NHS
Vale of York
Clinical Commissioning Group

Item 15

Minutes of the Quality and Finance Committee Meeting held on 20 October 2016 at West Offices, York

Present

Mr David Booker (DB) - Chair	Lay Member
Mr Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Mrs Fiona Bell (FB) - part	Deputy Chief Operating Officer
Mrs Michelle Carrington (MC) - part	Chief Nurse
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Tim Maycock (TM) - part	GP Governing Body Member, Lead for Out of Hospital Care
Mr Phil Mettam (PM) - part	Accountable Officer
Dr Shaun O'Connell (SOC)	GP Governing Body Member, Lead for Planned Care and Prescribing
Dr Andrew Phillips (AP)	GP Governing Body Member, Lead for Urgent Care/Interim Deputy Chief Clinical Officer
Mrs Rachel Potts (RP)	Chief Operating Officer
Mrs Tracey Preece (TP) - part	Chief Finance Officer

In attendance

Mrs Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Mrs Helen Rees (HR)	Assistant Head of Finance, NHS England
Ms Michèle Saidman (MS)	Executive Assistant

For items 1 to 3

Mrs Laura Angus (LA)	Lead Pharmacist
Mr Andrew Bucklee (AB)	Senior Innovation and Improvement Manager
Mrs Becky Case (BC)	Senior Innovation and Improvement Manager
Mr Paul Howatson (PH)	Senior Innovation and Improvement Manager
Mr Shaun Macey (SM)	Senior Innovation and Improvement Manager
Mrs Liza Smithson (LS)	Head of Contracting

The agenda was discussed in the following order.

Apologies

There were no apologies.

Declarations of Interest in Relation to the Business of the Meeting

There were no declarations of interest in relation to the business of the meeting. All declarations were as per the Register of Interests. It was additionally noted that the GPs did not have a conflict of interest in respect of the prescribing policies at item 2.1, which was a slight amendment from the policy considered at the previous meeting, or at item 8 as the policies were anonymised.

1. Minutes of the meeting held on 22 September 2016

The minutes of the meeting held on 22 September were agreed.

The Committee:

Approved the minutes of the meeting held on 22 September 2016.

2. Matters Arising

Review of the Ambulatory Care Unit activity: TP reported that the query notice had been issued but that due to the timescale the report was not yet available.

The other items on the matters arising scheduled related to agenda items 5 and 6.

2.1 Policy on Primary Care Rebate Schemes

LA explained that subsequent to approval of the Policy on Primary Care Rebate Schemes at the previous meeting advice had been received from the Acting Head of Medicines Management for the Harrogate and Rural District CCG recommending a further step – consideration by an appropriate committee – before sign off by the Chief Finance Officer of individual rebates. LA had made the proposed amendments at 6.2 to read *The Medicines Management Team will present the individual rebates to Quality and Finance Committee. The Quality and Finance Committee are asked to review the decisions on individual rebates and support the Chief Finance Officer in ensuring the rebates are appropriate for approval* and also at Appendix 3 Operating Procedures.

The Committee:

1. Noted the update.
2. Approved the minor amendment to the Policy on Primary Care Rebate Schemes.

'Good News'

FB reported that, following the Governing Body's agreement to extend the Proactive Health Coaching pilot, the CCG had been contacted by the Health Service Journal. They wished to publicise the work to share the approach across the system; information was being provided in response to this request.

3. Improvement Plan incorporating Financial Recovery Plan

In introducing this item PM emphasised the CCG as "one team" with responsibility for addressing the financial position. He referred to the new committee structure noting the separation of quality from finance and performance from November. The Finance and Performance Committee would hold responsibility and accountability for money, QIPP, contract delivery, performance issues and risk. PM advised that the composition of the Finance and Performance Committee was being finalised but confirmed that the Partnership Commissioning Unit would be represented. Reporting would be by exception based on turnaround requirements.

PM planned to propose that the Governing Body, including the Lay members, be assigned lead roles for recovery. He noted however that SP, as Audit Committee Chair, was required to remain independent.

PM reported that the Improvement Plan, supported by detail of medium term financial recovery, had been submitted to NHS England in response to the five headings of the Legal Directions: capacity, capability, governance, leadership and money. Feedback on the plan was expected imminently. Specific areas of clarification that had been discussed with NHS England would be incorporated. The Finance and Performance Committee would monitor progress on delivering the plan on behalf of the Governing Body.

PM highlighted the need for the CCG to provide confidence in its ability to address the financial challenge and, build relationships with partner organisations. This process would include re-establishing clinical leadership. PM noted that a summary of key messages and actions would be published.

In response to clarification sought by members, HR emphasised the requirement to live within plan in 2016/17 and within resources in 2017/18. Other aspects of the Improvement Plan would be reviewed by NHS England.

3.1 Financial Performance Report

TP reported that the financial position was £8.29m behind plan as at the end of September with a risk adjusted forecast of £24.1m deficit, agreed with NHS England. The year end forecast remained at £17.3m deficit but the risk had increased as a result of work on the Improvement Plan, reassessment of month 5 risks and mitigations and reassessment of QIPP. TP emphasised the need to achieve as close as possible to the £13.3m planned deficit for potential access to the 1% non recurrent requirement. She noted that reporting of the finanical recovery aspect of the Improvement Plan would be incoporated in the monthly Financial Performance Report.

TP explained that key areas of risk remained over performance of acute contracts and continuing healthcare noting that a number of improvements had been offset by other issues. In respect of York Teaching Hospital NHS Foundation Trust the full value of the gap between contracted and financial plan values was £4m but there was a further c£1.7m overtrade included in the risk position; an approach agreed with NHS England. Additionally, c£3.5m further risk was included within the £24.1m risk adjusted position.

In response to SP seeking assurance in the context of the Legal Directions and submission of a plan with a £5.4m gap, TP advised that, in addition to work taking place on ‘pipeline’ schemes, support from the wider system was required and would be sought from partner organisations. She also noted that discussion was taking place with all acute providers regarding the CCG’s position of needing to pay agreed contract levels.

PM reported on discussion with City of York Council, North Yorkshire County Council, York Teaching Hospital NHS Foundation Trust and NHS Hull CCG regarding potential support noting that these requests would be formalised. He also reported that he was seeking legal advice in respect of the York Teaching Hospital NHS Foundation Trust

contract. PM additionally emphasised the need to achieve maximum benefit from the current contract challenges both in terms of finance and demonstration of capability.

In respect of the contract challenges TP confirmed that no payment would be made prior to resolution. She clarified that a number of areas of challenge were subject to the six month notice of review as at 30 September, the unbundling of the rehabilitation bed days was in the forecast outturn, and due to timescales ambulatory care and septicaemia were not currently included.

PM highlighted that the main areas of spend that the CCG could influence were the cost of the acute contract, continuing healthcare and prescribing. It was imperative to prioritise these areas.

TP explained that the pro rata continuing healthcare forecast was an overspend of c£3m. The risk adjusted position was £2.3m based on assumption of c£700k improvement by the end of the year. There was an additional c£0.25m QIPP.

TP reported that the CCG, in collaboration with the local CCGs, was undertaking an independent review of detailed contract management processes with York Teaching Hospital NHS Foundation Trust. The outcome would be a clinical report highlighting risks from both a clinical and financial perspective.

TP also advised that the initial draft of the medium term financial strategy would be developed within the CCG and externally with stakeholders regarding specific areas.

3.2 QIPP Report

RP referred to the report which described the month 6 QIPP position, progress of current schemes and QIPP 2017/18 and going forward. She emphasised the need for discussion to focus on 2016/17 delivery by exception, i.e. schemes rated as ‘red’ or ‘amber’. Schemes denoted as grey were in delivery.

RP confirmed that all schemes had identified leads. This information would be incorporated on the next iteration of the report.

SM reported that while DVT remained in the ambulatory care block contract with York Teaching Hospital NHS Foundation Trust, there was no scope for generating additional savings from primary care. SM added that Practices had indicated that they would be willing to take on DVT with appropriate funding on the basis that the majority of the work did not need to be carried out in a hospital setting, and recent progress with the General Practice Warfarin-based anticoagulation contract would complement a primary care DVT pathway.

TM noted the significant cost difference between Warfarin and Novel Anticoagulants (NOACs) for the treatment of DVT and that development of DVT protocols had been delayed due to time constraints. Discussion included recognition that some level of DVT service would always be required at York Teaching Hospital NHS Foundation Trust for more complex patients, the need to simplify the DVT pathway if primary care was to be asked to take this on, complexity relating to potential savings with Warfarin and NOACs,

and the fact that the DVT scheme was a clinical pathway providing care closer to home but may not provide substantial financial benefit. The part year saving was £17k.

It was agreed that **DVT be removed from the QIPP list** as the return did not currently justify the commitment required, however TM would continue working with Primary Care in this regard to understand options.

RightCare

AB reported that trauma and injury was in phase 2 of the RightCare work programme and phase 1 would start to deliver with the MSK service starting from April 2017. Circulation and gastroenterology were also in phase 1.

As part of the RightCare circulation review the cardiovascular disease project required a system approach, including closer working with Primary Care to reduce non elective activity. AB advised that there would be a workshop at the Clinical Senate in November when further support from Primary Care would be sought. An additional approach was that the CCG would write to Practice cardiology leads. Work was also taking place with the acute trust and community teams on care pathways. AB noted that the project plan was on track in terms of achieving its milestones.

Members noted that RightCare was complex as it required stakeholder support from primary, community and acute care partners.

Discussion ensued on alternative approaches - collaborative working or commissioning a specific service based on RightCare data - with recognition of the importance of relationships between primary and secondary care and that changes such as management of hypertension and cholesterol would take time to have impact. SOC additionally noted that he had attended a RightCare presentation to York Teaching Hospital NHS Foundation Trust Executive Board who had been supportive of the work and AP advised that he was beginning monthly meetings with their Medical Director.

AB referred to the Community Diabetes programme which had been implemented but was not delivering the expected savings. MA-M explained that concern had been raised at the York Contract Management Board about Community Diabetes as it was delivering operationally but the savings appeared to be being offset by utilisation of the freed up capacity for reviews. LS also noted change from first to follow up attendances and a potential c£10k saving related to prevention of double amputations, advising that monitoring of savings was being reviewed. AB reported on the potential for generation of further savings via an opportunity to bid against the £40m available funding from the NHS England Diabetes Transformational Programme Budget in December. He proposed that submissions be made for improving structured education, extending the multi disciplinary team approach to prevent non elective readmissions and expanding community diabetes podiatry services to reduce minor amputations. It was agreed that the **Clinical Executive would review progress and prepare a bid for consideration by Senior Management Team**. Members noted the diabetes service in the context of a long term condition therefore part of the out of hospital opportunity cost.

It was agreed that **responsibility for delivery of RightCare be delegated to the Clinical Executive** and that a **RightCare report, including a plan for engagement**

with both primary and secondary care, be presented at the November Finance and Performance Committee meeting.

Emergency Department Front Door

BC reported that performance and finance were linked for this scheme as contributing towards the 95% A and E constitutional target. She noted that York Teaching Hospital NHS Foundation Trust Sustainability and Transformation Fund target in this regard was 92%; this trajectory had been achieved month on month.

The CCG element of the anticipated savings from the scheme was to date relatively modest as the planned level for the number of patients with no intervention and no treatment had not yet been reached. Current performance was 16% against a 23% plan at which time savings were expected. Performance had been at 100% on two days since the start of the scheme.

BC advised that monitoring of the scheme was continuing and that work was taking place with Yorkshire Doctors Urgent Care on care pathways.

Review of Community Inpatient Services

FB confirmed that the number of admissions to Archways was reducing and that the plan for no admissions from 1 December was on schedule. MA-M explained that the detail of the expected £333k savings had been requested by the York Contract Management Board. In 2017/18 there was potential to release the full year effect or make it available for the Out of Hospital strategy. FB noted that this work aligned with the Sustainability and Transformation Plan footprint highlighting that agreement was required of the appropriate forum for discussing work relating to the community units. **FB to organise a meeting to discuss work related to community units and care hubs.**

Integrated Care Team Roll Out

BC reported a planned phased roll out of the York Integrated Care Team across City of York Practices from 1 November 2016 to 31 March 2017. MA-M explained that this work was progressing on the basis of verbal confirmation of intention noting that in 2017/18 all three integrated pilots would be incorporated in the out of hospital care contracting.

PM provided an update on development of an accountable care system proposing establishment of three delivery units across the CCG footprint: North, South and City. TM sought and received assurance that Pocklington would be included.

Community Intravenous Therapy (IV)

BC reported that expansion of the successful bronchiectasis IV pilot had not been possible due to identification by York Teaching Hospital NHS Foundation Trust that this would be at increased cost to the CCG. A cost neutral plan had been requested in order to achieve the potential savings and improve patient flow. It was agreed that the

Clinical Executive identify opportunities to progress this work and submit a proposal for consideration by Senior Management Team.

Repeat Ordering Schemes ('Managed Repeats') for GP Practices Policy

LA explained that this policy had been in place since the end of August and that a review of spend at six months was planned. She highlighted the need to continue the work taking place to engage with Practices and community pharmacists to implement this policy in conjunction with the campaign to reduce waste medicines. SOC added that the Council of Representatives supported this policy.

Minor Ailments Prescribing

LA reported that a policy on prescribing medicines available to purchase was being implemented but required patient education which would take time.

FB and LA agreed to undertake work on opportunities for prescribing savings including further discussion with the Vale of York Clinical Network regarding the potential for them taking on responsibility for prescribing budgets.

York Teaching Hospital NHS Foundation Trust Follow-up Ratio

The follow-up ratio for each specialty had been reviewed and three areas of significant increase had emerged from conditions registers: clinical haematology, ophthalmology and rheumatology. The reasons for the increase had been clarified as due to additional complexity and ongoing treatments. TP referred to the Heads of Terms under which it had been agreed with York Teaching Hospital NHS Foundation Trust that any key decisions resulting from this would be implemented in year without the requirement for notice. She reported that review meetings were taking place emphasising the need for a resolution for contracting. LS added that for the longer term consideration was required in the context of care provided in hospital and in the community.

TP noted a number of 'pipeline' QIPPs for contracting differently for outpatients in terms of follow-up, including GP access to advice and guidance, diagnostics and virtual clinics. SOC additionally referred to sharing of Vanguard learning by NHS England. FB noted the potential to review the allocation of the Innovation and Improvement Team responsibilities to support this work but advised that prioritisation may be required. **FB agreed to discuss the associated requirements with AP, SOC and LS.**

Procedures of Limited Clinical Value / Clinical Thresholds

SOC reported that the review of procedures of limited clinical value was continuing and information would be provided to North of England Commissioning Support at the end of October to enable development of an electronic model for monitoring providers in respect of not routinely commissioned procedures. As the review continued the additional procedures would be incorporated.

SOC reported that he and MC had met with Dr David Black, Joint NHS England Medical Director, to discuss the delay at the request of NHS England to implementation of the Governing Body decision on the Commissioning Statement for Hip and Knee Joint

Replacement Surgery. SOC confirmed that the CCG now had NHS England support both in respect of restriction of a BMI of not more than 30 for surgery and for the proposed smoking cessation restriction across all elective procedures but emphasised that there would be no "blanket" bans. *(Post meeting note: The Governing Body had at its Part II meeting on 1 September supported BMI and smoking thresholds across all specialties where relevant to outcome).* SOC added that NHS England had also supported progressing the proposed Cataract Commissioning Statement discussed by the Governing Body on 1 September and advised that implementation of thresholds would take six to eight weeks. **SOC agreed to work with MC and MA-M on development of a detailed communications plan.** A 1 December 2016 implementation date was agreed.

TP and MA-M reported that discussions had taken place with York Teaching Hospital NHS Foundation Trust regarding implementation of restrictions. In respect of referral to treatment waiting times the Governing Body had supported waiting list validation against the trauma and orthopaedics threshold for patients who did not have a date to come in.

Continuing Healthcare

PH reported on discussions with the Partnership Commissioning Unit to expedite delivery of plans to reduce Section 117 spend. He noted challenges in the system in respect of the cost of care home places which were more in York than in North Yorkshire. Discussion was required with providers of specialist dementia care homes due to there being a widening gap in the market and other challenges. PH also noted that the recently implemented, alternate month, bulk supply and delivery of continence products to care homes was creating storage problems in some homes.

In respect of May Lodge, which provides services for carers of children with complex needs from across North Yorkshire and York, PH advised that prior to a decision to recommission services the Partnership Commissioning Unit would review each child with a support package for carers included as part of their care.

Further schemes

FB reported that work was taking place on further potential schemes and that **a capacity review would take place in light of identified requirements.**

DB requested a **report detailing priorities with lead officers and timescales**.

In terms of governance PM advised that progress at pace would be achieved through the Clinical Executive providing advice and insight on opportunities and issues to inform decisions taken by the new Executive Committee on behalf of the Governing Body. AP noted the intention for the Clinical Executive to focus on a specific area of RightCare each month. He noted the time commitment for this and the review of procedures of limited clinical value.

LA, AB, MC, BC, PH, SM, PM and TP left the meeting

3.3 Contract Report

LS presented the report which described the 2016 position and key issues relating to acute hospital contracts to the end of August. The position on the main contracts was a £1m overtrade in August and a £2.5m overtrade year to date. LS noted that the historic reduction in August against which the activity was profiled had not taken place in 2016 mainly due to non elective activity. The £2.7m year to date overtrade with York Teaching Hospital NHS Foundation Trust could be offset by c£1m undertrade at Ramsay and Nuffield Hospitals. The £350k overtrade at Leeds Teaching Hospitals NHS Trust was due to profiling of non elective activity.

LS further explained issues relating to the York Teaching Hospital NHS Foundation Trust contract. She confirmed that all contracts were being reviewed and challenged where appropriate to ensure maximum return.

Members agreed that the report provided assurance that the CCG's contracts were being reviewed and managed.

The Committee:

1. Noted the update on the Improvement Plan.
2. Noted the work in respect of QIPP emphasising the need to expedite delivery in-year.
3. Agreed that DVT be removed from the QIPP list.
4. Requested a report detailing priorities with lead officers and timescales.
5. Welcomed the assurance provided by the Contract Report that the CCG's contracts were being reviewed and managed.

LS left the meeting

7. Review of Numbers and Cost of People Currently Working to Support the CCG on a Consultancy or Similar Contract

DB noted that he had requested this agenda item following discussion at the Audit Committee of a number of waivers to tender.

MA-M presented the report which provided a comparison of the full year spend for 2015/16 and the 2016/17 year to date expenditure and forecast outturn in respect of consultancy or similar contractual commitments. FB and MA-M provided explanation of the contracts that had resulted in the increase from £290,459 in 2015/16 to the current £655,244.

Members sought and received further clarification recognising that the posts had been required but expressing concern about value for money, particularly in the context of the CCG being under Legal Directions. However, costs associated with the requirement for independent scrutiny as part of the Directions was also noted. Future capacity and capability would be addressed through the Improvement Plan. In this regard DB proposed that the new Finance and Performance Committee should receive a report describing capacity requirements.

SP referring to reporting on the Better Care Fund and requested a report on its status, achievements and value for money. RP advised that monitoring would be reported to the Finance and Performance Committee.

The Committee:

1. Noted the 2015/16 full year spend and the 2016/17 year to date expenditure and forecast outturn in respect of consultancy or similar contractual commitments.
2. Noted DB's request for a report on capacity in relation to the Improvement Plan to the Finance and Performance Committee.
3. Noted the request for a report on the Better Care Fund.

FB left the meeting

4. Quality and Performance Intelligence Report

Due to time constraints members noted the mitigations within the Quality and Performance Intelligence Report. RP highlighted the need to add information on progress towards achieving the 67% dementia coding target in General Practice, referred to in the Risk Report at item 9.

AP expressed concern in respect of the out of hours performance: 90.89% for urgent face to face consultations within two hours and 94.22% for less urgent within six hours, both against a 95% target. He advised that the former included palliative care patients who were not being seen quickly enough and noted that he would raise this at the Out of Hours Contract Management Board.

The Committee:

1. Noted the Quality and Performance Intelligence Report.
2. Noted that RP would request the addition to the report of dementia coding in General Practice.
3. Noted that AP would raise concerns about out of hours urgent face to face consultations within two yours in respect of palliative care patients.

5. RightCare Report

This was covered under item 3.2 above.

6. Progress Repoprt on Develoment of the Vale of York Clinical Network

AP reported that the position of the Vale of York Clinical Network would be reviewed in the context of development of an accountable care system.

The Committee:

Noted the update.

TM left the meeting having expressed a moral objection to item 8

8. Primary Care Rebate Scheme Decisions

In presenting this item SOC noted the requirement for the Decision Form to be further anonymised. He assured members that savings achieved through the Scheme would be fortuitous with no promotion of rebates.

In response to assurance sought by members from a governance perspective, SOC emphasised that neither he nor Laura Angus, Lead Pharmacist, would be involved in the scheme and Alex Molyneux, Senior Pharmacist, would ensure that any rebate offered was consistent with CCG prescribing policy and switch programmes. He advised that this approach was being implemented by many CCGs.

SOC agreed to discuss the detail of the Decision Form with Alex Molyneux, including requesting the addition of clinical area to the assessment criteria.

The Committee:

1. Approved the rebates for the medication DS1, AZ1 and AZ2.
2. Requested that SOC arrange for improved anonymisation and review the detail of the Decision Form including the addition of clinical area to the assessment criteria.

9. Corporate Risk Register

RP advised that eight events identified as having serious impact had materialised: failure to achieve 67% coding target in General Practice as referred to at item 4 above; lack of locally-based adult acute mental health inpatient services; failure to achieve an assured position for the 2016-17 plan; failure to manage Partnership Commissioning Unit areas of spend; failure to fulfil continuing healthcare fast track packages; failure to meet 4 hour A&E target Constitutional target; access to Choose and Book Office accommodation may not be adequately restricted which may lead to breach in confidentiality of patient information; and Judicial Review relating to the "closure" of Bootham Park Hospital.

RP noted that the Audit Committee had expressed concern about a number of the mitigations, in particular those relating to the Partnership Commissioning Unit and the financial position. She explained that the Better Care Fund would be reported to the new Finance and Performance Committee and confirmed that the targets could be reviewed following approval of the Improvement Plan.

DB referred to the risk relating to insufficient engagement with clinicians and the public/patients for service developments which may result in anticipated benefits not being delivered. He requested a report on the current status in this regard for the next meeting. RP noted that the recently appointed Patient Engagement Lead would assist addressing this risk.

The Committee:

1. Received the Corporate Risk Register report as at 13 October 2016.
2. Requested a report on public/patient engagement in service developments for the next meeting.

10. Key Messages to the Governing Body

- Report on consultancy or similar contracts linked with the Improvement Plan requested
- Report on current Better Care Fund status, achievements and value for money requested
- Dementia coding information to be incorporated in the Quality and Performance report
- Patient and Public Involvement Strategy to be presented at the next meeting
- Full summary of proposals and actions to achieve QIPP savings with responsible lead and timescales to be presented to the next meeting

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

11. Next meeting

Date and membership to be confirmed.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP QUALITY AND FINANCE COMMITTEE

SCHEDULE OF MATTERS ARISING/DECISIONS TAKEN ON 20 OCTOBER 2016 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
QF61	22 September 2016 20 October 2016	Quality and Performance Intelligence Report	• Report from the York Contract Management Board following its review of the Ambulatory Care Unit activity.	TP	20 October 2016 Report to go to the new Finance and Performance Committee
QF63	20 October 2016	QIPP Report	• DVT to be removed from QIPP • Clinical Executive to review progress with Community Diabetes and prepare a bid for submission to NHS England against available funding following review by Senior Management Team • Clinical Executive to present a report on progress with RightCare areas including engagement plan • Meeting to discuss work relating to community units and care hubs	 AP AP FB	 November 2016 November 2016 Finance and Performance Committee

			• Clinical Executive to identify opportunities to progress community IV work and submit a proposal to Senior Management Team • Work on opportunities for prescribing savings • Procedures of Limited Clinical Value / Clinical Thresholds communications plan for 1 December implementation • Capacity review to take place in light of identified requirements • Report detailing priorities with lead officers and timescales	AP LA,/FB MA-M, MC,SOC FB RP	November Finance and Performance Committee
QF64	20 October 2016	Review of Numbers and Cost of People Currently Working to Support the CCG on a Consultancy or Similar Contract	• Report on capacity in relation to the Improvement Plan to the Finance and Performance Committee • Report on the Better Care Fund	RP/TP RP	
QF65	20 October 2016	Primary Care Rebate Scheme Decisions	• Detail of the Decision Form to be reviewed including the addition of clinical area to the assessment criteria	SOC	

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
QF66	20 October 2016	Corporate Risk Report	• Report on public/patient engagement in service developments	RP	