AGENDA ITEM 11b.

NHS Southend Clinical Commissioning Group

CLINICAL EXECUTIVE COMMITTEE

Thursday 8th September 2016 at 1400h – 1600h
Priory Suite, 1st Floor, Harcourt House, Southend

MINUTES

Attendees (in alphabetical order):

Dr Andrea Atherton	Director of Public Health, Southend Borough Council
Dr Kate Barusya	GP Governing Body Member and Clinical Lead for Children and Maternity
Dr Krishna Chaturvedi	Clinical Executive Committee Chair and GP Governing Body Member
Melanie Craig	Chief Officer
Dr Sharon Hadley	Clinical Lead for Unplanned Care
Dr Fahim Khan	GP Governing Body Member and Joint Clinical Lead for Planned Care
Jacqui Lansley	Joint Associate Director of Integrated Care and Commissioning
Dr Jose Garcia Lobera	Southend CCG Chair
Dr Kelvin Ng	GP Governing Body Member and Clinical Lead for Prescribing
Sadie Parker	Associate Director for Primary Care and Engagement
Matt Rangue	Chief Nurse
Dr Taz Syed	GP Governing Body Member and Clinical Lead for Quality and CHC
Simon Williams	Associate Director for Medicines Management

In Attendance (in alphabetical order):

Alice Kelly	Personal Assistant and Minute Taker
Jayne Mason	Senior Commissioning Manager

1. Welcome and apologies for absence

1.1 KC welcomed the group and apologies were received for Margaret Hathaway, Interim Chief Finance Officer; Dr Brian Houston, GP Governing Body Member and Joint Clinical Lead for Planned Care and Robert Shaw, Joint Director of Acute Commissioning and Contracting.

2. Minutes and action log of the meeting held on the 11th August 2016

For approval

2.1 The minutes were reviewed and they were approved as an accurate record of the meeting.

2.2 Action log:

07 – Commissioning mailbox – The mailbox now has an automated response to all emails received. Further work will be undertaken by RS and SP to improve the process and re-launch its practices. This action has been completed and is now closed.

2.3 KC highlighted on the topics which were discussed in the Clinical Forum Group, these topics will be picked up under the agenda.

3. Declarations of interest

To record any members' declarations of interest in relation to agenda items.

3.1 All GP clinical leads declared an interest against item 5, £5 per head scheme due to their potential to receive income from such a scheme as providers.

4. Service Restrictions

For approval

4.1 JM attended the meeting on behalf of Robert Shaw, Joint Director of Acute Commissioning and Contracting. A paper was circulated to the group on service restrictions and JM thanked the public health team for their support. JM highlighted the five tables provided in the paper and members agreed they would review and agree the proposals in each of the five tables in turn.

4.2 Table 1 provided the descriptions of the procedures which are proposed to be on a stricter threshold going forward. Members discussed the procedures and agreed the amendments.

RESOLVED: THE CLINICAL EXECUTIVE COMMITTEE AGREED THE PROPOSED AMENDMENTS ON TABLE 1.

4.3 Table 2 listed procedures which are proposed to require prior approval from the CCG before the procedure takes place.

AA highlighted the breast procedures which are usually provided to cancer patients therefore this prior approval would need to receive additional funding for reconstruction. MR suggested having a slightly different approval process for cancer patients rather than a panel for reconstruction.

KN stated that within a breast procedure, up to two treatments can be carried out and it is not common that a third treatment is required.

JGL questioned how many of the facet joint or hip and knee injections could be done in primary care. Dependent on the figures primary care could absorb these patients which could potentially reduce the cost. AA highlighted joint injections, which are provided by the pain clinic and questioned if these are being funding twice. KN questioned where patients will need to be referred to once they no longer respond to pain medicine.

KN questioned the timescale for approval of the procedures; JM confirmed that the approval process would be rapid. MC added that these procedures have already been suggested to move to prior approval by GPs in mid Essex.

Members agreed the proposed amendments.

RESOLVED: THE CLINICAL EXECUTIVE COMMITTEE AGREED THE PROPOSED AMENDMENTS ON TABLE 2.

4.4 Table 3 proposed procedures to no longer fund.

JGL questioned the figure for vasectomies; JM confirmed that there have only been four procedures at Southend University Hospital NHS Trust (SUHFT) for 2015/16 as a lot of these procedures are carried out within primary care.

KC advised that the clinical leads discussed this topic at Clinical Forum Group and the majority agreed that female and male sterilisation should be funded as it is low cost in comparison to the bigger picture. KB added that she could support the female sterilisation being on the non-funded list as contraceptive is a cheaper alternative. JGL questioned the exceptional decision of

the sterilisation as reported in the table.

SP informed the clinical leads that vasectomies were provided in primary care by Valkyrie surgery with a procedure cost of £200 per person (including counselling) and the total spend for 2015/16 was slightly over £18,000.

KB highlighted that there could potentially be some negative coverage in the media regarding IVF no longer being funded by the NHS and questioned how this information would be provided to the public. It was confirmed full communications plans would support all proposals.

Members agreed the proposed amendments.

4.5 **RESOLVED: THE CLINICAL EXECUTIVE COMMITTEE AGREED THE PROPOSED AMENDMENTS ON TABLE 3.**

JM advised that table 4 and 5 are for further consideration which will be brought back to the Clinical Executive Committee in due course. Formal consultation plans would now be developed by the CCG communication team to consult on these proposed amendments.

5. Locality update and supporting primary care

For discussion

5.1 JL provided an update on the project to develop a locality approach to care coordination for patients with complex care needs. JL highlighted the four workshops which took place on 2nd and 3rd August 2016 which received high attendance and proactive engagement. JL confirmed that work is ongoing to design the localities.

5.2 Patient data on a cohort of patients is being ratified and reviewed to ensure the risk stratification criteria are appropriate and they are the right patients to be managed through the complex care service. An agreement between South Essex Partnership Trust (SEPT) and Southend Borough Council (SBC) has been signed and is now in place and plans are being discussed on how to implement the service.

5.3 JL advised that recruitment for care coordinators and navigators for SEPT and SBC is underway. The team leader positions are also out for advert with SEPT, and the CCG is recruiting for technical pharmacist support. Finally, the clinical lead roles are currently in development to be put out for advert as soon as possible.

5.4 There will be a two week advertising campaign for the jobs followed by shortlisting and then interviews will be organised for the roles. There is concern that it will not be possible for new recruits to take up their roles by 1st October 2016, especially for SUHFT staff as the majority are required to complete a three month notice period. The social workers are largely ready and in place and will be based in their localities between one/two days a week in identified practices.

5.5 JL highlighted the significant time resource for the CCG and SBC to prepare for the localities, however there has been significant progress in the last few months.

5.6 JL shared that Boston Consultancy Group has been developing deep dives into three separate CCG localities to support development of the pre-consultation business case and it has been confirmed they have chosen Southend as one of the localities. The submission date is 23rd September 2016 and a plan is in place to submit.

6. £5 per head scheme

For approval

6.1 SP circulated a presentation on the £5 per head scheme which was discussed in the last Clinical Executive Committee (CEC) meeting on Thursday 11th August 2016. The finance team have reviewed the current level of emergency admissions for over 75s and advised the CCG that the payment scheme used for the incentive scheme in 2015/16 remains valid.

6.2 The recommendation is for the same incentive model to be offered to practices for the period of April 2016 through to March 2017. In order to participate in the scheme it is proposed practices will need to provide details on how they plan to deliver the scheme and commit to sharing lessons learned. This is particularly important given that in the 2015/16 scheme, the scheme was self-funding – as emergency admissions reduced, so funding was freed up to invest in the scheme. In 2016/17 the CCG has negotiated a block contract, as such no

6.3 funding would be freed up from the scheme and this would be a cost pressure to the CCG.

6.4 SP shared the incentive payment model with the group. If this is approved by CEC members, the next steps would be to finalise the scheme activity and budget with finance, followed by engagement with South Essex Local Medical Committee (LMC). The financial case would then need to be approved by the Quality, Performance and Finance committee or Governing Body. Once this process has been completed, the scheme would be circulated to practices to sign up.

6.5 MR flagged that any scheme which prevents patients being admitted into hospital is beneficial. JGL highlighted that CEC members had today approved the service restriction proposals as part of the CCG's QIPP programme, however this scheme is then investing in primary care to avoid admissions as part of a block contract arrangement which will create a cost pressure for the CCG. He noted it was a difficult decision to justify. TS highlighted the need to invest in local GP practices and his concern that not investing in this scheme would

6.6 be a lost opportunity.

GP clinical leads discussed the potential for sharing best practice and conversely when initiatives didn't have an impact as part of the scheme. KC reminded the GP clinical leads that it is not mandatory for practices to sign up to this scheme. KC questioned if there was an alternative for investing the funding within primary care.

6.7

JGL stated that the scheme needs to be justified as a whole not just clinically and how else this scheme has contributed (for example quality and outcomes) other than the decrease in admissions. If this scheme has not made a major impact then it should not go ahead for 2016/17.

KN noted that the original intention of the scheme was 'invest to save' to reduce avoidable emergency admissions to acute care, with the savings made as a result being invested into funding the scheme. This would make the scheme cost neutral. If there is no saving from implementing the scheme, it is not cost neutral and therefore should not be implemented.

KB questioned whether it was possible to delay the scheme this year until further detailed justification has been provided to prove there is enough impact and other contributing factors. For example, if emergency admissions increase as a result of ceasing the scheme, there may be a case for commissioning it in 2017/18.

RESOLVED: THE CLINICAL EXECUTIVE COMMITTEE AGREED NOT TO PROCEED WITH THE £5 PER HEAD SCHEME.

7. Commissioning intentions internal process

For discussion

7.1 It was agreed to remove this item from the Clinical Executive Committee agenda therefore no discussions were held.

8. Success Regime – case for change

For discussion

8.1 MC provided an update on the Success Regime. MC advised that the central team have organised a workshop on Tuesday 20th September 2016 at 6.00pm which will be held at Saxon Hall. JGL and MC met with the organiser this morning and it was confirmed the public across Southend will be invited. The workshop will have a private audience from 8.00pm for the practices of Southend to discuss any of the information which was shared regarding the Success Regime.

8.2 MC advised that the Annual General Meeting (AGM) is being held on Wednesday 28th September 2016 at 7.00pm, at Harcourt House. MC encouraged the GP clinical leads to attend the meeting.

8.3 KN questioned if locums would be invited to the events as they would benefit from being informed of the updates. SH advised that there is a locum group who meet once a month at the Wellesley hospital where they are provided with regular updates.

9. Any other business

9.1 KC highlighted the MSK referral update which was sent via email from the communications department. The GP clinical leads felt that this email was not communicated well, RS and SP noted the comments and JM advised feedback will be provided in the next meeting. Future emails will be sent from the communications address.

Action: RS to advise the GP clinical leads of the MSK e-referral process.

Date of Next Meeting: Thursday 13th October 2016, 14.00 until 16.00, Priory Suite, Harcourt House, Southend

NHS
Southend
Clinical Commissioning Group

CLINICAL EXECUTIVE COMMITTEE

Thursday 13th October 2016 at 14.00 until 16.00hrs
Priory Suite, Harcourt House, 5-15 Harcourt Avenue, Southend on Sea, Essex SS2 6HT

MINUTES

Attendees:

Dr Andrea Atherton	Director of Public Health	Southend Borough Council
Dr Kate Barusya	GP Governing Body Member and Clinical Lead for Children and Maternity	NHS Southend CCG
Dr Krishna Chaturvedi	Clinical Executive Committee Chair and GP Governing Body Member	NHS Southend CCG
Melanie Craig	Chief Officer	NHS Southend CCG
Dr Brian Houston	GP Governing Body Member and Clinical Lead for Planned Care	NHS Southend CCG
Dr Fahim Khan	GP Governing Body Member and Joint Clinical Lead for Planned Care	NHS Southend CCG
Jacqui Lansley	Joint Associate Director of Integrated Care and Commissioning	NHS Southend CCG / Southend Borough Council
Dr Jose Garcia Lobera	Southend CCG Chair	NHS Southend CCG
Dr Kelvin Ng	GP Governing Body Member and Clinical Lead for Prescribing	NHS Southend CCG
Sadie Parker	Associate Director for Primary Care and Engagement	NHS Southend CCG
Matt Rangue	Chief Nurse	NHS Southend CCG
Dr Alex Shaw	Clinical Lead for Diabetes	NHS Southend CCG
Robert Shaw	Joint Director of Acute Commissioning and Contracting	NHS Southend / NHS Castl Point and Rochford CCG
Dr Taz Syed	Clinical Lead for Quality and CHC	NHS Southend CCG

In Attendance:

Samantha Shepherd	Executive Assistant | Minute Taker	NHS Southend CCG

General Business

1. Welcome, apologies for absences and declarations of interest

1.1. KC welcomed all members to the Clinical Executive Committee.

1.2. Apologies were received from Margaret Hathaway, Interim Chief Finance Officer; Sharon Hadley, Clinical Lead for Unplanned Care; and Simon Williams, Head of Medicines Management.

2. Declarations of interest

2.1. No declarations of interest were received.

3. Minutes and action log of meeting held on 8th September 2016

3.1. The minutes of the meeting held on 8th September 2016 were reviewed for accuracy. BH advised that he was not at the meeting but would like to discuss the £5.00 per head scheme section as it does not seem to clarify what was discussed in the meeting (following conversations with other Clinical Leads) and what the actual decision was.

3.2. KC apologised and advised that it was not reflected in the minutes, and should have been written to capture the discussion.

3.3. KC confirmed that the £5.00 per head scheme was a majority decision and resulted in the recommendation being approved.

3.4. TS expressed his disagreement and that the minutes were not properly minuted in relation to the correct decision. TS confirmed that it was the Senior Management Team who was in agreement of the decision.

3.5. It was advised that the minutes would be rewritten to reflect the correct information and discussion made.

ACTION: SP to rewrite the Clinical Executive Committee minutes on 13th October 2016 to reflect the correct discussion of the £5.00 per head scheme.

UNRESOLVED: The minutes on 8th September 2016 were NOT APPROVED as an accurate record of the meeting. SP is to rewrite the minutes to reflect the correct discussion.

3.6. With regards to the outstanding actions from the log dated 8th September 2016, the following was confirmed:

Action 08 – RS advised that an e-referral process started on the 1st September 2016. Two practices in Southend are not using e-referral yet as they are changing clinical systems. The e-referral data shows that five practices have not yet made a referral to MSK.

80% of practices are using referral forms and appointments are going in. 20% is still struggling with the process. RS confirmed that 1:1 training support is offered to all practices.

RS noted that some practices are not using choose and book properly. KN expressed that Paul Ilett, Head of Communications, sent out the process to follow but it is wrong. KN noted that if process guidance cannot be right, do not send out until correct.

KN noted that the process itself is too long and is achieving the same result but takes twice as long.

RS confirmed that he needs to address the practices that do not use choose and book fundamentally. RS confirmed he will pick up the process guidance with Paul Ilett and correct it as soon as possible.

KN requested the process is made easier. RS advised that it is compulsory to use referrals electronically. The form can be changed to make it more streamlined for practices.

RESOLVED: The Clinical Executive NOTED the action log as recorded on 8th September 2016

4. Success regime update and process for further discussion

4.1. MC advised the Clinical Executive Committee on the Success Regime touch points that the CCG need to be involved with, as well as the process between now and January 2017.

4.2. With regards to the Pre Consultation Business Case (PCBC), MC advised that the draft documentation will be circulated this week. It is still a very private document and will be worked upon between now and mid December 2016. It is a requirement that the PCBC is looked at together and to discuss what points the CCG want to influence and determine how to correctly achieve the outcome required.

4.3. MC would like to discover what the CCG wants to change and why and what work will follow the change.

4.4. MC explained that the purpose of the PCBC is for the National Investment Committee to agree to release the required money for the CCG.

4.5. MC confirmed that two meetings have been scheduled for 20th and 27th October 2016, which will focus on Success Regime and Sustainability and Transformation Plan preparation. Ben Horner from Boston Consultancy Group has been invited. MC advised the Clinical Leads they are welcome to invite one of the hospital consultants to the meeting so they can understand the business case in full detail, if required as an organisation.

4.6. MC expressed that there is a lot of concern at present. MC advised that the PCBC is not a document that the CCG had influence in writing or understanding the rationale behind it.

4.7. MC advised there are currently five options included in the document which need to be scaled to either two or three options. Two of the options are highly unlikely; however the CCG need to be clear on what is to be acquired.

4.8. MC confirmed that there will be a number of option appraisal events in the coming weeks. Caroline Rassell and Andy Vowles will be obtaining the dates, and advising the CCG clinicians as necessary.

4.9. MC noted at present there are three commissioning teams (Basildon, Mid and Southend) who discuss and make decisions to/for individual hospitals. A group arrangement will be made going forward and the CCG need to try and work through how best to provide the new model. A proposal will be put forward to the NHS Southend CCG Governing Body who will decide upon the move to one joint commissioning team for Mid and South Essex on 3rd November 2016.

4.10. MC advised that assuming the above happens, there will be one Accountable Officer out of the five CCGs who will be responsible for the team. The Governing Body will be asked via a HR process of the Accountable Officer. Caroline Rassell is the only Accountable Officer applying for the role.

4.11. KB noted that primary care is required to change and she looks positively towards working with the community.

4.12. MR advised that during the period of significant change, the CCG must maintain an assurance that the hospital stays safe.

4.13. TS advised that with regards to the CCG being a membership organisation, when will our membership in Southend be able to have a say? MC confirmed that the there are many opportunities for the Southend membership to be involved such as the CCG's Annual General Meeting, Governing Body in Public and Time to Learn. MC would like to reach out the membership involved as much as possible.

4.14. KC asked what will happen to the constitution. MC confirmed that it is something that will need to be discussed.

4.15. RS advised as being the Director of the Southend CCG Acute Commissioning team, the proposal will affect his staff, however with his objective hat on; one team is the most effective thing to do.

4.16. AS noted that as a clinician, he has an invested interest and therefore needs to make sure the population are not lost within the decisions being made. He does not want the decisions to be made without the clinical leads expressions.

4.17. MC advised that the CCG are in meetings more often and require a clear and compelling case for the change.

RESOLVED: The Clinical Executive NOTED the Success Regime update.

5. Learning Disabilities health checks

5.1. HJ presented the Learning Disabilities (LD) health checks and reminded the Clinical Executive Committee of the need for the CCG to increase the number of annual health checks for people with a LD.

5.2. HJ advised that people with LD have poorer health than their non-disabled peers.

5.3. The Department of Health commissioned the specialist Public Health Observatory for LD to undertake a systematic review of the impact of health checks for people with LD. The review concluded that an introduction of health checks for people with LD typically leads to the detection of unmet, unrecognised and potentially treatable health conditions (including serious and life threatening conditions such as cancer, heart disease and dementia).

5.4. HJ confirmed that health checks provide a way to detect, treat and prevent new health conditions within Southend's population. Health checks can help provide baseline information against which changes in health status can be monitored. A particular issue given the frequency of changes in paid carers supporting people with learning disabilities and the difficulties that people with learning disabilities may have in detecting and reporting longer term changers in health status.

5.5. HJ noted that health checks may be cost effective as the detection of new or underlying medical conditions, which may reduce the consumption of resources in other areas of healthcare, such as services for challenging behaviour and mental health problems, which ultimately reduces the need for future and potentially more expensive treatment.

5.6. HJ advised that discussions have identified a number of options, with particular focus on identifying practices not participating in the DES and identifying any obstacles to this; identifying alternative arrangements for patients not covered by the DES; and ensuring that people with a learning disability, families and careers are aware of the importance of annual health checks.

5.7. HJ expressed that the CCG is currently working on a funding bid, as part of its pioneer work, and therefore looking to commission an LD Ambassador Programme, with clinical support.

5.8. HJ confirmed that the three phases of the programme are as follows:

Phase one

5.8.1. Recruitment of LD Register Coordinator to work with social care teams and primary care to validate GP practices LD registers. Once the register has been validated GPs will be empowered to effectively manage their own register. Registers will reduce in size and patients will be redirected to appropriate services.

5.8.2. Recruitment of four Care Ambassadors to work with GPs, providers and the learning disability community (along with family and carers) to increase uptake of LD Health Checks. Additional resource will be invested into Southend's Learning Disabled Parliament to provide Ambassadors, while Southend's Carer's Consortia will also be able to fulfil some of this function at no additional cost;

5.8.3. Update SystemOne to improve functionality to support Doctors to conduct the health checks. North East London Commissioning Support Unit is able to provide developments at no extra cost;

5.8.4. Develop digital technology which is compatible with SystmOne to ensure health action plans are produced, shared and managed in an accessible, is an easy read format.

5.8.5. Provide clinical leadership to support system by carrying out LD health checks within the community.

5.8.6. Referral of complex cases into Southend's Locality Complex Care Service or community facilitation nurse.

Phase 2

5.8.7. *To develop a system wide, Southend based, kite mark to raise awareness of reasonable adjustments throughout the borough.*

Phase 3

5.8.8. To launch an additional platform to the health app, which transfers all organisations with the Southend Community' kite mark on to the system. Local organisations will appear on the map and it will be possible to filter the list according to health action plan priorities – e.g. exercise, employment, restaurants, and entertainment etc.

5.8.9. The app will also offer travel advice, key contacts and cost information.

5.9. FK asked what the provision is for training general practices. MC advised that the CCG have exhausted the resources of training and general practices have had a long time to implement the system. It is now about the patients and the time has come to put them first to access good health care.

5.10. On conclusion, HJ advised that evidence shows the substantial benefits to providing annual health checks for people with a learning disability. NHS England requires the CCG to improve its performance in this area. Detailed information on variations in performance between practices will soon be available and the CCG need to develop plans for increasing the number of people receiving health checks.

5.11. It is recommended that the CCG should seek to achieve in the region of 85% delivery for 2016/17 by sharing information with practices, publicising annual health checks to local people and consider commissioning alternative provisions.

5.12. HJ invited the Clinical Executive Committee to approve the above recommendations.

RESOLVED: The Clinical Executive committee APPROVED the Learning Disabilities health checks.

6. General Practice Forward View and planning guidance for 2017-19

6.1. MH presented the General Practice Forward View (GPFV) and planning guidance for 2017/19.

6.2. MH confirmed that the GPFV was published in April 2016, whereby five initiatives were produced over five areas. These included investment, workforce, workload, practice infrastructure and care redesign.

6.3. The planning guidance was then published in September 2016 with a very clear requirement for primary care, which linked into the GPFV. MH advised that CCGs are required to submit a GPFV plan to NHS England on 23rd December 2016, which sets out how access to primary care will be improved; how funds for transformational support will be created and deployed to support general practice, how ring-fenced funding will be devolved to the CCG's to support training of care navigators and stimulate the use of online consultations, will be deployed.

6.4. MH advised on the planning requirements for the CCG, whereby the organisation should plan to spend a total of £3.00 per head as a one-off recurrent investment for practice transformational support.

6.5. MH noted that no additional funding is being provided to the CCGs and they should be accountable for any additional spend (yet to be confirmed) to implement online consultation software systems in general practices.

6.6. MH confirmed that improved access requirements is requested and should include commissioning and funding "extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services".

6.7. MH advised with regards to the improving access, CCGs will need to demonstrate timing of appointments, minimum additional 30 minutes capacity per 1000 patients rising to 45 minutes, use of new national tool to measure access, to be published in 2017/18, advertising and ease of access to make clear for patients.

6.8. MH updated on the current GP forward view initiative for Southend CCG as follows:

6.8.1. Investment = Plans to commission services for care home residents / Complex care coordination service / Developing a locality deep dive for PCBC / Bids for GP resilience programme

6.8.2. Workforce = EU GP recruitment initiative / EPIC workforce development centre / Workforce mapping across practices underway / Developing plans for training funding

6.8.3. Workload = Plans to commission services for care home residents and complex care coordination service should release time in GP surgeries / Review of Babylon pilot.

6.9. MH advised the priorities for Southend CCG, whereby there is a need to focus on the ten high impact changes and how the CCG can support practices, developing a training programme, testing of new primary care roles, delivery a solution of care homes. As well as developing the CCG workforce plans to meet the needs of future models of care and resilient primary care, ensuring we understand each practice's plans for the future, involving member practices more in our developing plans and reviewing co-commissioning and considering the future.

Action: SS to circulate the General Practice Forward View and planning guidance for 2017/19.

RESOLVED: The Clinical Executive committee NOTED the General Practice Forward View and planning guidance for 2017-19.

7. Any other business

7.1. ***Commissioning intentions update:*** RS advised the final set of commissioning intentions has been pulled together. It will go to the Quality, Finance and Performance committee for approval. There is nothing in the intentions which should be a surprise to anyone. RS confirmed that the commissioning intentions are not in relation to the Pre-Consultation Business Case (PCBC).

7.2. ***MSK:*** It was noted that there is a percentage change in seeing patients within a week and referrals have gone down by 10%.

7.3. ***Movember 2016:*** KC kindly sked if any Clinical Leads would like to do Movember from 1st to 30th November 2016 by growing a moustache and raising money for men's health. If so, they are to see Paul Ilett, Head of Communications.

Closed

Date of next meeting: Thursday 10th November 2016 at 14.00 until 16.00, Priory Suite, Harcourt House, Southend