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 4 December 2014 at West Offices, Station Rise, York YO1 6GA**

**Present**

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| Professor Alan Maynard | Chair |
| Mr Michael Ash-McMahon | Interim Chief Finance Officer |
| Dr Louise Barker (LB) | GP Member |
| Mr David Booker (DB) | Lay Member |
| Dr Emma Broughton (EB) | GP Member |
| Mrs Michelle Carrington (MC) | Head of Quality Assurance/Deputy Chief Nurse |
| Dr Paula Evans(PE) | GP, Council of Representatives Member |
| Dr Mark Hayes (MH) | Chief Clinical Officer |
| Dr Tim Hughes | 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 Rachel Potts (RP) | Chief Operating Officer |
| Mr Keith Ramsay (KR) | Lay Member and Audit Committee Chair |

**In Attendance (Non Voting)**

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| Dr John Lethem (JL) | Local Medical Committee Liaison Officer, Selby and York |
| Ms Michèle Saidman (MS) | Executive Assistant |
| Mr Guy Van Dichele (GvD) on behalf of Ms Kersten England | Director of Adult Social Care, City of York Council |
| Mr Richard Webb (RW) | Corporate Director of Health and Adult Services, North Yorkshire County Council |

**Apologies**

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| Ms Kersten England | Chief Executive, City of York Council |

Seventeen members of the public were in attendance.

AM welcomed everyone to the meeting. He particularly welcomed MC and GvD and to their first meeting and noted that Channel 4 were filming.

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

There were no declarations of members' interests in relation to the business of the meeting. Members' interests were as per the Register of Interests.

### 3. Minutes of the Meetings held 2 October 2014

The minutes of the meeting held on 2 October were agreed.

**The Governing Body:**

Approved the minutes of the meeting held on 2 October 2014.

### 4. Matters Arising from the Minutes

*Better Care Fund:* MA-M advised that risk share arrangements with the local authorities were expected to be completed by March 2015 at the latest.

*Integrated Quality and Performance Report:* In respect of the symptomatic breast performance data SO reported that changes in the way GPs referred patients were being implemented, namely via the Referral Support Service so that, where appropriate, they were not subject to the two week referral performance criteria.

**The Governing Body:**

Noted the updates.

### 5. Chief Clinical Officer Report

MH presented his report which included updates on the Better Care Fund; system resilience; Strategic Plan Refresh for Year 2 – 2015/16; Primary Care Co-Commissioning; Mental Health Out of Contract Placements; CCG Senior Management Team discussions and decisions; procurement of Mental Health and Learning Disabilities Services contract; communications; and public and patient engagement.

In regard to the Better Care Fund MH reported that work was taking place with NHS England to remove the status "approved with conditions" for the City of York plan for the resubmission process in early January 2015. The plans for North Yorkshire and East Riding of Yorkshire had been "approved with support".

Meetings were taking place across the health and social care system to manage planned and unplanned care demand and work was continuing to refresh the CCG;s Strategic Plan for Year 2.

In respect of primary care co-commissioning consideration was being given to applying for delegated commissioning arrangements. The timescale for submission was 9 January 2015. Discussion with NHS England had indicated that a submission for fully delegated commissioning could be amended to joint commissioning within the process.

The CCG had agreed a non-recurrent block contract variation with Leeds and York Partnership NHS Foundation Trust for management of out of area and out of contract Mental Health placements. This would minimise these placements until 1 October 2015 when this activity would be included within the new Mental Health Tender; risk share arrangements were included. MH noted that, following a successful consultation programme, the specification for the Mental Health Tender would go out in January for provision of innovative services, potentially through a lead provider working with one or more organisations.

A successful Public and Patient Engagement Forum working with North Yorkshire Healthwatch had taken the format of asking participants to "Be the Commissioner" in simulated commissioning healthcare decision making.

In response to clarification sought by members regarding the Better Care Fund MH explained that the condition on the City of York plan related to confidence in delivery of the schemes to achieve11.7% reduction in urgent care admissions. Work was taking place with NHS England to address this concern. MH also provided additional information on the progress of the integration pilots: the Priory Medical Group scheme, started in June, was moving to its second phase and was being joined by four neighbouring practices taking coverage to 114,000 patients; work was taking place with York Teaching Hospital NHS Foundation Trust, the provider of community services, in regard to the scheme for Selby patients; and meetings were taking place to progress the City and Vale plans. TM explained that the Pocklington scheme, which related to a smaller footprint, was looking to develop the community team and to provide flexible services based on individual patient need. AM emphasised the need for regular updates on the schemes to provide assurance that the objectives were being achieved. In this regard AP referred to the aim to recruit 12 Urgent Care Practitioners highlighting that four had been in post for some time and that Yorkshire Ambulance Service had recruited a further eight from 1 December. A phased approach was being implemented for mobilisation with a view to gradually opening access to care homes, then district nursing and eventually GPs. This process would be under continual review determined by activity. Data collected since the Urgent Care Practitioners had taken up post indicated a c50% non conveyance rate and forecast achievement of reducing c1800 non elective admissions over a year. AP also explained the difference between paramedics, who were required to take a patient to hospital on receipt of a 999 call, and Urgent Care Practitioners who were able to prescribe and treat at the scene. Urgent Care Practitioners would be effectively utilised for urgent care in preference to emergency care calls to Yorkshire Ambulance Service.

In regard to the Senior Management Team decision about Student Health and subsequent discussion with the Council of Representatives, MH confirmed that the CCG recognised the specific circumstances of this service and did not envisage significant change in relation to the two practices currently providing it.

In respect of assurance sought that the Mental Health Tender would address the current issue relating to Improving Access to Psychological Therapies (IAPT), LB explained that the national requirement was achievement of access for 15% of patients who required the service with a 50% recovery rate. The Mental Health Tender comprised five specifications and had the potential for a single provider to sub contract for these areas, one of which was Primary Care and IAPT.

In response to AP reporting that there had been no acute mental health beds available in the region the previous weekend, LB referred to the contract variation described in MH's report and noted that this would provide robust evidence for the new Mental Health contract which would include responsibility for out of area placements.

In regard to "rumours" about decommissioning the Falls Prevention Service at York Teaching Hospital NHS Foundation Trust MH advised that the service was being remodelled and that the four registered nursing staff currently undertaking the assessments would be redeployed to the wider community services team. He assured members that this was a service reconfiguration that would not place patients at risk and that the services to which patients were referred wee still available.

In response to AM seeking an update on progress with improving neurology services and addressing cataract waiting times, SO reported that cataract patients were being managed through the Referral Support System but that improvement was not expected until the New Year. The Ophthalmology Services Review was taking place to identify potential efficiencies and learn from other areas. The report from this joint review with NHS Scarborough and Ryedale and NHS East Riding CCGs was expected in the New Year.

In regard to neurology SO advised that the CCG was working with York Teaching Hospital NHS Foundation Trust and Neurological Commissioning Support on service redesign that included Parkinson's Disease, Epilepsy, Motor Neurone Disease and Multiple Sclerosis. He noted that the proposals had been presented at national events and commended by the NHS England Service Lead with particular reference to the fact that they exceeded the national published standards. A detailed specification was being developed that also aimed to address historical and national issues relating to data collection and analysis. SO noted that improvements would be achieved through new specifications; implementation of this collaborative work was expected early in the new financial year.

In response to AM seeking clarification regarding improvements in provision of child psychiatry, LB reported that the capacity was at an appropriate level but that support was required for case mix. She noted that child psychiatry would be included in the new Mental Health Tender highlighting innovative work in localities by primary care mental health workers and collaborative work with Child and Adolescent Mental Health Service teams. LB emphasised the need for data collection to ensure that levels of activity were known. MA-M added that to date in 2014/15 there had been 54 new referrals, 68 children had had a first appointment, and the average wait had come down from 72 weeks to 19 weeks. At the end of October 37 children had still been waiting for assessment, with an average wait of 15 weeks. The longest wait

was 65 weeks and the three longest waiters, from the Ryedale patch, had been transferred to Socrates, who were providing additional short term capacity, for spot purchase assessment. MA-M noted the potential for further improvement in this service from this additional capacity. JL additionally highlighted the issue of student mental health in the period of transition from adolescence to adulthood.

TH noted in regard to the Better Care Fund scheme to reduce urgent care admissions that any such progress would constitute success. He commended the culture change in the collaborative work on neurological services.

AM referred to the section of MH's report on decisions and discussion by Senior Management Team and noted the need for establishment of criteria for reporting to the Governing Body.

**The Governing Body:**

1. Noted the Chief Clinical Officer Report.
2. Noted the need for establishment of criteria for reporting Senior Management Team discussions and decisions.

**6. NHS Vale of York CCG Assurance Update**

GPo referred to the CCG Quarter 1 2014/15 Assurance Report from NHS England, assessed as Assured with Support. He requested an update on the continuing work to achieve a safe and sustainable resolution to Bootham Park Hospital. MH responded that the CCG was working with Leeds and York Partnership NHS Foundation Trust, NHS Property Services Limited and English Heritage on the interim solution which was expected to be completed by July 2015. Sign off of the award of contract for the permanent solution was expected in April 2015; there were no new issues in this regard.

RP added that the report did not identify any issues that had not already been reported to the Governing Body. She highlighted recognition by the Area Team of good practice, for example the opening of the Section 136 Suite, and noted the report related to Quarter 1 therefore considerable work had taken place since the Assurance Meeting with the Area Team.

AM referred to the impact on the cancer two week wait performance target from patients who did not attend their appointment and requested information about any follow up implemented. SO advised that as far as he was aware the provider would follow up any such patient and that in the event of no response the patient would be referred back to the GP; SO would seek clarification that this was the case. The referral process did include a leaflet for patients referred for potential cancer but the provider performance was monitored on the two week waiting time and the patient may not be aware of this.

**The Governing Body:**

1. Noted the Quarter 1 2014/15 Assurance Report from the NHS England North Yorkshire and Humber Area Team.
2. Requested that SO seek further information regarding follow up of cancer patients who did not attend their appointment.

## 7. Integrated Quality and Performance Report

In presenting this item JM noted that it was an Exceptions Report and highlighted issues of performance which were being addressed in part by the main provider sub contracting to other organisations. In response to JM seeking assurance of quality of the sub contractors MC advised that performance was closely monitored through discussion with providers and quality assurance was sought when services were outsourced for purposes of meeting targets.

JM referred to the forecast achievement by Yorkshire Ambulance Service of 75% for the Red Combined Response Time target by January 2015 noting that the local position was improving but this was not the case regionally. MC reported that this performance was monitored through the Urgent Care Working Group. AP reiterated that the Urgent Care Working Group regularly sought assurance from Yorkshire Ambulance Service and noted the additional challenge due to the CCG not being the lead commissioner for the contract. In this regard KR enquired as to whether there were any contractual mechanisms that the CCG could invoke to address concerns about this longstanding performance issue. MA-M explained that as an associate to the contract the CCG had equal leverage and noted strength in the collaborative approach. He also highlighted that performance across the Vale of York had improved through local initiatives.

JM commended improvement in the 15 minute ambulance handover performance but expressed concern at the impact of the poor performance, due to bed capacity issues at Scarborough District Hospital, on overall performance against this target.

In response to JM's concern about A and E performance due to shortage of consultants MC advised that assurance was sought via the Contract Management Board. She noted that York Teaching Hospital NHS Foundation Trust was undertaking a variety of approaches to recruitment to address this but that they were hard posts to recruit to. AP added that there had been a considerable increase, from 50,000 to 80,000, in attendances for "minors" which the System Resilience Group was addressing through requesting support from GPs in this area of work. He also noted that the CCG was working with York Teaching Hospital NHS Foundation Trust to address issues of safety and quality but highlighted that the CCG could not be involved in their recruitment.

In regard to vacancies for theatre nurses in cystoscopy MC explained that this was a national issue but that recruitment had taken place and York Teaching Hospital NHS Foundation Trust had confirmed that there would be improved performance by January 2015. In respect of the CT scanner that was currently out of use MC confirmed that extra capacity was in place to address this.

JM referred to referral to treatment, specifically pertaining to cancer and the impact on primary care of breast referrals being sent via the Referral Support Service. SO referred to the earlier discussion in this regard and advised that a GP Reviewer would consider referrals for appropriateness for secondary care as not all breast pain required this course of action.

JM sought clarification regarding the NHS England Enhanced Service relating to skin cancer referrals. SO responded that minor surgery was a historical issue and noted that consideration was being given to improving minor surgery in primary care. Consideration was also being given to commissioning a biopsy service. TM added that primary care co-commissioning would provide opportunities, for example the potential to develop a full dermatology pathway.

In response to GPo enquiring whether migrants had an impact on A and E four hour performance, AP advised that no such data was currently available.

SO referred to the 68 patients who had waited more than six weeks for non obstetric ultrasound, and those waiting for CT or MRI scans and reported on discussion at the Council of Representatives to ensure that all GPs were aware of an alternative provider where there was a two week turnaround and availability of additional capacity. He also noted that the current scan reporting timescales, up to six weeks, by the main provider were of concern. MC advised that consideration was being given to improving this through introduction of a Commissioning for Quality and Innovation scheme.

In response to AM's enquiry regarding GP access to the Integrated Clinical Environment (ICE) system, SO advised that complexities with the software were causing delay; work was taking place to carry out the necessary testing. Further discussion ensued regarding potential metrics for A and E performance and developments in place to support the four hour target, including additional consultant staff, facilitated discharge through the system resilience work, admission avoidance, for example through Arclight, Patient Transport, and seven day a week social care.

TH referred to concerns relating to Mental Health Services in Ryedale which were provided by Tees, Esk and Wear Valleys NHS Foundation Trust and sought information on improving the position. LB explained that Tees, Esk and Wear Valleys NHS Foundation Trust had taken over these services from 1 July 2014 when they had notified commissioners that for the first three months performance in terms of outcomes and accessibility would be poor. LB advised that performance was improving and access had doubled to 4.8%. She also noted that Tees, Esk and Wear Valleys NHS Foundation Trust had expressed confidence that the 15% access and 50% recovery targets would be achieved by March 2015. In regard to Leeds and York NHS Partnership Foundation Trust LB referred to the £250k additional non-recurrent funding provided in 2014/15, their role as broker with the voluntary sector to provide patient choice, and the recruitment of high and low intensity workers. She noted the need to communicate these measures to GPs to increase activity and achieve at least the national target of 15% access.

In regard to the temporary closure of Worsley Court, Selby, MC advised that the reopening had been deferred to 15 January 2015 due to further requirement for staff training and supervision.

**The Governing Body:**

Noted the Integrated Quality and Performance Report.

## 8. Finance, Activity and QIPP Report

DB presented the Finance, Activity and QIPP report as at 31 October, month 7, which included detail of allocations, programme costs, running costs, QIPP schemes, risk, and working capital. He noted that the overall programme allocation of £375.6m included the return of the 2013/14 surplus with a further £8.3m for running costs giving a total of £383.9m and recognised achievement of the year to date £1.2m surplus. There was an overall over spend on programme costs which was off-set by an under spend on running costs, maintaining delivery of the forecast £2.1m surplus. These figures included best estimates of any new services to be commissioned. DB additionally noted the process for the CCG's overall management of resources and identification of initiatives, including QIPP, for the next year.

DB highlighted the £712k pressure in programme costs that was off-set by £508k underspend in running costs noting the risk to future predictions. He referred to the £10m difference between the best and worst case risk scenarios noting the contingencies which had increased overall from a probable value of £3.58m to £4.37m and also highlighted the CCG's approach of working with providers who had not met targets rather than imposing penalties.

In response to DB seeking clarification regarding the areas of over spend on programmes, MA-M advised that this related to an issue of c£900k brought forward from 2013/14 year-end agreements with a number of providers. These had now all been resolved. In regard to York Teaching Hospital NHS Foundation Trust this related to planned care capacity issues which were off-set by activity at Ramsay Healthcare, contract variations relating to mental health out of contract placements, and overspends of c£600k each for continuing healthcare, funded nursing care and prescribing.

DB referred to the contingency measures and expressed concern that they would be insufficient in the event of a bad winter or unforeseen financial impact, such as ebola. MA-M explained that the activity plans were profiled to take account of winter and that additional system resilience funding schemes aimed to accommodate unforeseen peak demand. He also noted that, depending on the nature of the pressure, there was the potential for national funding.

In regard to the under trade with York Teaching Hospital NHS Foundation Trust MA-M clarified that this was not included in the forecast as the planned activity was being provided at Ramsay Healthcare. The overall CCG Orthopaedics plan had been correct but there was acknowledgement that activity may require moving between providers. He also noted that the coding changes that had been implemented by the Trust had not materialised to the levels anticipated over the first half of the year, but that these areas of underspend were expected to return to planned levels for the remainder of the year.

In response to JM's concern about the impact of recruitment and performance issues, MC noted that York Teaching Hospital NHS Foundation Trust was not unique in this regard. She noted the impact on services of acute admissions and delayed transfers of care advising that mitigation was in place as far as possible.

KR referred to the over trade with providers and sought assurance for purposes of planning future contracts. MA-M advised that overall the CCG capacity was correct but that consideration may be required in regard to providers of the activity. He also noted that some of the current pressures were a result of issues from 2013/14. MA-M added that a number of baseline allocation issues had been corrected and robust contingencies had been identified. He also highlighted that the current financial position, which took account of the potential to commission IVF, was more certain than earlier in the year.

PE noted that the City and Vale integration scheme had been omitted from the report and sought clarification on the General Practice Improvement Programme. MA-M apologised for omitting the former and in regard to the latter TM described the work to improve capacity in primary care which had initially taken place with four practices through an independent assessment process. The intention was to extend this to all practices through a rolling programme; 12 practices had signed up to date.

AM referred to the Autumn Statement and highlighted the importance of delivering QIPP in view of forthcoming national pressures the NHS could expect.

**The Governing Body:**

Noted the Finance, Activity and QIPP Report.

**9. Access to Infertility Treatment: Commissioning Policy**

TM referred to the Access to Infertility Treatment: Commissioning Policy which included four appendices: Access Criteria, NHS Vale of York CCG Access to Infertility Treatment: Commissioning Policy Document. Draft Referral Form and Equality Impact Analysis. He noted that the policy was presented following a review of the CCG's financial position which was more certain than when the proposal to commission IVF had been previously considered in August 2014. Additionally further analysis had been undertaken using local CCGs' activity. TM commended the work undertaken to produce the documentation and noted that if the decision to make one cycle of IVF treatment available to eligible couples was ratified a communication would be issued immediately to GP practices detailing the criteria and process.

EB noted that the proposal had been discussed with and supported by the Council of Representatives when MA-M had provided a financial update and described the potential backlog of requests. PE additionally confirmed that MA-M had provided evidence to the Council of Representatives to support their decision.

DB highlighted the current position of being the only CCG in the UK not to provide any IVF from the equalities perspective and commended the work undertaken to reach the position proposed.

EB confirmed that if the Governing Body ratified the Council of Representative's decision the policy would take effect immediately for eligible couples. She also confirmed that the tertiary care providers were aware of the potential policy change.

**The Governing Body:**

1. Ratified the decision of the Council of Representatives to recommence the commissioning of in-vitro fertilisation.
2. Adopted the Access to Infertility Treatment: Commissioning Policy Document.
3. Agreed implementation with immediate effect.

## 10. Commissioning an Alternative Anti-VEGF Service

AP presented the report which sought approval for a business case proposal regarding planned care treatment for Age Related Macular Degeneration (AMD) and specifically to encourage a bevacizumab (avastin) only (or first) service for patients with AMD to replace the currently used and vastly more expensive ranibizumab (lucentis) for this condition. AP described the impact of AMD on patients, the history of licensing of ranibizumab and therefore the requirement for ophthalmologists to use it in accordance with General Medical Council (GMC) guidelines as set out in the report, and the comparative costs of ranibizumab, the licensed AMD drug, against the unlicensed for AMD bevacizumab. There was reliable, independent evidence, the most recent being the Cochrane Review in September 2014, providing assurance that both drugs were equally effective and safe therefore the outstanding issue remained the fact that bevacizumab, licensed for treatment of breast and bowel cancer, was not licensed for AMD.

AP highlighted that a change to using bevacizumab could release c£4m with which the CCG could commission innovative services. To put this in context AP noted that the savings achieved through such a switch equated to almost a full year of community nursing, six months of a full A and E service at York Hospital, and 5,000 cataract operations. In addition to this issue being considered at a local level AP noted that consideration was taking place both nationally and internationally.

Detailed discussion included:

- Clarification that NICE would only undertake a Technical Appraisal with the support of the company producing the drug and it would take two years; bevacizumab and ranibizumab were made by the same company.
- Once a license for a drug was applied for and granted, clinicians were obliged to stop using drugs that were off licence for the same condition.
- Concern about the c£4m NHS resources that could be utilised more effectively. GPs reported in this context that a number of patients were expressing a wish to be treated with bevacizumab due to the difference in cost to the NHS.
- Patients receiving treatment privately were able to choose bevacizumab. The GMC should therefore explain why only the licensed alternative was permitted on the NHS, particularly as this was a contradiction to the GMC requirement of ensuring best use of NHS resources.
- The potential for the drug company to show compassion and an understanding of the NHS through seeking a licence for bevacizumab, the drug of choice for AMD in America.
- Recognition of the value of the benefits of licensing drugs as a form of regulation and protection for clinicians in respect of personal liability but in light of the

evidence that bevacizumab and ranibizumab were equally safe and effective a review should take place of the current position.
- Recognition of risk of potential litigation under the current regulations if commissioning of the unlicensed bevacizumab was implemented.
- Recognition that a move to the unlicensed drug may impact on the drug company's research and development.
- Acknowledgement that GPs often use unlicensed drugs in for example prescribing for pain relief.

MH additionally reported that the York Blind and Partially Sighted Society had put him in contact with the Macular Degeneration Society who supported the proposed change or that bevacizumab and ranibizumab should be on an equal footing with the proviso that NICE and/or the GMC changed their position. He also highlighted the opportunity for the CCG to take a proactive approach in seeking support for the change.

In regard to consideration of further action AM advised that he had written to the Competition Commission requesting review of the current position relating to bevacizumab and ranibizumab. MH referred to the proposal for an open letter to be issued, either alone or with other CCGs, to the General Medical Council calling for a change in the guidance around the prescribing of "unlicensed medicines" in order to allow clinicians to comply with paragraph 18 of Good Medical Practice which stated "You must make good use of the resources available to you".

**The Governing Body:**

1. Acknowledged the opportunity cost of continuing with the current commissioning policy for Anti-VEGF agents.
2. Approved the preparation of a business case to fully assess the implications of a "Bevacizumab First" commissioning policy to commence in April 2015.
3. Agreed that an open letter be issued, either alone or with other CCGs, to the General Medical Council calling for a change in the guidance around the prescribing of "unlicensed medicines" in order to allow clinicians to comply with paragraph 18 of Good Medical Practice which states "You must make good use of the resources available to you".
4. Agreed that an open letter be issued, either alone or with other CCGs, to the National Institute for Clinical Excellence calling for the licensing of bevacizumab or the unlicensing of ranibizumab so that both drugs were on an equal footing.

**11. NHS Vale of York CCG Review and Refresh of the Constitution**

EB referred to the list of proposed amendments to the CCG's Constitution which were currently under consultation. She noted that these had been supported by the Council of Representatives.

RP added that the CCG's decision on primary care co-commissioning would require incorporating into the revised Constitution.

In response to JL seeking clarification about the North Yorkshire Local Medical Committee role on the Governing Body, MH confirmed that this was a co-opted position with NHS Vale of York CCG although recognising that for other CCGs it was a full member position.

**The Governing Body:**

Noted the Constitution consultation process, proposed changes to the Constitution, and the potential for further changes pending the outcome of the consultation process.

## 12. Audit Committee Annual Report 2013/14

KR presented the Audit Committee Annual Report for the CCG's first year as a statutory body. He noted continuing improvement and ambitious plans for Year 2 following the initial year when there had been significant pressures and inherited issues. The Head of Internal Audit Opinion of Significant Assurance for 2013/14 had been welcomed although a number of weaknesses, including QIPP and inherited problems, had been recognised. KR commended the report and highlighted improvements to the CCG's control framework and assurances obtained and communicated to the Governing Body through the Audit Committee's activity.

In regard to audits that had received Limited Assurance, MA-M reported that the Payroll Verification audit had been revised to Significant Assurance, noting ongoing improvements and tendering of the CCG's payroll provider; specific reports had been requested from Internal Audit in respect of the Partnership Commissioning Unit where, despite progress, further issues had been identified. In regard to the latter progress was routinely monitored by the Quality and Finance Committee.

**The Governing Body:**

Received the Audit Committee Annual Report 2013/14.

## 13. Emergency Preparedness, Resilience and Response - NHS Vale of York CCG Arrangements

SO presented the Emergency Preparedness, Resilience and Response Policy and On-Call Policy which detailed the local arrangements. He highlighted that Senior Managers had undertaken a full day's training and that a desk top exercise was being planned to test the arrangements. The CCG had assessed itself overall as "Green" in relation to compliance with the NHS core standards for Emergency Preparedness, Resilience and Response.

RP reiterated that the training had been attended by herself, MH, MA-M and AP and highlighted the Action Cards which defined the respective roles in the event of an emergency; "flash cards" were also being developed for such an event. Additionally, the on-call arrangements were more robust than previously and consideration was being given to a pager replacing mobile phones.

In response to AM seeking clarification about the Director of Public Health role in terms of resilience GvD reported that City of York Council would be considering a proposed restructure including this role in the New Year.

SB noted a potential role for voluntary organisations depending on the nature of the emergency and DB sought clarification about the Lay Members' role. In regard to the latter RP advised that Lay Members would be kept informed of the on-call rota arrangements and could attend the subsequent debrief if they so wished.

**The Governing Body:**

1. Approved the CCG's arrangements for Emergency Preparedness, Resilience and Response.
2. Noted the CCG's Emergency Preparedness, Resilience and Response Assurance Self-Assessment for 2014/15 and current Compliance Level.

## 14. Policy for the Reporting and Management of Patient Complaints

SO referred to the policy which had been updated in response to the newly established Patient Experience function within the CCG and which was responsible for managing and handling all CCG complaints. He commended the work to formalise the structure and highlighted that the CCG listened to comments and complaints noting their influence on policy where appropriate.

SO additionally noted that the Governing Body would receive summaries of complaints.

SB sought and received assurance that a "user friendly" version of the policy would be available for the public.

**The Governing Body:**

Approved the Policy for the Reporting and Management of Patient Complaints.

## 15. NHS Vale of York CCG Audit Committee

**The Governing Body:**

Received the minutes of the Audit Committee of 10 September 2014.

## 16. NHS Vale of York CCG Quality and Finance Committee

**The Governing Body:**

Received the minutes of the Quality and Finance Committee of 18 September, 23 October and 20 November 20.14

## 17. Medicines Commissioning Committee

**The Governing Body:**

Received the minutes and recommendations of the Medicines Commissioning Committee of 17 September and the recommendations of 14 October 2014.

## 18. Next Meeting

**The Governing Body:**

Noted that the next meeting was on 5 February 2015 at 10am at West Offices, Station Rise, York YO1 6GA.

## 19. Exclusion of Press and Public

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it was considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted.

## 20. 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 4 DECEMBER 2014 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

| Meeting Date | Item | Description | Director/Person Responsible | Action completed due to be completed (as applicable) |
|---|---|---|---|---|
| 7 August 2014 | Matters Arising:<br>QIPP Update | • Meetings with Lay Members of provider organisations to be progressed | AM/KR | |
| 2 October 2014 | Referral Support Service Progress Report | • Evaluation of Stop Before Your Op to be discussed | EB/JH | |
| 4 December 2014 | Chief Clinical Officer Report | • Criteria to be established for reporting Senior Management Team discussions and decisions to the Governing Body | MH/RP | 5 February 2015 meeting |
| 4 December 2014 | NHS Vale of York CCG Assurance Update | • Information regarding follow up of cancer patients who did not attend their appointment to be sought | SO | 5 February 2015 meeting |