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 5 February 2015 at West Offices, Station Rise, York YO1 6GA

Present

Mr Keith Ramsay (KR) - Chair	Deputy Chair and Audit Committee Chair
Mr Michael Ash-McMahon (MA-M)	Interim Chief Finance Officer
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 (TH)	GP, Council of Representatives Member
Dr Tim Maycock (TM)	GP 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

In Attendance (Non Voting)

Miss Siân Balsom (SB)	Manager, Healthwatch York
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

Professor Alan Maynard (AM)	Chair
Dr Louise Barker (LB)	GP Member
Ms Kersten England (KE)	Chief Executive, City of York Council

Twenty one members of the public were in attendance.

The following matter was raised in the public questions allotted time:

Chris Mangham

Some people referred for counselling or mental health issues are taking up to two years before receiving counselling. When the CCG commissions new services for mental health issues how long do they think it will take before patients can receive counselling, let's say two months after being referred?

MH responded that the CCG was currently out to tender for mental health and learning disability services with the expectation that the new contract holder would deliver at least the required 15% access to psychological therapies with a 50% rate of recovery. The provider would be expected to deliver access for 75% of people within 6 weeks and 95% within 18 weeks, a significant improvement on the current performance. Return of the completed tender documents with evidence of how this would be achieved was keenly awaited.

In response to Chris Mangham expressing concern about the remaining 5% of referrals, MH advised that the performance targets described were the same as those for physical procedure waiting times and that the maximum waiting time was 52 weeks, however a wait of this length was unacceptable.

Julie Nichol, Chief Executive Officer, Scarborough, Whitby and Ryedale MIND

To what extent is NHS Vale of York CCG intending to engage with the Voluntary and Community Sector in Ryedale to provide services attached to the CCG surgeries in the area?

AP responded that the CCG had been meeting with Healthwatch in York and North Yorkshire and that a number of engagement events had been held with the CVS over the past 12 months for the voluntary and community sector. The next event was a Commissioning and Development Workshop on the afternoon of 12 February at Priory Street Centre. The focus of these events had been on how the CCG could communicate more effectively, engage and work together in all areas to co-design support for people in their communities to enable them to be supported closer to home.

The CCG had taken the opportunity at these events to share current developments and provide updates on the work of the "hub" pilots and to gather ideas and opinions from providers on what types of support they could develop locally. The "hub" model, currently being piloted with some surgeries through the Better Care Fund, was a model of integration and collaboration around the individual that included all sectors. Greater involvement from the voluntary and community sector was key to improving support provided to individuals, their families and carers.

Some projects were not initiated by the CCG but information was shared about these events and the CCG routinely sent invitations and flyers to Coast and Vale Community Action (CaVCA) which had developed from Ryedale Voluntary Action. AP noted that, as a GP in Ryedale, he had in the past worked with this organisation.

Voluntary sector organisations holding contracts with the CCG specific to Ryedale included Ryedale Carers Support Scheme, the Carers Resource, Ryedale Older People's Forum and Ryedale Voluntary Action. The engagement plan developed by the CCG for the community services procurement aimed to hold conversations in local communities and arrange meetings with interested voluntary groups.

AP referred to meetings in Harrogate and Scarborough which brought together the voluntary sector and primary care to share information and opportunities for greater collaboration noting the potential for a similar initiative, particularly in terms of voluntary sector schemes that required pump priming.

AP highlighted recent engagement events on integrated care that were opening the discussion about what out of hospital community care should look like. The voluntary sector had been included in these invitations. In a similar approach the *DISCOVER* programme had invited all stakeholders, including the voluntary sector, to take part in shaping mental health provision in the area.

The CCG had strongly stated its commitment to support people closer to home and hoped to achieve this by working closely with the voluntary sector, local authority partners and other stakeholders. Over the next 12 months contractual models would be developed that clearly reflected the local needs of the population with demonstration of effective outcomes for individuals.

S**inead Willis**

Could a Mother and Baby Unit be included in the plans for a new mental health building in York? I am aware that NHS England are responsible for funding Mother and Baby Units, but is it not possible to ask NHS England for funding for a Mother and Baby Unit as well as funding for a new building? It would make sense for it to be in the same building.

EB expressed appreciation to Sinead for describing her personal journey when submitting her question and noted that such information helped to inform strategy development. EB advised that she sat on the Maternity Strategy Network and that guidance was expected to inform strategy moving forward.

Perinatal mental health services were included in consideration of the current mental health and learning disability services tender process. There were historic reasons in York why the specialist mother and baby unit was separate. However perinatal health was being considered in policy development and patient views would be sought through forums such as the *DISCOVER* programme.

Bob Towner, Chair York Older People's Assembly

Question 1

The importance of prevention work to sustain and improve health and wellbeing is a cornerstone of CCG and Health and Wellbeing strategies in York.

In what way does the axing of the dedicated falls prevention service contribute to these strategies?
What are the cost savings arising from this decision?
What message does this action send out to the public of York?

RP emphasised that the falls service and falls prevention was a high priority for the CCG. The service had been remodelled jointly with York Teaching Hospital NHS Foundation Trust and had been incorporated in the generic community nursing team. This decision had been based on evidence from the Scarborough locality that the remodelled integrated service delivered the same benefits to patients in a more effective way and was in line with the consistent request from the community for joined up services. RP reiterated that the service had not been axed.

In regard to cost savings MA-M explained that £200k of funding had been released. This had been reinvested in the community services contract held by York Teaching Hospital NHS Foundation Trust.

Question 2

Members of the Governing Body will be aware of the recent statement from Professor Bruce Keogh medical director of NHS England that if the NHS continues to function as it does now it will not be fit for the future.

He further states that assistive technology will have a vital role to play in securing the future of the NHS and in preventing unnecessary admissions to hospital.

In the light of the disturbing performance reports at agenda item 6 will the CCG reconsider its previous decision to reject the use of "Telemedicine" in preventing avoidable hospital admissions particularly of older people.

RP responded that assisted technology in its widest sense was part of the CCG's plans for integrated community services and that all elements were included in discussion with local authorities for developing new models of community care. She noted that the decision by the former NHS North Yorkshire and York had related specifically to telehealth and emphasised that telemedicine was being considered for future provision.

Anne Leonard on behalf of Defend our NHS York

What has been the response of the CCG to concerns that have recently been made public about the integrity of the Yorkshire ambulance service?

MH responded that Yorkshire Ambulance Service had received approximately 25 complaints alleging racial discrimination in its recruitment practices but refuted these complaints. Nevertheless there was an acceptance that minority ethnic representation amongst its workforce was lower than desirable.

The majority of complaints received had referred to a recruitment process for Urgent Care Practitioners that was conducted towards the end of September. As part of that process 158 applications were received, five of which were from minority ethnic applicants. Two of those minority ethnic applicants were shortlisted but, unfortunately, neither was deemed suitable for the post.

Concerns are about:

- *Care Assistants being sent to deal with emergencies without qualified paramedics*

Yorkshire Ambulance Service had advised that Emergency Care Assistants did not pair up under any circumstances and always worked supervised. The senior clinician held the clinical responsibility; the Emergency Care Assistant role was to provide them with assistance.

- *Changes to documentation about emergency attendances so as to appear to meet targets*

The Care Quality Commission had reviewed the coding of calls by Yorkshire Ambulance Service due to concerns raised with them. No concerns were raised following this review.

- *Concerns over the accuracy of accounts*
- *The penalisation of those members of staff who have raised these issues*

While appreciating that the CCG has no formal authority over the Yorkshire Ambulance Service, the risks to the population of the Vale of York (and the rest of Yorkshire) that ensue from such practices (if proven) must be the concern of the CCG, especially in your role as commissioners of the service and therefore warrant a response. Hence the question from Defend our NHS York.

The CCG was unable to comment on the final two bullet points.

MH noted that diary commitments had not yet permitted arrangements but he would be available for a meeting with Unite both locally and nationally.

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 on 4 December 2014

The minutes of the meeting held on 4 December were agreed, subject to the amendment that Siân Balsom had been in attendance.

The Governing Body:

Approved the minutes of the meeting held on 4 December 2014, subject to the above amendment.

4. Matters Arising from the Minutes

Chief Clinical Officer Report: KR referred to clarification sought from AM about the City of York Better Care Fund condition relating to confidence in delivery of the schemes to achieve 11.7% reduction in urgent care admissions. MH advised that the CCG expected this condition to be removed following discussion with York Teaching Hospital NHS Foundation Trust.

Integrated Quality and Performance Report: In respect of the Integrated Clinical Environment (ICE) SO reported that York Teaching Hospital NHS Foundation Trust had experienced difficulties in implementing this across the community in the CCG area. The company was working on test solutions to address the issues relating to ICE not allow two systems of inputting and the CCG was engaged in discussions with York Teaching Hospital NHS Foundation Trust. SO noted disappointment that ICE had not yet been implemented and advised that there were consequently significant associated programme costs that could not be saved without this. In response to GPo advising that ICE was widely used SO requested that he email any information that may assist a resolution.

Commissioning an Alternative Anti-VEGF Service: MH reported that discussions were currently taking place with NHS Clinical Commissioners and the Secretary of State.

CCG Lay Members meeting with Lay Members of provider organisations: KR reported that this had been completed.

Evaluation of Stop Before Your Op: EB reported that she was working on an evaluation process with Julie Hotchkiss, Acting Director of Public Health at City of York Council.

Criteria for reporting Senior Management Team discussions and decisions to the Governing Body: RP reported that, following a review of the CCG's Scheme of Delegation, Senior Management Team meeting notes were now being circulated to the Lay Members for information. Any items requiring a decision would be presented separately as appropriate.

Follow up of cancer patients who did not attend (DNA) their appointment: SO reported that data received indicated a low number of DNAs with a rate of c1% in most specialties except dermatology which was c2.5%. The latter was expected to reduce in view of work taking place in this specialty. The York Teaching Hospital NHS Foundation Trust follow up policy regarding DNAs for patients with suspected cancer was to offer a second appointment. In the event of a second DNA patients would be referred back to their GP to check the need for an urgent appointment.

Post meeting note: SO circulated to members York Teaching Hospital NHS Foundation Trust's DNA of first appointment following referral policy.

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; primary care co-commissioning; the new CCG Assurance Framework for 2015/16; Strategic Planning – Operational Plan for 2015/16; proposed changes to the CCG Constitution; pioneering through partnerships; application to become a Vanguard site – New Models of Care; changes to Governing Body membership; Mental Health Services; communications; and public and patient engagement.

In regard to the Better Care Fund MH referred to the discussion at item 4 above welcoming the progress that had led to the expectation of the removal of the condition from the City of York plan.

MH noted that the system resilience planning had enabled York Hospital to manage the pressures comparatively well during the recent national challenges across A and E services. He expressed appreciation to all staff – hospital, primary care, social care and Yorkshire Ambulance Service – for their work during this difficult period.

MH highlighted the recent announcement that the CCG, already one of six national pilots for New Models of Care, was now also one of eleven Wave 2 Pioneer sites and was, with partner organisations, in the process of preparing an application to become a Vanguard site; submission of an expression of interest was required by 9 February. Success would potentially provide access to the £200m transformation fund and £250m available to improve primary care.

In terms of changes to Governing Body membership MH paid tribute to John McEvoy's contribution to the CCG's work and to Lucy Botting who, as a local councillor in Surrey, was seeking a new post in the south. Processes were ongoing to appoint replacement members.

MH expressed regret that, due to illness, AM had not been able to be present at the meeting which would have been his last in public as Chair of the CCG. MH wished to record particular appreciation to AM who had been with the organisation since 2011 through being a General Practice Commissioning Consortium to establishment as a CCG. MH commended AM's ethos and evidence based approach as foundations of the CCG.

In regard to the Mental Health Services procurement MH advised that a fair and transparent process was taking place. To avoid prejudice members would not know which organisation had been awarded the contract until the decision had been approved.

KR, on behalf of the Governing Body, endorsed MH's comments about AM and wished him good health.

In response to DB seeking clarification of how the new models of care successes and applications for primary care co-commissioning and to become a Vanguard site related to the CCG's overall plan and potential impact on staff capacity, MH advised that all the bids were in accord with the CCG's Five Year Plan. He acknowledged that the forthcoming 10% reduction in running costs posed a challenge and noted that no additional resource would accompany primary care co-commissioning. Workforce recruitment and retention was a concern but if the Vanguard bid was successful there would be the potential to create jobs and career structures. MH additionally noted that the integration pilots were establishing generic workers.

In respect of evaluation of the integration pilots and Better Care Fund Schemes MH advised that all possible data was being collected but that this was a concern due to paucity of availability. Part of the Vanguard bid was for real time data collection which would be shared across the health and social care system.

The Governing Body:

Noted the Chief Clinical Officer Report.

6. Integrated Quality and Performance Exception Report

AP presented the report which provided information as at January 2015 in respect of unplanned care, planned care and mental health, and included a special report on the 2014/15 Christmas and New Year period at York Hospital. He noted that, in addition to the exceptions detailed, he would inform members of positive aspects of performance and reported that the CCG had provided support to York Hospital on 5 January when there had been particular pressure across the system as all hospitals around York had been on red alert.

AP highlighted the impact on unplanned care of the increased activity in the system during the Christmas and New Year period noting that the Yorkshire Ambulance Service CCG area Red Combined performance, reported at 71.5% for December against the 75% target, was currently 75.2%. In regard to the 8 and 19 minute response times, which had not been met, AP explained that in terms of quality measures Yorkshire Ambulance Service performed well and cited a number of

examples: the survival to discharge measure was 8.5% for England and 15.4% for the CCG area; a number of stroke targets were above the national target, as were heart attack measures. Performance against the 8 minute target was met at 9 minutes and the 19 minute target was met in 22 minutes. This was in the context of demand which had increased by 19.8% since 2012.

In respect of 12 hour breaches in A and E AP reported that new guidance had been issued by the Department of Health which required root cause analysis to take place within 48 hours. He noted that, in addition to the two reported, there had been five breaches on 5 January when Scarborough Hospital had declared a MAJAX. AP confirmed that all the breaches had been investigated and that assurance in terms of care and safety had been received; apologies had been sent to the patients affected.

In terms of planned care, diagnostic waiting times had been affected by both the unavailability of one CT scanner due to scheduled maintenance and the increased activity during December; the latter had also affected capacity for the 18 week referral to treatment pathway. In this regard performance was also being affected by recruitment issues, particularly shortage of nurses and theatre staff. MC noted that recruitment was a national issue and that discussions were taking place about nurse training to increase numbers and look at different roles.

AP noted impact on skin cancer two week waits from a public campaign which had resulted in an increase in activity through primary care. A newly appointed consultant would focus on the 14 week skin cancer referrals as a priority.

AP highlighted successful partnership working to address the impact of delayed transfers of care noting the expectation that the national requirement for a reduction of 25% in two weeks and 50% in four weeks, i.e. from 21 January to 18 February, would be achieved.

In regard to Improving Access to Psychological Therapies Leeds and York Partnership NHS Foundation Trust was forecasting achievement of the 8% target by 31 March 2015 but was not expected to meet this in quarter 3; staff had been recruited from January 2015.

SO referred to the two week wait for suspected skin cancer noting capacity issues due to increased demand. He advised that it would be helpful if GPs submitted photographs of lesions with referrals, an approach supported by dermatologists. The Referral Support Service had also requested this and offered guidance but only c10% of dermatology referrals were accompanied by a photograph. In response to SO's request for support in progressing this practice, TH and JL agreed to discuss it respectively with the Council of Representatives and Local Medical Committee.

TH referred to the fact that the report presented related to exceptions and recognised that recruitment, retention and staff morale were issues. However he highlighted that it was important to recognise and learn from the positive aspects of the system noting that patients were receiving good quality care. In response to TH's proposal that a proactive approach be pursued to reducing admissions TM referred to enhanced services from which coding could be utilised to identify patient admissions

history to inform learning. AP additionally noted the Urgent Care Practitioner role in reducing non elective activity for which robust data was not currently available and that awareness of potential double counting was required.

DB referred to the issue of capacity in regard to delayed transfers of care. GvD and RW expressed appreciation to staff across health and social care and the voluntary and independent sectors for their support in creating flexibility within the system. Discussions were taking place across the region about workforce issues and development of generic roles to provide flexibility. Additionally, not all delayed transfers of care were due to the need for social care input; SB further noted the role of the public in making the right choice.

Members remarked that the forthcoming Easter weekend coincided with the start of the new out of hours provider contract. The need to learn from the Christmas and New Year pressures in the system was highlighted in terms of GPs providing support to A and E at such times. In this regard AP also noted the potential for consideration to extending primary care schemes that had demonstrated an impact.

KR reiterated the need for qualitative outcomes to be incorporated in the report and for patients to be reassured regarding the performance against national averages.

The Governing Body:

1. Noted the Integrated Quality and Performance Exception Report.
2. Requested that consideration be given to the format so that qualitative outcomes were also reported.

7. Finance, Activity and QIPP Report

In presenting the Finance, Activity and QIPP report as at 31 December 2014, month 9, SO commended the CCG's achievement in progressing from inherited debt to the current forecast delivery of £2.9m surplus. He highlighted the reallocation of £888k provision to the CCG from the historic continuing healthcare legacy risk pool due to underutilisation in 2014/15.

In regard to programme costs SO noted the increase of c£0.25m due to activity with Yorkshire Ambulance Service, Ramsay and Nuffield Hospitals and a number of other private providers. This was balanced by an underspend at York Teaching Hospital NHS Foundation Trust due in part to cancellation of elective procedures.

An overspend on mental health services due to an increase in out of contract placements was being mitigated by Leeds and York Partnership NHS Foundation Trust, as previously reported; work was taking place to bring patients closer to home. There was also a slight overspend on the community services contract. Primary care budgets continued to underspend but SO noted that for the current year these were based on realistic planning.

In regard to the Quality, Innovation Productivity and Prevention (QIPP) programme SO noted that further consideration of reporting was required to provide enhanced information. In terms of the 'red amber green' rating SO advised that prescribing

should not be ‘green’ as it was not expected to deliver in year. He also explained that, due to their complexity, the deep vein thrombosis pathway and dressings project were taking longer than anticipated and were not expected to achieve savings in the current year.

SO noted that the risk in respect of best and worst case scenarios had reduced due to the increased forecast surplus and commended delivery of the overall target cumulatively for payment to NHS creditors.

MA-M explained that the increase in planned surplus emanating from the continuing healthcare legacy was a national issue and that every CCG was mandated to increase their surplus by the corresponding amount.

In respect of the underspend with York Teaching Hospital NHS Foundation Trust MA-M noted that this was in part offset by the significant overtrade with Ramsay and Nuffield Hospitals. This provided assurance about orthopaedic capacity within the overall CCG economy.

MA-M advised that, in recognition of QIPP slippage, non recurrent contingencies had been released and this had been built into the planning for 2015/16 schemes. Prescribing discrepancies related, in part, to the two month delay in data availability.

MA-M reported that discussions were taking place with York Teaching Hospital NHS Foundation Trust to hopefully agree a year end position. These were taking account of the national payment mechanism which meant that York Teaching Hospital NHS Foundation Trust carried the pressure from cancellation of planned activity to cope with the urgent demand.

The Governing Body:

Noted the Finance, Activity and QIPP Report.

8. Updated Audit Committee Terms of Reference and Work Plan

KR referred to the Audit Committee Terms of Reference and Work Plan which had been reviewed and updated to ensure they remained accurate and relevant, including in respect of the recent guidance published within the NHS Audit Committee Handbook. KR noted an inconsistency in regard to the quorum in the changes listed on the template and as detailed in the terms of reference.

Post meeting note: The quorum for the Committee within the terms of reference was correct, namely two members with a Chief Officer in attendance.

The Governing Body:

Approved the updated Audit Committee Terms of Reference and Work Plan.

9. Quality and Finance Committee Terms of Reference

In presenting this item DB reported that the Quality and Finance Committee had reviewed and approved the proposed changes to its terms of reference on 22 January. He highlighted that the changes would ensure an integrated approach in terms of audit and quality assurance and noted the potential for further amendments in respect of primary care co-commissioning. DB also highlighted the addition of procurement advising that the Chair of the Audit Committee would be invited to attend for this item.

Members discussed CCG GP Clinical Leads membership of the Committee, reduced from three to two to maximise use of their expertise within the organisation. Whilst recognising the need to prioritise their roles it was noted that attendance of two GPs was a minimum; additional GPs could attend as appropriate.

In regard to primary care co-commissioning SB welcomed the involvement of Healthwatch and agreed to discuss potential attendance and availability outside of the meeting.

The Governing Body:

1. Approved the amended Quality and Finance Committee Terms of Reference.
2. Noted that SB would progress discussion of potential attendance of Healthwatch in respect of primary care co-commissioning outside of the meeting.

10. Policy Management

GPo referred to the report which comprised the revised Risk Management Strategy and Policy and the Business Continuity Policy and Strategy which had been approved by the Senior Management Team and Audit Committee. RP noted in regard to the former policy implementation of Covalent which had significantly improved risk management; the latter aligned with the Emergency Preparedness, Resilience and Response arrangements approved at the December 2014 meeting. Work was now taking place to ensure that all teams had robust business continuity plans.

KR, on behalf of the Governing Body, expressed appreciation to Pennie Furneaux, Policy and Assurance Manager, for her work on updating the fundamental CCG policies.

The Governing Body:

1. Approved the revised Risk Management Strategy and Policy.
2. Approved the revised Business Continuity Policy and Strategy.
3. Expressed appreciation to Pennie Furneaux, Policy and Assurance Manager.

11. Equality Strategy Implementation Plan: Performance Report

EB presented the CCG's Equality Strategy Implementation Plan Performance Report for 2013/14 which included five equality objectives, performance, recommendations, a conclusion describing progress achieved and recognising the need for continued work. EB highlighted the importance of working with stakeholders to ensure objectives aligned with Joint Strategic Needs Assessments and for all aspects of the CCG's work to include an Equality Impact Statement.

In response to SO seeking clarification about the appropriate font size for documents, it was noted that font size 11 was the minimum to be used and that the statement advising that information was available on request in other formats was required to be in font size 14.

The Governing Body:

Noted the progress being made to implement the Equality Strategy and discharge the CCG's duties relating to equality as well as areas for development.

12. Referral Support Service

In presenting this item TM expressed appreciation of the comprehensive report and highlighted the recommendations which, following discussion, were supported. He noted that the Referral Support Service was still a pilot and that an expansion of electronic referrals for further specialties was planned. To date the reviewer role had been GP dominated but secondary care colleagues were becoming increasingly engaged in this regard.

TM noted the complexity in evaluation of the data highlighting that a reduction in GP referrals would not have an impact until the backlog of referrals had been cleared but that there were indications of impact on the specialties currently being monitored. The aim of the Referral Support Service was to achieve consistency of appropriate referrals and alternatives to referrals to consultants. TM highlighted that the Referral Support Service section on the CCG website, which included Policies of Limited Clinical Value, was key from the GP perspective.

In response to KR referring to AM's request for information on the rate of return of the £0.5m investment SO reiterated that the Referral Support Service was still a pilot and the fact that a culture change was required both from primary and secondary care in its implementation. He noted the effect of delays in NHS data flows but advised that a reduction of c8% referrals was being achieved, as planned within the business case, highlighting that a flat rate of activity in terms of GP and non GP referrals was a demonstration of change; further reduction was expected.

Members commended the report and detailed discussion ensued.

SO advised GP feedback was that the Referral Support Service website was greatly valued and noted that, in addition to the resources provided there, further education events were planned for both primary and secondary care. SO reiterated the need for culture change and advised that optimising administrative support was a priority to increase the work of the Referral Support Service.

SO explained that pressures on general practice contributed to the fact that there was currently a low number of GP reviewers. He noted however that they comprised a dedicated, committed team and that monthly meetings were held to discuss issues. Governance concerns had been mitigated and there was increasing support from secondary care. SO also noted that the CCG was supporting a number of GPs on diploma courses and reiterated that further specialties were becoming involved. Additionally, there was the requirement for processes to fit with the hospital systems and for patient choice to be taken into account.

JL advised that he planned to take the report to the Local Medical Committee meeting on 12 February. He noted that currently the only options were to refer or not refer and suggested that a survey be carried out of patients whose referrals were returned to GPs. JL also requested information at the next meeting regarding further roll out of the service and associated costs. In this regard SO noted that further work was required but advised that cost per specialty was being reviewed to ascertain return on investment.

TH welcomed the report as a key enabler for working with secondary care but highlighted that clarity was required as to when the referral review started and noted the need for further development of pathways to ensure the right care for patients every time. In regard to the fact that all GP practices had signed up to the Referral Support Service TH noted that further discussion was required with the CCG's membership to achieve sign up of all GPs within each practice. He also referred to the Referral Support Service in the context of addressing unwarranted variation between practices which was being hindered by lack of good quality, timely data, additionally requesting that the website be considered as a resource for patient choice in terms of best practice for elective care.

SO welcomed TH's comments in terms of quality and reported that implementation of the lean productive approach was being considered to ensure quality and efficiency. SO also noted that the support of the Council of Representatives and Local Medical Committee would be welcomed in terms of the culture change required to enable the Referral Support Service to be utilised for addressing unwarranted variation between GP practices.

In response to clarification sought by AP, SO agreed that the issue of missing referral attachments required addressing and welcomed the suggestion that the GP workforce be offered the education events which were led by the GP reviewers. The issue of referrals being timed out was due to reviewer capacity and would be addressed by an increased number of reviewers in the specialties.

PE referred to maximising available education resources and sought information for further plans in this regard. SO noted that to date two training videos had been produced and further training material was planned. Additionally an introductory QIPP prescribing guide was on the website.

The Governing Body:

1. Agreed that the Referral Support Service should continue for a further 12 months, noting that the first six months would include a review and promotion

of the service, incorporating actions identified through the current evaluation, and a feasibility study of long term procurement options for the service would be carried out, with a further report for July 2015.

2. Instructed pursuing of the new NHS England target of 80% of all referrals within the CCG being made electronically by March 2016, utilising the Referral Support Service as the enabler for this.
3. Supported the evaluation of the administrative support required to maximise the potential for change and ongoing evaluation whilst ensuring patient safety and good governance.
4. Supported the investigation of alternatives to the current provision of GP reviewers to ensure appropriate skills were available to act on opportunities for improvement promptly.
5. Requested further information regarding extending roll out of the service and associated costs and associated savings.

13. NHS Vale of York CCG Audit Committee

The Governing Body:

Received the unconfirmed minutes of the Audit Committee of 10 December 2014.

14. NHS Vale of York CCG Quality and Finance Committee

The Governing Body:

Received the minutes of the Quality and Finance Committee of 18 December 2014 and the unconfirmed minutes of 22 January 2015.

15. Medicines Commissioning Committee

The Governing Body:

Received the recommendations of the Medicines Commissioning Committee of 19 November and 17 December 2014.

16. Next Meeting

The Governing Body:

Noted that the next meeting was on 2 April 2015 at 10am at West Offices, Station Rise, York YO1 6GA.

17. 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.

18. 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 5 FEBRUARY 2015 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: QIPP Update	• Meetings with Lay Members of provider organisations to be progressed	AM/KR	25 February 2015
2 October 2014	Referral Support Service Progress Report	• Evaluation of Stop Before Your Op to be discussed	EB/JH	Ongoing
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
5 February 2015	Integrated Quality and Performance Report	• Consideration to be given to the format to include qualitative outcomes	MC	2 April 2015

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
5 February 2015	Referral Support Service	• Information requested regarding further roll out of the service and associated costs	SO	2 April 2015