NHS
Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body held 7 August 2014 at West Offices, Station Rise, York YO1 6GA

Present

Professor Alan Maynard (AM)	Chair
Mr David Booker (DB)	Lay Member
Miss Lucy Botting (LB)	Chief Nurse
Dr Mark Hayes (MH)	Chief Clinical Officer
Dr Tim Hughes (TH)	GP, Council of Representatives Member
Dr Tim Maycock (TM)	GP Member
Mr John McEvoy (JM)	Practice Manager Member
Dr Shaun O'Connell (SO)	GP Member
Dr Andrew Phillips (AP)	GP Member
Dr Guy Porter (GPo)	Consultant Radiologist, Airedale Hospital NHS Foundation Trust – Secondary Care Doctor Member
Mrs Tracey Preece (TP)	Chief Finance Officer
Mr Keith Ramsay (KR)	Lay Member and Audit Committee Chair

In Attendance (Non Voting)

Miss Siân Balsom (SB)	Manager, Healthwatch York
Mrs Fiona Bell (FB) on behalf of Rachel Potts	Deputy Chief Operating Officer/Innovation Lead
Dr Paul Edmondson-Jones (PE-J)	Director of Public Health and Well-being, City of York Council
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Ms Michèle Saidman (MS)	Executive Assistant
Paul Cresswell (PC) on behalf of Mr Richard Webb	Assistant Director, Resources, North Yorkshire County Council

Apologies

Dr Emma Broughton (EB)	GP Member
Mrs Rachel Potts (RP)	Chief Operating Officer
Mr Richard Webb (RW)	Corporate Director of Health and Adult Services, North Yorkshire County Council

Twelve members of the public were in attendance.

AM welcomed everyone to the meeting and in particular welcomed David Booker, newly appointed Lay Member, Siân Balsom appointed as a co-opted member, Fiona Bell attending on behalf of Rachel Potts, and Paul Cresswell attending on behalf of Richard Webb.

There were no questions from members of the public.

AGENDA ITEMS

1. Apologies

As noted above.

2. Declaration of Members' Interests in Relation to the Business of the Meeting

MH declared an interest in view of his recent selection as a constituency Labour Party candidate for Selby and Ainsty in the 2015 general election.

3. Minutes of the Meetings held 5 June 2014

The minutes of the meeting held on 5 June were agreed.

The Governing Body:

Approved the minutes of the meeting held on 5 June 2014.

4. Matters Arising from the Minutes

Quality, Innovation, Productivity and Prevention Report (QIPP): AM noted that meetings between himself and KR with provider organisation Lay Members had not yet been progressed.

Referral Support Service: SO reported that there had been good progress with take up of the Referral Support Service noting utilisation by all GP practices. To date 19,000 referrals had been processed. Clinical involvement, particularly from secondary care, was also progressing. SO agreed to provide an update report to the October meeting of the Governing Body.

CCG Decision Making and Performance Arrangements – Review of Performance and Finance Committee: A full review of the CCG committee structure was currently being completed.

Performance and Quality Report: In regard to comparative data for levels of depression where Cognitive Behavioural Therapy (CBT) was available, LB reported that evidence did indicate that CBT was one of the effective treatments for depression. The report relating to ongoing alerts and associated issues at York Teaching Hospital NHS Foundation Trust was presented at item 11 on the agenda.

QIPP Update – Availability of Domiciliary Care: LB reported that recruitment was a critical problem for domiciliary care, including reablement. She was involved in discussion with Chief Nurses across the Northern Region to address workforce issues. However social carers should be considered within the context of the Better Care Fund.

Partnership Commissioning Unit Assurance: FB advised that a report would be provided at the next meeting as specifications were currently being finalised.

The Governing Body:

1. Noted that AM and KR would progress arrangement of meetings with Lay Members of provider organisations.
2. Requested a report on progress of the Referral Support Service at the next meeting.
3. Noted the updates.

5. Chief Clinical Officer Report

MH presented his report which included updates on systems resilience planning, CCG Assurance Framework 2014/15 Operational Guidance, CCG appointments, CCG Senior Management Team decisions, Mental Health Summit, communications, Sign up for Safety, public and patient engagement, raising funds for York MIND, and MH's parliamentary candidacy for Selby and Ainsty. MH highlighted the establishment of the System Resilience Group (SRG) comprising the CCG, York Teaching Hospital NHS Foundation Trust, NHS Scarborough and Ryedale CCG and NHS East Riding CCG. The SRG would meet monthly and be informed by two working groups: Unplanned Care Working Group and Planned Care Working Group.

In regard to CCG Assurance MH reported that the Quarter 1 meeting for 2014/15 with the Area Team was scheduled for 16 September. Feedback was awaited from submission of the Integrated Operational Plan.

MH welcomed agreement of an interim solution for delivering safe services at Bootham Park Hospital while a business case for a long term solution was being developed. He noted three potential sites for the long term – Bootham Park, The Retreat and Clifton – with the expectation of completion within a three year timescale for this work. MH particularly commended the support of English Heritage in the discussions to date.

In referring to his declaration of interest at item 2 MH reported on discussion with the Governing Body Lay Members. It had been agreed that a temporary/interim Deputy Chief Clinical Officer would be appointed due to the potential risk for perceived conflict of interest; this was being progressed.

In response to AM seeking clarification regarding Leeds and York NHS Partnership Foundation Trust Improving Access to Psychological Therapies (IAPT) threshold by 8% by the end of the financial year, LB reported on the aspiration to bridge the gap between the 8% and the national 15% target. Work was being undertaken to increase capacity through provision of services by the voluntary sector, charities and primary care. LB explained that the primary purpose of this indicator was to measure improved access to psychological services for people with depression and /or anxiety disorders. The indicator measured the proportion of people who entered treatment against the level of

need in the general population. The numerator was the number of people who receive psychological therapies and the denominator was the number of people who have depression and / or anxiety disorders. (The local estimate was based on an adult psychiatric morbidity survey undertaken in 2000). LB noted historic underfunding and recruitment as ongoing issues and, in response to specific concerns raised by SB and SO, requested detail of patients who had been on waiting lists for a long time.

KR endorsed MH's comments regarding perceived conflict of interests and welcomed the agreed resolution. He also commended the work on mental health services.

The Governing Body:

Noted the Chief Clinical Officer Report.

6. NHS Vale of York CCG Assurance Update

This was covered in item 5 above.

7. Better Care Fund

FB presented the report which described the joint work between health and social care aiming to reduce the number of unplanned attendances at and admissions to hospital through development of integration pilots and care hubs. She highlighted the early models currently being developed by Priory Medical Group and York Teaching Hospital NHS Foundation Trust, the latter in Selby, and the developments taking place in Pocklington and with the City and Vale Collaborative Group.

FB advised that since the report had been written new national guidance had been published and that a refreshed Better Care Fund submission was required by 19 September 2014. The focus had been changed from performance indicators to a single metric of the impact on reducing emergency admissions; 30% of the allocation fund would now being linked to this reduction. In the event of joint schemes not delivering this target, then some funding would be retained by the CCG to pay for activity in hospital. FB emphasised that spending on implementing schemes was already taking place and highlighted the continuing pressure to achieve delivery of joint outcomes. Work was taking place to fulfil the resubmission requirements.

FB described the NHS Accelerate programme to which the CCG had applied for consideration as a pilot site. If successful the CCG would receive national support including financial modelling, information governance and record sharing, and workforce development. An assessment visit was taking place on 15 August when the NHS Accelerate team would visit the Priory Medical Group and Selby integration pilots followed by a panel session in the afternoon. FB noted that networks would be established for sites not chosen for the programme to access the learning from the pilots.

Detailed discussion included the assessment of the integration pilots, concern that reduction in admissions could not automatically be wholly attributed to the Better Care Fund, assurance that evidence of interventions would be shared across all practices, recognition of the challenges and opportunities of working with three local authorities, and the need for members to support FB's team in the work to complete the resubmission of the Better Care Fund plans.

In response to AM's concerns about timescale for delivery of schemes and workforce issues, FB noted that the latter was a national issue but that locally workforce modelling was taking place including development of competencies for generic roles to undertake health, social care and reablement work. LB additionally noted discussions on workforce modelling, both with NHS England at a regional level and with the local CCGs, and referred to a number of opportunities including potential establishment of joint posts across acute and primary care; SB noted opportunities for voluntary sector involvement in this regard.

In relation to timescales FB acknowledged the challenge for delivery emphasising that implementation would be through a phased approach to this major system change. She highlighted that improvements expected through 2014/15 and 2015/16 would be built upon.

The Governing Body:

Noted the update.

Item 8 was discussed after item 10 which was moved up the agenda

8. Access to Infertility Treatment: Commissioning Policy

AP presented the report which proposed three options for consideration to implement a commissioning policy for Access to Infertility Treatment following the announcement in June 2014 that the Governing Body had agreed one cycle of IVF for individuals that met specific criteria. He highlighted the CCG's responsibility to commission safe and effective services within its budget and noted the financial risk for the CCG in commissioning IVF services was estimated at between £350k and £2m based on prevalence data of approximately 110 couples per year coming forward for IVF treatment in addition to potential backlog. AP described this in the context of £2m equating to either two fully staffed and operational hospital wards, 293 major hip replacements, treatment for more than 21,500 average attendances at Accident and Emergency or 43 qualified nurses employed full time for a year. He also referred to recent public and patient engagement events when IVF had been viewed as a low priority by attendees discussing services.

In terms of NICE guidance, which supported commissioning of IVF, and equity of services, AP noted local CCG decision making responsibility and advised that the commissioning policy document presented had been signed up to by the Yorkshire and Humber CCGs with local adjustment as appropriate. He referred to the three options presented for consideration by members – open

the policy and accept unknown costs, phased implementation, and prioritisation via a weighted eligibility list managed by the Individual Funding Request process – and highlighted the monitoring requirements of implementation. AP additionally noted that the third option would require further operational clarification.

GPo expressed the view that in the context of the financial position described by TP, and the discussion reported from public and patient engagement events, IVF should not be commissioned. He highlighted the impact on other commissioning decisions if the decision to commission IVF was progressed.

TH described the complexity of this issue in the context of the GP consulting room. He noted that the information had changed since the decision in June to commission one cycle of IVF for eligible couples and emphasised that a decision not to proceed at this time, which was now regretfully his view, would be on the basis of resources being invested to support the wider population.

SB felt unable to adequately reflect the patient voice on this matter and noted IVF in the context of a national issue due to inequity of provision on financial grounds. She also suggested that information be sought from GP practices as to numbers of people seeking this support to inform future consideration.

SO cited the CCG's reputation, the responsibility of commissioning decisions within available resources, and political and media pressures, whilst recognising the personal effect on couples who were seeking IVF. He referred to the impact of the financial position in terms of a number of quality targets that would potentially not be achieved, the further restriction of gluten free foods for people with coeliac disease as noted in MHs' report, and the challenge of the work to deliver the current QIPP plan and develop further schemes, additionally noting that formal discussions should take place with practices regarding commissioning IVF. In considering the overall financial context SO's view was that commissioning of IVF should be delayed with an aspiration for implementation as soon as possible.

TM highlighted that, although a minority of the population was affected by the issue of IVF, the impact on them was significant and experienced across all social groups and a wide age range. He supported limited funding for the service but with further discussion regarding value for money.

JM described the challenge of ensuring that there was a balance between criteria for services and available funding. Whilst empathising with couples in the position of seeking IVF he did not support implementation at this time but expressed the view that it should remain a future ambition for the CCG.

JL reported that he had taken soundings from a number of GPs prior to the meeting. The majority had expressed the view that members of the Governing Body were best placed to make this and other commissioning decisions. JL also commended the Governing Body's considered decision making and expressed the view that to commission IVF at the present time would add to the risk described by TP.

DB emphasised the difficulty of the decision and expressed the view that, in the context of discussion about potential decommissioning, the issue was one of affordability. He would wish IVF to remain open for consideration at a future date. DB also highlighted adoption as an option and noted availability of updated information.

TP stated that from the financial perspective IVF was not affordable due to the level of risk involved. She referred to the fact that there were other services that the CCG did not commission and management of the contract with York Teaching Hospital NHS Foundation Trust. TP also referred to the context of services that were a national requirement or were mandated but in regard to IVF there was a local element. She supported a delay in implementation with the intent to commission an IVF service at a time when it was affordable to the CCG.

LB referred to her work with children from the perspective of a nurse and her role as the CCG's Safeguarding Lead. She welcomed DB's highlighting of adoption as an option. LB's view was that a decision should be delayed and that IVF be taken into account in the wider consideration of commissioning and decommissioning decisions.

AP highlighted the emotive nature of any decision in regard to IVF. He noted risk due to the fact that activity levels were not known and supported commissioning of IVF but not at the present time. AP proposed that further work be undertaken in regard to criteria to ensure decisions based on clinical priority and that adoption be included in discussion with couples seeking IVF.

KR reflected on the CCG's accomplishments to date and commended the Management Team on the achievement of financial balance in 2013/14. He referred to prioritisation of commissioning and decommissioning and the context of decisions being taken across the whole health economy. KR's view was therefore that the decision be delayed to allow further consideration within the prioritisation work.

From the GP perspective TH and TM expressed concern at the proposal that the decision be delayed due to the impact of such uncertainty on patients seeking IVF.

Giving due consideration to the views expressed by members in the extended debate, AM proposed a vote on the motion that the CCG should aspire to commission IVF services but did not have the funds to do so in the current financial year.

MH abstained from the discussion and the vote due to his potential perceived conflict of interest.

The Governing Body:

Members eligible to vote approved AM's motion that the CCG should aspire to commission IVF services but did not have the funds to do so in the current

financial year. DB, TH, JM, SO, GPo and TP voted in favour; LB, TM, AP and KR voted against; MH and AM abstained.

In Favour	6
Against	4
Abstentions	2

9. Integrated Quality and Performance Report

In presenting this report LB highlighted increasing difficulties within the local health system with particular reference to a diminished workforce (with recruitment difficulties) and increasing unplanned and planned activity. LB referred to reducing avoidable admissions and attendance at A and E noting the requirement to work with the young to middle aged as well as the elderly in this regard. She also noted that NHS 111 activity had increased from 2012/13 but that this was not impacting on A and E as patients were being appropriately referred to primary care centres and the GP out of hours service.

LB noted that Yorkshire Ambulance Service Category A Red 1 and Red 2 response times continued to be a challenge although these performance targets relating to the CCG had improved due to work undertaken via the Urgent Care Working Group. Work was continuing to progress overall improvement. As a whole system Yorkshire Ambulance Service was involved in discussions with the lead commissioner and NHS England with regard to failing targets and a plan (with an improvement trajectory) was being closely monitored.

In regard to planned care LB noted ongoing issues with diagnostic wait times. There had been an increase from 71 to 84 MRI breaches of the six week target waiting time. This had been due to staffing which was now rectified; the MRI waiting list should resolve by October 2014. With regard to referral to treatment, cancer and diagnostics the System Resilience Planned Care Group were due to have their initial meeting on 17 September and an action plan was being put in place to address performance. In regard to two week waits for breast symptom screening, outpatient facilities for York and Scarborough had been brought together from 1 August to increase the capacity, which should look to resolve waiting times.

In terms of quality assurance LB reported that falls with fracture remained an issue at York Teaching Hospital NHS Foundation Trust. She was meeting with the Medical Director in August and September to discuss concerns which included workforce issues and NICE Guidance – falls risk assessments on admission.

In summary while certain aspects of the health system were managing well LB highlighted an increase in activity (planned and unplanned) which related to young to middle aged as well as to the frail elderly.

In response to clarification sought by KR, LB confirmed that prevention data for North Yorkshire County Council and East Riding of Yorkshire Council would be

incorporated in addition to that currently included for City of York Council. In regard to cancer performance target issues at York Teaching Hospital NHS Foundation Trust LB described work, including with national teams, to address this target and other performance issues noting the role of the SRG. LB also reported that consultant specialty capacity was an issue across the North of England. This had been noted by all CCGs and NHS England

Members discussed increased activity in the context of national political initiatives including breast and bowel awareness campaigns. SO also reported that the Referral Support Service was working with breast consultants in terms of appropriate referral and with radiologists regarding access to MRI scans to manage demand.

In response to TH requesting that practices be informed when there was a capacity issue at a particular provider in order to inform patient choice, SO agreed that this information could be provided for GPs; additionally practice comparative referral rates could be provided.

The Governing Body:

Noted the Integrated Quality and Performance Report.

10. Finance, Activity and QIPP Report

TP presented the Finance, Activity and QIPP Report which was moved up the agenda and considered after item 7 to inform discussion of item 8. She noted that it was based on the financial plan submitted on 20 June 2014 which incorporated a number of changes. These included a reduced surplus of 0.57%, namely £2.1m instead of £3.6m, due to the plan being for achievement of long term financial sustainability over the three years 2013/14 to 2015/16. TP described contributory factors to the decision to reduce the surplus. She noted that the agreed contract baseline with York Teaching Hospital NHS Foundation Trust for 2014/15 was higher than the original plan, but was realistic for both organisations, with a joint understanding of the requirements. Additionally, significant reductions had emanated from a detailed review of all budget lines as part of the contract agreement. TP reported Area Team support for the plan submitted.

In terms of the Month 3 position TP reported that Programme Costs were slightly worse than the year to date plan overall but this was offset by a corresponding underspend in Running Costs; the CCG was therefore on plan. TP noted some under performance with providers, including £415k with the York Teaching Hospital NHS Foundation Trust contract mainly due to trauma and orthopaedic activity which was offset by corresponding over performance at the Ramsay and Nuffield Hospitals.

TP detailed outstanding issues from 2013/14 in terms of a £179k pressure relating to Leeds Teaching Hospitals NHS Foundation Trust, £110k with Mid Yorkshire Hospitals NHS Trust, and a Yorkshire Ambulance Service contract challenge relating to coding and counting that was being addressed through the Contract Management Board.

TP reported that prescribing was behind plan year to date, noting that this data was always two months in arrears to the report so based on only one month of data at this stage. She also referred to the £4.5m unidentified QIPP gap. She noted that the agreed plans were robust and had activity profiles but that assurance was required of full benefits realisation. TP highlighted the need for new schemes, contingencies, managing demand through contracts and potential consideration of decommissioning to ensure delivery of the financial plan.

In response to PE-J seeking clarification of the transfer of reablement funding and carers' grants to the three local authorities, TP reported on the potential for a reduced contribution in 2014/15 as previously notified to the Governing Body with the full amount being provided in 2015/16. She confirmed that the funding was included in the plan.

KR referred to the aged debtor information of £97.5k with NHS Harrogate and Rural District CCG and £167k and £241k respectively with North Yorkshire County Council and City of York Council. TP confirmed that the latter two related to public health prescribing, a national issue; work was taking place to resolve this. She would provide clarification regarding the debt with NHS Harrogate and Rural District CCG.

In response to clarification sought of the potential for decommissioning of services to deliver year end financial balance TP advised that detailed work was being undertaken in terms of benchmarking services, ensuring value for money and patient outcomes and confirmed that consideration of decommissioning was also required. SB highlighted willingness on the part of the public and voluntary sector to work with the CCG in regard services.

JM referred to discussion at the Quality and Finance Committee regarding risk and mitigation and sought clarification on the £16m potential worst case financial risk. TP advised that further major risks were emerging that required mitigation and noted that the acute providers were in a similar position in terms of financial pressures. She referred to the discussion that would take place in the Governing Body Workshop later in the day about difficult decisions to potentially decommission services noting that the CCG had already taken the decision that it would not be possible to deliver the Business Rules in the current year.

AM emphasised the statutory requirement for the CCG to deliver financial balance with a small surplus and highlighted the need for transparency in decision making.

The Governing Body:

1. Noted the Finance, Activity and QIPP Report.
2. Noted that TP would provide clarification regarding the NHS Harrogate and Rural District CCG aged debt.

Post meeting note: Section 256 of the National Health Act allows Primary Care Trusts to enter into arrangements with local authorities to carry out activities with health benefits. This debt related to a recharge for Section 256 agreements as NHS Harrogate and Rural District CCG (HaRD) had established and informed NHS Vale of York CCG that Harrogate District NHS Foundation Trust (HDFT) had received the budget for an element of the Community Equipment Store. North Yorkshire County Council were actually billing, incorrectly, the CCGs for this directly. HaRD had therefore asked HDFT for reimbursement and for NHS Vale of York CCG to invoice them for the corresponding amount.

11. Urgent Care Report: Bank Holiday and Easter Pressures 2014

LB referred to the report presented at the request of the Governing Body. She noted that a combination of health and service issues from various sectors of the NHS had come together over this period to cause increased activity and impact on A and E. This included an increase in referrals from primary care, ambulance batching from midday to early afternoon, out of hour and NHS 111 increased activity (young to middle aged), and ambulance capacity issues. There were also continuing issues with delayed discharges which had an impact on patient flow through the acute hospital. All these issues were being picked up following the Emergency Care Intensive Support Team visit and subsequent report through the SRG Planned Care and Unplanned Care Working Groups.

LB highlighted two potential issues which were not currently being addressed. Staffing numbers in A and E and contingency planning for increased activity to include bank holiday weekends and the increased attendance of 19 to 24 and 24-35 year olds at A and E. Work was required to understand the rationale for attendance to ensure avoidable admissions were identified and mitigated.

Members discussed the capacity of NHS111, ability to predict demand at the hospital and ensure appropriate staffing levels, work with the local authorities around alcohol related admissions, and the need for the payment system to be adapted to support major transformational change.

The Governing Body:

Noted the analysis and recommendations in the report.

12. Commissioning Support Unit Provision

TP reported that the current contract with the Commissioning Support Unit (CSU) expired at the end of September 2014 and noted that the CSU had proposed the new contract be agreed for 18 months, to the end of March 2016. She noted that efficiencies were expected from the merger of the North Yorkshire and Humber CSU with the South and West Yorkshire and Bassetlaw CSU and advised that, following detailed work, the service specifications were in the process of being signed off. TP advised that the CSU had recosted services and that, although this would not have an overall impact for NHS Vale

of York CCG, consideration was being given in the context of the national requirement of the 10% reduction in CCG running costs. She also noted that a formal Contract Management Board with the CSU had been established.

TP advised that discussions were taking place between the North Yorkshire CCGs regarding the potential for joint working with the CSU and that the process for the CSU Audit Report had begun which would address the late submission of the last report for the annual accounts.

KR welcomed the acceleration of the service audit. He sought clarification both on efficiencies expected from the merged CSU and enhanced business intelligence provision. TP advised that it was too early to assess the impact of the former but in regard to the latter key performance indicators were being agreed for each service specification, with an approach of core elements supplemented by specific additional areas. TP also noted the CSU's recent appointment of Mark Dundon as Chief Information and Technical Officer and that he was consulting with the CCGs on their requirements. She confirmed that there was a CSU network and noted that she would look to ensure learning from CSUs across the country through discussion at the Contract Management Board. AP additionally noted that, in view of issues across many CCGs relating to urgent care dashboards, consideration was being given to establishing an Urgent Care Network.

In response to JM seeking clarification regarding information technology (IT) TP reported that neither the corporate nor GP IT service specifications had been signed off yet. She also advised that, through attendance at the Practice Managers Group meeting, discussion was taking place to ensure their involvement in development of the key performance indicators.

The Governing Body:

Noted the update.

13. Policy, Procedure and Guidance for Responding to Allegations of Abuse or Neglect of a Child Against an Employee of NHS Vale of York CCG

LB referred to the Policy, Procedure and Guidance for Responding to Allegations of Abuse or Neglect of a Child Against an Employee of NHS Vale of York CCG which had been revised in accordance with the *Working Together to Safeguard Children* published in 2013.

The Governing Body:

Approved Policy, Procedure and Guidance for Responding to Allegations of Abuse or Neglect of a Child Against an Employee of NHS Vale of York CCG

14. NHS Vale of York CCG Audit Committee

The Governing Body:

Received the minutes of the Audit Committee of 2 June 2014.

19. NHS Vale of York CCG Quality and Finance Committee

The Governing Body:

Received the minutes of the Quality and Finance Committee of 19 June and 17 July 2014.

20. Medicines Commissioning Committee

The Governing Body:

Received the minutes and recommendations of the Medicines Commissioning Committee of 21 May and 18 June and the recommendations of the meeting of 16 July 2014.

21. Next Meeting

The Governing Body:

Noted that the next meeting was on 2 October 2014 at 10am at West Offices, Station Rise, York YO1 6GA.

AM requested that members consider for this meeting his proposal that discussion of reports be led by members other than their authors.

22. Follow Up Actions

The actions required as detailed above in these minutes are attached at Appendix A.

A glossary of commonly used terms is available at
http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/governing-body-glossary.pdf

Appendix A

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 7 AUGUST 2014 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
7 November 2013	CCG Decision Making and Performance Arrangements	• Review of Performance and Finance Committee	RP/LS	Six months after implementation – May 2014, to be Confirmed
6 March 2014	Audit Committee Reforms and Lay Representation	• Proposals for additional Lay representation at CCG decision making meetings to be presented • Options to be developed to increase opportunities for non Governing Body clinical representatives to attend decision making meetings	LS LS	3 April 2014 meeting

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
5 June 2014	Partnership Commissioning Unit Assurance	• Report detailing the respective responsibilities of the CCG and Specialist Commissioning	RP	7 August 2014
7 August 2014		• Report to be presented at next meeting		2 October 2014
7 August 2014	Matters Arising: QIPP Update	• Meetings with Lay Members of provider organisations to be progressed	AM/KR	
	Referral Support Service	• Progress report to be provided	SO	2 October 2014