleagues and identify opportunities for reducing waste and improving quality. It's an opportunity for debate and finding a way forward; there are three task and finish groups for each area. RG mentioned that there are some interested GPs who cannot attend due to work commitments. CT said sessions would be reviewed – any surplus will be made available to generate more sessions. SM asked who received comms for these sessions and CT explained that an		

Item No.	Discussions and New Actions	Who	When
	email about the sessions was sent on 18th August to PCN, Governing Bodies and Federation leads. RH asked about FiT testing. NM explained that the delay in FiT is with the contracting team. The issue of how this fits with the GI pathway will be discussed at the planned workshops. CT explained about cancer transformation money (£100k). The previous FOB testing has been discontinued and replaced by FiT. **Action:** Provide an update about FiT contract (completed). JE mentioned that the patients who have missed out on the bowel screening can ring the service directly. FiT screening is not set at the same threshold for diagnostic FiT (low risk but not no risk). Training will be organised in localities to explain the difference. **The Clinical Cabinet NOTED the Planned Care Programme Monthly Highlight Report**	CT	
12	**Paediatrics, Maternity and Children's Services Highlight Report** SM highlighted: • All Surrey CCGs have achieved the 2018-19 32% access target mandated by NHS England.The target for the current year is 34% but the submission will be a monthly submission into the MHSDS portal unlike a one off submission in previous years. • An Expert, Multi-sector Leadership Framework for Children, Learning Disability and Mental Health Services was proposed to enable a richer and more diverse input. The framework described a triumvirate of representative clinical and professional groups made up from Nurses, AHPs, Doctors, Healthcare Scientists, Midwives, Pharmacists, Psychologists and Social workers. • Procurement process for a new CAMHS provider procurement has started. Discussion: There was a discussion about reservations and difficulties to understand the framework. We already had that connectivity (MH exec) and it is important for this new forum not to lose that locality going forward. SM commented there needs to be support through commissioning management for this linkage to happen. More fluidity is needed to feel a sense of value from the clinical perspective (pieces of pathway development). MT added that the key issue would be clarifying the link between at Scale and at Place. We will have a debate about what moves from Scale to Place. What is best to be done where will be clarified in the next two years. SM said we need to improve comms. Better connectivity is needed (e.g. patient lists not up to date). System wide comms needs to address this. RH agreed and said a more joined up approach was needed. **Clinical Cabinet NOTED the Children's Services Highlight Report.**		

Item No.	Discussions and New Actions	Who	When
13	**Mental Health Services Highlight Report** SG highlighted: • The South East Clinical Network completed an independent Quality and Workforce review of Adult Psychological Therapies in August 2019. The review recommendations will be implemented via transformation work with providers and stakeholders due to commence in October 2019. The review will be shared with cabinet members. • The contract has been extended to 2021. Procurement work will start early next year. The transformation of IAPT will be in line with new PCN models. (RH noted RG's CoI) Discussion: There was a discussion about preparations for procurement (market warming, staffing, etc). SG explained discussions will be held with potential providers about procurement and issues, for instance, where the ratio of low-intensity to high-intensity staff is not good. SM asked about how provision will be shaped in the new system. SG explained it would be in line with the new PCN ways of working. MT asked about outcomes for patients and SM added that often patients experience a boost by therapy but then go back to the real world. SG said maintaining improvement can be difficult and CT suggested that this can be monitored by producing a patients' list, then running a report 12 months later to see whether they came back. RH mentioned that the new ICS steering group for Equality, Diversity and Inclusion (EDI) could look at deprivation and harder to reach groups. SG will be going to Making Every Adult Matter (MEAM) event and EDI impact assessments workshop aimed at improving the way they are completed. SG said that a more cohesive, simpler explanation is needed about how to access IAPT services that are delivered by 6 different providers (explaining where they are based, who to contact, etc). NK added that each provider has different areas of expertise and suggested a triage type service. RG said it's a nationally prescribed procurement process so Surrey Downs could not change it. Holding off the procurement while PCNs develop could be an option as we need to look for procuring differently in the future. JE said they have a mental health (MH) practitioner in the hub and he already deals with housebound patients. SG said we need to keep feeding back and getting advice on how to promote discussion and RH added that, with the PCN board, discussion will be easier. **The Mental Health Services Highlight Report was NOTED**		

Item No.	Discussions and New Actions	Who	When
14	**The Primary Care Highlight Report** SE highlighted: • Primary Care (PC) Transformation Board has agreed the development money to support PCNs (£624k). Clinical Directors will decide how to use the money (masterclasses in leadership,etc. being considered). CT asked if the funding has come through and RG confirmed - maturity index was used so it is personalised. The funding is recurrent but we do not know about amounts for the next 4 years yet. **Action:** SE to double check whether PCN money for care navigation had been sent (completed). • Population health management (PHM) Wave 2 – Primary Care Transition Board is looking at how to develop PHM. The deadline for completing expressions of interest is 13th September. Support from the national team will be provided to practices interested in this pilot. RG raised that this could lead to PCNs developing at different rates and JE called for transparency. CT agreed and confirmed that objective criteria will be used. • National team are undertaking a review of improved access; Surrey Heartlands have put themselves forward as a site to visit. The National Team will be meeting with the Federations, GP Practices and the SHs team. Part of the discussions would be over digital access. • Intranet – the CSU will be meeting with the CCG the day after the Clinical Cabinet meeting to discuss the issues arising from the distribution of the laptops. • QMasters – procurement has been delayed. KMC to discuss with Niki Baier. **Action:** KMC (completed). • Criteria for allocation of Resilience money will be coming out shortly. • Contract meeting with SD Alliance was held recently to discuss issues with diabetes nurses. Update will be provided in the next report. • New GMS contract at Molebridge practice has been agreed. **Clinical Cabinet NOTED The Primary Care Highlight Report**	SE KMC	
15	**Medicines Management Update – Medicines Optimisation Group (MOG)** KS presented the Surrey & North West Sussex Area Prescribing Committee & Medicines Commissioning Group recommendations for July 2019. The following recommendations were highlighted: • Cox-II inhibitors have been reviewed and may now be prescribed in certain circumstances. • Duavive (HRT product) has been discontinued. This prompted discussion around ongoing short supply of HRT products. JE asked why and RG said some providers were having difficulties obtaining raw materials. • Lithium Blue information sheet – it was noted that ECG should be arranged by initiating clinician and RG said it was up to the GP to decide whether to issue a warning to the patient for non-attendance, most GPs will write to the patient.		

Item No.	Discussions and New Actions	Who	When
	• The Surrey wound management formulary has been updated. SD CCG will organise training for staff. Discussion: • Transfer of Care Around Medicines (TCAM) - information provided on progress on this across Surrey Heartlands, likely to be rolled out in Surrey Downs in Q4. SM said there is sometimes confusion between community pharmacists and GPs about medicines reconciliation and that any discrepancies need to be discussed with the GP. • Further evaluation is being carried out – JE said GPs do need to be involved. There will be more pharmacist resource in PCNs. GP added that two practices in Dorking do medicine reconciliation with the patient. The issue is that some discharge information is incorrect and individual practices manage that communication in different ways. **Action:** disseminate updated guidance on inhalers, emollients and stock shortages tracker via Start the Week (completed). **The Clinical Cabinet ADOPTED the Area Prescribing Committee, and Surrey Medicines Commissioning Group recommendations from July 2019.**	KS	
16	**Surrey Priorities Committee (SPC) Update** LS highlighted: • Next meeting of SPC will take place at the end of September to review Platelet Rich Plasma (PRP) for MSK conditions. • Two evidence reviews – plasma injections and gynaecomastia. • Workplan for the forthcoming year - all CCGs have been contacted for suggestions for interventions. Three suggestions have been received so far: umbilical hernia, female genital prolapse and inguinal hernia. • NHSE - the consultation process is starting about the next wave of evidence based interventions (restrictions on commissioning). Discussion: RH said David Clayton Smith will let us know about where SPC work will sit in the ICS. MT said it would probably be a part of the re-branded academy and LS added that we asked for an interim position so that work can continue without a gap. MT said this will be part of Surrey wide discussions. SM raised an issue about procedures for referral support services within Surrey. Very few new policy recommendations don't get supported by all of the Governing Bodies (a notable exception to this is the Assisted Conception differences). **The Clinical Cabinet NOTED the Surrey Priorities Committee (SPC) Update**		

Item No.	Discussions and New Actions	Who	When
17	**Any Other Business - None** RH thanked everyone for the last few years as this was the last CC meeting, the new SD ICP Board will officially meet in November for the first time. Meeting closed at 12.12		
18	**Dates for Future Meetings:** Thursday, 3rd October 2019, 9am-12noon **CANCELLED**		

Minutes agreed for publication by:

Dr Russell Hills, Chair

Date: 14/11/2019