### RCCG/GB/14/108 Welcome and Introduction
Mrs. Hyde welcomed everyone to the meeting of the Governing Body.

### RCCG/GB/14/109 Apologies for Absence
Apologies were received from Dr. Stephen Shortt and Dr. Crocker.

### RCCG/GB/14/110 Declarations of Interest
Members were reminded to declare any items of interest for agenda discussions.

Dr. Griffiths and Dr. Derbyshire declared an interest in items 14/117 and 14/118 as partners in Ludlow Hill Surgery and Musters Medical Practice respectively. These items were updates on progress.

#### Action

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therefore action taken to manage this conflict of interest was for Dr. Griffiths and Dr. Derbyshire to take no part in the discussion. This also applied to Mrs. Griffiths as Dr. Griffiths’ spouse.

There were no further declarations of interest for this agenda over and above those in the Register of Interests.

RCCG/GB/14/111 Minutes of the Last Meeting held on 15 May 2014
The minutes of the previous meeting were agreed as a correct record.

RCCG/GB/14/112 Matters Arising from the Meeting held on 15 May 2014
The Governing Body noted the completed actions and updates:

i) RCCG/GB/14/007 – the development programme would be sent out with the minutes.

ii) RCCG/GB/14/036 – the item on the Public Health Grant would be deferred until September.

iii) RCCG/GB/14/072 – a working group to look at the Assisted Conception Policy across the County and City CCGs had just been convened to review the former East Midlands Specialised Commissioning Group policy and to ensure that it fitted with the recently approved IVF/ICSI policy. It was anticipated that a draft policy would be circulated to the CCGs for comments in the autumn.

iv) RCCG/GB/14/073 - comments from Rushcliffe CCG would be collated along with any comments from other East Midlands CCGs and considered at a meeting at the end of July. The observation about rape tattoo had not been raised by other CCGs.

v) RCCG/GB/14/078 – a procedure for notifying GP practices of care home closures was now in place. Mr. Hall and Ms. Baria would discuss outside of the meeting the process for informing the CCG, as this would involve patient confidential data.

An updated action list would be appended to the minutes. There were no further matters arising.

RCCGB/GB/14/113 Clinical Update - Diabetes
This was the sixth of a series of presentations to inform the Governing Body of the clinical development work in progress presented by Dr Rahul Mohan, Clinical Lead for Diabetes.

Dr. Mohan explained that there were almost 5,000 patients in Rushcliffe diagnosed with Diabetes and a further approximately 1,000 who were currently undiagnosed. Although the CCG was in the top 25% across all CCGs for the 8 care processes, there was still room for improvement.

A Community Diabetes Service had been developed which was delivered by one Diabetic Specialist Nurse (DSN) for 30 hours per week employed by NUH. There were risks to business continuity with this model as there was no cover provided by NUH for annual leave or sickness although it was part of the specification.

Going forward, the CCG was currently scoping options with leads in NNE and NW CCGs to address the DSN service risk that could also support increased numbers and potential to transfer eligible Type 1 Diabetes patients from hospital. One potential option would be for the three south CCGs to put together a joint business case to increase DSN workforce that would work across the three CCGs and would address anticipated growth, enable existing DSNs to conduct quality audits, and ensure the service was robust and sustainable.

Dr. Mohan highlighted the service provided by Juggle which was structured education for Type 2 diabetics (excluding patients on insulin) provided over four sessions covering dietary, lifestyle and
patient education. Where patients attended structured education, a reduction in the number of appointments with clinicians had been seen as patients were more confident in managing their own condition.

Dr. Mohan highlighted the pathway development for hypoglycaemic patients which aimed to:

- reduce unnecessary ambulance conveyances to hospital
- reduce unnecessary unplanned admissions
- improve patient experience
- enable timely follow-ups for patients with their practice/DSN
- provide targeted patient educational support to prevent further occurrences

Mrs Hyde thanked Dr. Mohan for his presentation and requested a progress report on the future of the Community Diabetes Service when a decision had been taken on the options.

RCCGB/GB/14/114 East Midlands Ambulance Service (EMAS)

Following scrutiny of performance targets at Governing Body meetings over the last 12 months including deep dives into the performance detail around each target, the Governing Body invited Sue Noyes, EMAS acting Chief Executive to attend a Governing Body meeting to discuss specifically the poor performance in Rushcliffe and the impact of poor quality ambulance services on the CCG’s population.

Richard Henderson, Director of Operations, attended the meeting on behalf of Ms. Noyes together with Mike Casey from NHS Erewash CCG the co-ordinating commissioners for the EMAS contract.

They outlined the recent background, that in October 2013 EMAS was the worst performing ambulance trust in the country and the situation was getting worse. This brought into question the viability and future of the organisation. A risk summit was arranged which brought scrutiny of the organisation on a weekly basis and a wholesale change of the Trust Board executive. The Trust responded by developing the Better Patient Care Programme covering four areas: Quality; Performance; Finance and Workforce.

For the first time since 2010, the Trust achieved all the national performance standards for the first quarter of this year.

With regard to performance in Rushcliffe specifically, this was still the lowest performing area. Rurality was a factor but EMAS recognised that patients in rural areas should get as good a service as those in urban areas. Mr. Henderson pointed out that the measure of a quality service with a good clinical outcome was not solely about arriving on time. A breakdown of calls in Rushcliffe demonstrated that one in five calls were for falls. Mr. Casey highlighted the Commissioner Intentions Events which looked at future service design.

In response to a question from Professor Hawkey, Mr. Henderson responded that compared to the highest performing ambulance service at the time, there were a number of reasons why EMAS was performing poorly: not enough staff – lack of recruitment and inability to recruit; wrong profile of resources and the way of deploying those resources; control room changes and new protocols for despatch; and focussing on too many priorities. The organisation needed a cultural change and change in leadership style which was now happening. Ms. Noyes had a very different style and was engaging with the whole workforce. A change in staff attitudes was being seen with a real appetite for change.
In response to a question, Mr. Henderson responded that there was no national appetite for an increased number of smaller ambulance service organisations. He also added that there was a strong drive to change targets from response times to clinical outcomes.

Mr. Hall asked, based on the current improvement plan, what the timescales were for achieving the three targets consistently. Mr. Henderson responded for the contract as a whole:

- Leicestershire and Nottinghamshire – 1-7-14
- Northamptonshire – 1-10-14
- Derbyshire and Lincolnshire – 1-2-15

He added that these were very challenging dates and that there would be a gradual step down to each individual CCG area, but that it was necessary to be realistic about timescales for achieving this. Mr. Hall stated that commissioners needed to discuss the EMAS differential performance based on population numbers, activity levels and performance in the meantime.

Mrs. Bailey added that EMAS performance in Rushcliffe had been a concern for the Clinical Cabinet for a long time. Much richer data was available now, down to individual patient level. This showed that the numbers affected by this underperformance were low. However, more importantly, it would also allow audits to be undertaken to assess the real clinical impact on individual patients.

Mrs Hyde thanked Mr Henderson and Mr Casey for their presentation.

RCCGB/GB/14/115 Vice Chair and Lay Members Verbal Report

i) Mr. Blair reported he had joined an NHS England Patient and Information Open House event via webcast on 17 June 2014.

ii) Dr. Rix reported he had attended an Audit and Governance Workshop with Ms. Sharp on 16 July 2014

iii) Mrs. Greenwood had attended an Audit Committee Institute breakfast seminar organised by KPMG on 16 May 2014

RCCG/GB/14/116 Chief Officer’s Report

Mrs. Bailey spoke to her report noting the following:

Co-commissioning of Primary Care
The expression of interest on behalf of Rushcliffe, Nottingham West and Nottingham North and East CCGs was submitted on 20 June 2014. The options were:

i) Greater CCG involvement in influencing commissioning decisions made by NHS England area teams;

ii) Joint commissioning arrangements, whereby CCGs and area teams made decisions together, potentially supported by pooled funding arrangements;

iii) Delegated commissioning arrangements, whereby CCGs carried out defined functions on behalf of NHS England and area teams held CCGs to account for how effectively they carried out these functions.

The CCGs had opted for option 1 but had the opportunity to revise this at a later date when more detail was available. A response was now awaited from the Area Team.

Operational Resilience and Referral to Treatment
NHS England had published a framework to support planning for operational resilience during 2014/15 which covered both urgent and planned care. All NHS Accountable officers and Local Authority Chief
Executives had received letters setting out NHS England’s expectations for how the system would work together to develop robust plans for managing operational resilience through 2014/15. The guidance set out best practice each local system should reflect in their local plan and the evolution of Urgent Care Working Groups into System Resilience Groups (SRGs). CCGs were expected to play a full role in leading these groups, ensuring that all partners across health and social care were included whether commissioners or providers. Non-recurrent funding 2014/15 was being made available to support the successful delivery of these plans. Urgent care funding would be allocated to CCGs to be shared amongst local systems through the System Resilience Groups in the same way as 2013/14. Rushcliffe CCG would receive just over £678k with monies being made available upon successful assurance of plans.

Rushcliffe Health Profile
Public Health England had just published the 2014 Health Profiles for local authorities. This showed again that road traffic accidents and incidence of malignant melanoma were higher than the national average in Rushcliffe. It also indicated that for breast feeding initiation and smoking status at time of delivery, the CCG was an outlier compared to the national average, though Mr. Gribbin warned that these indicators might still be at County level.

Mr. Hall asked if there could be any false “good” indicators. Mr. Gribbin agreed to provide a detailed report for the Clinical Cabinet and an update on this for the next Governing Body.

Strengthening Patient Safety in the NHS
Rushcliffe CCG together with Nottingham West and Nottingham North and East had signed up to this campaign developing the work started in the Quality Strategy. More detail would come to the September meeting.

South Nottinghamshire Transformation
i) The final version of the plan was submitted on 20 June 2014.

ii) Following an extensive recruitment process, Rebecca Larder had been appointed as Director of Transformation for the South Nottinghamshire Transformation Programme. Rebecca was previously Associate Director of the East Midlands NHS Strategic Clinical Networks and Clinical Senate and came into post on 16 June 2014. Her post was hosted by Nottingham North and East CCG.

The Governing Body NOTED this report.

Dr. and Mrs. Griffiths and Dr. Derbyshire took no part in the discussion of the following item 14/117 and 14/118.

RCCG/GB/14/117 and 118 General Practice Local Enhanced Specification and Prime Minister’s Challenge Fund
Mrs. Bailey re-capped on the background to this enhanced specification highlighting that it had been discussed already at both open and development sessions for the Governing Body to fully understand the proposal. Previously, a task and finish group had been established to advise on the decommissioning of existing Local Enhanced Services inherited from the PCT and the commissioning of new enhanced services which were for Long Term Conditions and Care Homes. This task and finish group had no GP representation due to conflicts of interest. A single action tender procurement was recommended by this group for both enhanced services as they provided strong continuity of care and integration of services. This was strongly supported by the Patient Cabinet. Both specifications were
submitted to the Procurement Panel and the single action tender was deemed to be appropriate. On recommendation from the Patient Cabinet, the Governing Body approved the single action tender for both specifications at its meeting in January 2014. Alongside these specifications the CCG was working on the Primary Care Strategy - the overarching specification for the delivery of primary care in the future which provided the strategic context.

The care homes specification went ahead as planned however, following central guidance, the long term condition specification was subsumed into the Primary Care Strategy – General Practice Local Enhanced Service, as NHS England specified national services to be delivered locally including the £5 per patient over 75 with a named GP.

The paper being considered by the Governing Body was a presentation of the key elements of the future service which would have a detailed specification with measures and outcomes which would offer an extended quality and service offer to Rushcliffe patients. It would also support the development of a sustainable base of high quality local practices and the CCG’s business objectives. It addressed themes of access, long term conditions care, the interface with secondary care, relationships with other professionals and integration of care, appropriate use of resources and governance.

The presentation had been to practices for their comments, and also to ascertain the likelihood of practices delivering the specification. Practices had been asked to consider the proposal, seek clarification or explanation, confirm areas they were content with, suggest amendments (additions, deletions) for the purpose of assessment of the ability to deliver the specification.

Mrs. Bailey drew attention to the funding required to deliver the specification which was detailed in pages 9 and 10 of the presentation. The financial risk to the Governing Body in this financial year was approximately £700k, as this was the sum that would equalise practice £ per head per patient (to be confirmed by NHS England). The total sums were greater as they detailed schemes either national or locally determined in the GP contract - the £5 per head for example was in the CCG baseline funding. In addition, the element of funding bid for from NHS England for the Prime Minister’s Challenge Fund was included – although as the Governing Body was aware this was subject to the outcome of the patient survey. The majority of this funding was therefore non recurrent.

It was intended that the GP Local Enhanced Delivery Specification would be an annual, recurrent investment subject to a review of its performance and its contribution to achieving the CCG’s QIPP objectives. The risk to the Governing Body was that the specification did not deliver the intended outcomes – especially in relation to QIPP as the overall funding for the specification came from the CCG total resource. It could therefore be described as an invest-to-save scheme. The risk to the GP practices was that in order to deliver some of the changes required they would need to recruit and /or share workforce without a guarantee of future funding.

This specification enhanced the opportunity for sustainable collaboration across general practice in Rushcliffe and this would bring with it significant benefits for patients. At this meeting the Governing Body was asked to approve the provisional financial implications in order to take this specification development forward, after which, practices would be invited to sign up to the proposal, with an anticipated start date of September/October 2014.

In response to a question from Mr. Blair, Mrs. Bailey stated that the funding would become recurrent when a return was seen in terms of the impact on the QIPP target. This would change the commissioning system and it was critical that practices worked together. Professor Hawkey added that
the CCG needed to be clear about the measurements of success and how these would be monitored. Mrs. Bailey added that work was ongoing on benchmarking success measures and also incorporating the aspirations in the patient survey once the analysis and focus group work was completed. This service was a significant strategic shift in direction and the questions to be answered were whether it would deliver higher quality primary care and would it have an impact on the way secondary care was commissioned.

Mrs. Hyde added that it was imperative to get the governance and scrutiny right and ensure that the Governing Body’s role was clear.

The Governing Body APPROVED the development of the specification and the financial implications for 14/15 and potentially 15/16.

**RCCG/GB/14/119 Better Care Fund**

Mrs. Bailey reported that the Nottinghamshire plan had been assessed as one of 18 exemplar plans nationally and the application was being fast tracked. A revised version had been submitted which had more detail around the targets. A further submission was required and delegated authority would need to continue due to short deadlines.

The Governing Body APPROVED delegated authority to the Chief Officer and GP Clinical Lead to sign off the next versions of the plan.

**RCCG/GB/14/120 Being Open Policy**

Mrs. Stone explained that the purpose of this policy was to identify the meaning of openness in practice and to give guidance for how CCG officers would ensure that Being Open principles were implemented and embedded in risk management and clinical governance processes for all commissioned services and internal CCG functions.

This policy had been produced in line with the National Patient Safety Agency (NPSA) Being Open Framework and recommendations from the Francis report to implement the Duty of Candor (as part of the NHS standard contract). Providers had their own policies for the Duty of Candor which was monitored via their Quality Scrutiny Panels.

This policy had been approved by the Quality and Risk Committee, subject to comments from Patient Cabinets. This feedback had now been received.

Mrs. Hyde drew Governing Body members’ attention to section 5.1 Governing Body Level Commitment.

The Governing Body APPROVED the Being Open Policy.

**RCCG/GB/14/121 Patient Story**

Mrs. Stone presented the Patient Story explaining that this was a positive patient experience story. The patient was diagnosed with a long term condition and had participated in the Expert Patient Programme and was overwhelmed by the difference to her health and wellbeing.

Mrs. Bailey explained that this was a nationally validated programme and it fitted with the CCG’s strategic priority of self-care. However, the current service was only delivered in Mansfield and therefore there was low up take from Rushcliffe patients and the CCG’s contract quota was not taken up. This was a longstanding issue and the CCG was looking to decommission the service and re-commission it in a more appropriate way. There was little point therefore publicizing the service in its current form. Mrs. Bailey
stated that Dr. Neil Fraser, Clinical Lead for Long Term Conditions was looking into this.

The Governing Body **NOTED** the content of the patient story.

**RCCG/GB/14/122 Quality Report**

Mrs. Stone highlighted the following key messages from her report:

- All Provider Quality Accounts were published on NHS Choices on 30 June 2014
- Annual Patient Safety Conference 21/22 May 2014 in Liverpool – “Sign up to Safety” campaign aimed at halving avoidable harm launched in June; update on the new patient safety alerting system launched in January 2014; new CQC inspection process
- Quality Visits to Providers – planned visits for 2014/15 and an invitation to Governing Body members and CCG officers to attend
- Safeguarding – serious case review health overview briefing event held on 7 July to share learning across the health community; multi-disciplinary primary care event took place on 18 June to reflect on the case of the death of a baby as a result of neglect and the actions required by primary care in response to this.

Dr. Derbyshire raised the issue of clinicians’ concerns about sharing information and breaking confidentiality. As this had now been raised, it would have to be formally addressed. Dr. Derbyshire would contact Val Simnett, Safeguarding Lead.

- Care Homes – Eton Park continued to be a concern. A meeting had taken place with relatives to express concerns and alternative provision was being considered. The CCG and local authority suspension of contracts continued.
- Latest information on complaints, Patient Experience and PALS contacts.

The Governing Body **NOTED** the Quality Report.

**RCCG/GB/14/123 Patient Experience and Quality Issues in A&E**

Mrs. Stone explained that this paper had been requested as a result of scrutiny of the continued non-achievement of the 4 hour A&E target and the quality issues arising from this missed target. The analytical focus on A&E presented to the Governing Body in March highlighted that there was not one single issue but a number of factors that impacted on performance at A&E. In response to poor performance, a number of measures had been put in place:

- Review of patient safety incidents quarterly for trends and patterns at Quality Scrutiny Panels – falls infections, pressure ulcers and the National Safety Thermometer. None showed any deterioration in quality standards within A&E
- Analysis of Patient Experience measures – Patient Reported Experience Measures (PREM), complaints and Friends and Family Tests. Complaints had increased in number and included missed diagnosis, lack of assessment, lack of treatment and care, lost property and delays. NUH performed well compared to its peers both in terms of response percentage and overall net promoter score.
- Quality visits both announced and unannounced

In conclusion it was noted that NUH had established internal mechanisms to monitor and mitigate against the risks of harm and poor patient experience as a result of reduced performance against the 4 hour ED target.

Commissioners were scrutinising the service regularly through a number of mechanisms and felt assured that there were sufficient mechanisms in place. However it was more difficult to understand...
and measure the unintended consequences of poor performance against the 4 hour target such as increased length of stay or other quality metrics once the patient had been admitted.

The Governing Body NOTED this report.

**RCCG/GB/14/124 Transforming Participation in Health and Care**

Mr. Blair updated the Governing Body on progress so far from this task and finish group. The stage 1 report had been drafted and presented to the Patient Cabinet for comment. The final version would come to the Governing Body in September 2014. The work of the group had attracted the attention of one of the national PPI leads who was interested in visiting.

In addition, the review by the East Midlands Leadership Academy on the Active Group had been widened slightly to encompass the Patient Cabinet and the Governing Body lay members’ role for PPI and this would inform a future governance review of structures for PPI.

These two areas of work would come together at the end of the year with a revised structure and agreed work plan.

The Governing Body NOTED this update.

**RCCG/GB/14/125 Patient Cabinet Minutes 12.06.14**

The Governing Body NOTED the minutes.

**RCCG/GB/14/126 Implications for Health within the Care Act 2014**

Ms. Baria explained that the Care Act 2014 consolidated social care law (currently thirty Acts) and had an underlying vision of a more integrated approach to the design and delivery of social, housing and health care services. The Better Care Fund was the vehicle for this.

The draft regulations and guidance for the Care Act were published on 6 June 2014, for consultation between 6 June and 15 August 2014. This consultation was only for the elements of the Care Act that came into effect in 2015/16. Consultation on items, including the cap on care costs, which would come into effect in 2016/17 would be carried out later.

The consultation had been published in the Nottinghamshire Care Act newsletter, which had been circulated to partners. In addition, the Health and Well Being Board had received a briefing and a presentation was planned for the Health and Well Being Implementation Group on 16 July 2014.

The changes would place new obligations on local authorities at a time when budgets were being cut as it would give more people the right to access assessments and services. This increased the urgency to work collaboratively to increase the uptake of personal health budgets.

Mrs. Bailey agreed to discuss a collective response with her Chief Officer colleagues locally.

The Governing Body NOTED the report.

**RCCG/GB/14/127 Finance Report**

Mr. Bemrose highlighted the following from his report:

- The CCG had kept expenditure within the Revenue Resource Limit for the period April 2014 to
June 2014
- The CCG was forecasting to deliver the annual QIPP plan by year end.
- The CCG was on target to be within the running cost allowance.
- Whilst forecasting to achieve the required surplus, there were still a number of risks that the CCG faced in delivering this financial requirement. These included:
  - Increasing activity pressures at NUHT and Circle
  - Continuing Care pressures
  - Delivery of the QIPP target for the year

The financial position of the CCG had been maintained by drawing down on reserves. In response to a question, Mr. Bemrose confirmed that the CCG was in a good position with regard to reserves and had so far drawn down considerably less than other CCGs locally.

The September report would include more detail on the prescribing workstream.

The Governing Body:
- **NOTED** the financial position of the CCG for the period April 2014 to June 2014
- **APPROVED** the Finance Report for the period April 2014 to June 2014

**RCCG/GB/14/128 Financial Risk Pooling in Nottinghamshire 2014-15**

Mr. Bemrose reported that a financial risk pooling agreement had been agreed by the Nottinghamshire County and Nottingham City CCGs. The approval of the setting up of the Risk Pool Steering Committee was agreed by the Governing Body and update reports had been received regularly. At its meeting in February 2014, the Governing Body approved the recommendations of the Steering Committee one of which was that a risk pool covering High Cost Patients and “one-off” major incidents existed across Nottinghamshire for 2014-15 onwards.

High cost patients covered as part of this 2014/15 Risk Pool, included acute secondary and critical care services. It did not include Continuing Care, Non NHS Low Secure Services and Prescribing High Cost Patients which were previously risk shared across the Nottinghamshire County CCGs as part of its Risk Pooling Agreement for 2013/14.

In respect of these areas currently risked shared by County CCGs but outside the current risk sharing agreement, the Chief Finance Officers for the north and south County CCGs had agreed that:

- Continuing Care, Non-NHS Low Secure/Locked Rehabilitation and High Cost Patients (Non-acute) including prescribing would continue to be risk shared between the County CCGs in 2014/15 on the same basis as 2013/14.


**RCCG/GB/14/129 Quality and Performance Report**

Mr. Hall presented the key messages on performance for May 2014 noting the following:

- Cancer – 2 week wait and 31 day diagnosis to treatment subsequent treatment surgery were below target. All other cancer targets had been achieved.
- Referral to Treatment for all three pathways had been achieved overall, although there were some specialties which were below the national standard (Admitted – Plastic Surgery; Other. Non-

- A&E 4 hour wait – the CCG failed to reach this target of 95% due to performance issues at NUH: May – 89.17%. In response to a question Mrs. Bailey responded that it was too early to see the impact of measures put in place so far. Workforce was the biggest risk facing NUH who were currently recruiting in Portugal, Italy and Scotland.
- More detail was included this month on Nottinghamshire Healthcare Trust including Primary Care Psychological Therapies, Dementia and the Child and Adolescent Mental Health Service
- Quality Premium – there was a new set of metrics for 14/15: five based on national measures and one locally determined measure which was Long Term Conditions Personalised Care Plans. The current forecast overall was £425,494 against a possible total of £567,325. The A&E target was the only area below target at the present time.

The Governing Body **NOTED** this report.

**RCCG/GB/14/130 (i) CCG Assurance – Annual Report and Accounts**

The final submission of the Annual Report and Annual Accounts had been completed. The final copy could be found on the CCG’s website:


This was the first year CCGs had had to complete an annual report and annual accounts and the hard work of the teams involved in completing it according to guidance and within the timescales had been commended by the Audit Committee.

An annual general meeting was being planned provisionally for 24 September 2014. Further details would follow in due course.

The Governing Body:

- **NOTED** the final submission of the Annual Report and Annual Accounts as approved and adopted by the Audit Committee under delegated authority.

**RCCG/GB/14/130 (ii) Audit Committee Annual Report**

Mrs Greenwood presented the Audit Committee Annual Report which covered the financial period 1 April 2013 to 31 March 2014. Its purpose was to provide the Governing Body with a summary of the work carried out by the Audit Committee during the year and demonstrated that it had fulfilled its functions in accordance with its Terms of Reference.

The reports also highlighted points of focus for the Committee’s work during 2014/15, based on lessons learnt throughout the year.

The Governing Body **NOTED** the content of this report.

**RCCG/GB/14/131 Assurance Framework**

Mrs Greenwood reported that the Assurance Framework had been reviewed and updated and showed the latest position as at 17 July 2014. The updated Assurance Framework contained risks to the achievement of the strategic objectives for the year, plus risks 'escalated' from the constituent risk registers where there was an inherent risk of 10 or more (Amber/red or red).
There had been no change to the risk ratings and monitoring was ongoing. The Assurance Framework directed the focus of the Audit Committee in terms of requesting deep dives into particular risks. It also drove the Internal Audit workplan.

Members agreed that the risks attached to the South Nottinghamshire Transformation plan and the GP Local Enhanced Delivery specification needed to be identified.

The Governing Body:

- **APPROVED** the latest iteration of the 2013/14 Assurance Framework.
- **DISCUSSED** if any further risks should be added or if any further actions are required to address existing risks.

**RCCG/GB/14/132 Checkpoint Q4 Assurance 03.06.14**

The letter was a summary of progress and on-going discussions over the last year (aligned to the six domains of assurance), and provided an outline of the development needs and any agreed actions that were discussed at the meeting in June.

The CCG was commended for its excellent engagement with both clinicians and patients reflected in the recent stakeholder survey. Noted was the positive approach to learning from other areas and the innovative work on new models of working between primary and secondary care. Also highlighted were the performance on waiting times for patients who had good access to services and the CCG’s in-depth analysis and continued scrutiny of the ambulance service under-performance. The A&E performance and the urgent care system in general continued to be a challenge going forward. The level of transformation required across the local system and the CCG’s QIPP target were also highlighted as challenging.

The Area Team understood and agreed to support the CCG with its plans for commissioning support services.

Subject to regional moderation, the CCG remained assured with support for consistent failure of delivery of the 4 hour A&E standard and management of the urgent care system as a health community.

The Governing Body **NOTED** the content of this letter.

**RCCG/GB/14/088 Health and Well Being Board 07.5.14 and 02.07.14**

Dr. Griffiths informed the Governing Body that the Health and Wellbeing Strategy Delivery Plan was going to the next HWB Board in September; and that Derbyshire Community Health Services who had won the tender for obesity services had now withdrawn so the service would be re-tendered.

The Governing Body **NOTED** this update.

**RCCG/GB/14/134 Rushcliffe Audit Committee Minutes 07.05.14 and 04.06.14**

Mrs. Greenwood highlighted the following:

i) The Committee had received a deep dive into the QIPP plan to assure itself and the Governing Body that there was a plan in place, that progress was being made and there were mechanisms for identifying issues as they arose. The work was not confined to the current financial year as schemes were being identified which would have an impact next year. The Committee was assured that the process was robust and that there was appropriate
Ten days from the 13/14 Internal Audit plan had been carried forward to this year. Discussions were taking place to do a joint audit across the CCG and NUH. At the moment audit work stopped at organisational boundary so the full picture was not always evident. The Audit Committee supported this idea.

The Governing Body **NOTED** the following minutes:

- RCCG/GB/13/135 IGMT Minutes and Highlight Report 30.05.14
- RCCG/GB/14/136 Clinical Cabinet Minutes 01.05.14
- RCCG/GB/14/137 Commissioning Congress Minutes 14.05.14
- RCCG/GB/14/138 (i) Safeguarding Children 14.04.14 and (ii) Adult Minutes 14.04.14

Mrs. Stone asked that the information on named doctor was disregarded as this applied to the north of the county only.

**RCCG/GB/14/139 Any Other Business**

There was no further business.

**DATE OF NEXT MEETING**

The next meeting would be held on:
Thursday 18 September 2014 at 1.30pm

**Clumber Room**
**Easthorpe House**
165 Loughborough Road
Ruddington
Nottingham
NG11 26LQ

Signed by………………………………… Chair – Mrs. Sheila Hyde

Date  ______________________________