Minutes of NHS Norwich CCG
Governing Body
Tuesday 23rd January 2018

NHS Norwich Clinical Commissioning Group

	Present: Tracy Williams (TW) – Nurse Practitioner/Chair Dr Victoria Stanley (VS) – GP / Elected Member Dr Jeanine Smirl (JeS) – GP / Elected Member John Isherwood (JIs) – Practice Manager / Elected Manager Dr Chris Dent (CD) – GP / Elected Member Paul Fisher (PFi) – Lay Member – Governance & Audit Rob Bennett (RB) – Lay Member Dr Neil Ashford (NA) – Secondary Care Doctor Irene Macdonald (IM) – Lay Member – PPI Pam Fenner (PFe) – Non Executive Nurse Jo Smithson (JoS) – Chief Officer John Ingham (JIn) – Chief Finance Officer **In attendance:** Frank Hume (FH) – Deputy POD Director, NELCSU (on behalf of Nikki Cocks) James Elliott (JE) – Director of Clinical Transformation Karen Watts (KW) – Director of Quality Lynette Dagless (LD) – Executive Assistant (Minute taker) Euan Williamson (EW) – Mental Health Commissioning Programme Manager (Agenda Items 7 and 19) **Attending to support meeting:** Jean Clark (JC) – Head of Governance Chris Turner (CT) – Head of Quality Tim Curtis (TC) – Head of Comms Laura McCartney-Gray (LMG) – Head of Engagement	
1.	**Welcome and apologies**	
	TW welcomed Frank Hume to the meeting who is attending on behalf of Nikki Cocks who is on extended leave and will be presenting the performance report. TW also acknowledged that Cllr Emma Corlett, Norfolk HOSC Link Member was at the meeting and had submitted a question prior to the meeting which will be answered in due course. Apologies were received from; Nikki Cocks (NC) – Director of Operations and Delivery Dr Andy Douglass (AD) – GP / Elected Member	
2.	**Declaration of Conflicts of Interest**	
	The Chair reminded the group that any declarations of conflicts of interest should be disclosed as soon as possible for a decision as to whether it is appropriate for the member to participate in discussion and voting for decision making. <u>Item 16 - Primary Care Committee Chair's Report</u> – All those working in Primary Care have a CoI. These are TW, VS, CD, JeS, AD and JIs.	
3.	**Items Exempt Under Freedom of Information Act (FOI)**	
	None	

4.	**Minutes of the meeting held on Tuesday 28th November 2017**	
	Amendments to be made to the minutes as follows; Page 3; (Agenda Item 9) to be reworded *"It was confirmed that there has been progress on 62 day waits and some clinical pathways are being reviewed"* Page 4; (Agenda Item 10) "detecting" to be reworded to "diagnosing". Page 5; (Agenda Item 13) to be reworded *"The main source of concern currently is Mental Health"* Page 9; (Agenda Item 23) to be reworded *"The Scheme of Reservation and Delegation were recommended to go to Council of Members for approval"* Once these amendments have been made the minutes will be signed off as accurate.	
	Action Log	
	There were no further updates to the action log.	
5.	**Chair's Actions**	
	CoM approved the changes to the Constitution however this needs to be approved by NHSE so will be on the agenda for the March meeting.	
6.	**Questions from the Public**	
	Mr Robert Smith submitted four questions prior to the meeting. As they do not relate to today's agenda, NCCG have taken the opportunity to provide the questions and answers to GB members and members of the audience. The first two questions have been received previously and dealt with through the complaints process and there is nothing further to add. With regards to the third question; *Can the CCG confirm that it has followed all its statutory requirements under The Public Contracts Regulations and The NHS (Procurement, Patient Choice and Competition) Regulations, and NHS England guidelines, including the CCG's Standing Financial Instructions for the appointment of its service providers over the last 4 year period? If the CCG is unable to confirm in the affirmative, can the CCG state where statute and guidelines have not been followed, and why?* NCCG have asked for a response from NELCSU, have consulted auditors and Governing Body. The response is also included within the document that has been shared. With regards to the fourth question; *Can the CCG confirm that the minutes of the Public Governing Body meeting of 23rd January 2018 will show the responses to the above questions?* The responses have all been published on the CCG's website and the response will be captured in the minutes of this meeting.  2018.01.23 - Response to the ques Cllr Emma Corlett also submitted some questions prior to the meeting.	

	The first question; *What are the implications for Norwich CCG and for services of the £10 million deficit in West Norfolk CCG budget?* At this point in time, each CCG is a Statutory Organisation and is responsible for our own finances so there will be no impact. However, there is joint work across health and social care for many programmes of work and we foresee that being partners in the STP will benefit the system as a whole. With regards to the second question; *NHOSC made several recommendations for provider (NSFT) and commissioners at December's scrutiny:* *Recommendation 4 (open more beds) was 'partially accepted' and discussions were 'ongoing' about the need for at least interim beds while potential 'crisis hub' impact was assessed. Please can you provide an update on beds discussion?* *Recommendation 8 (to provide funding for mental health services that takes in to account increased demand and demographic need) was rejected. Please explain why this would be incompatible with "parity of esteem" directive from DoH? NSFT reported an increase in referrals of 48% yet an increase in cash received of only 3.2%, which was itself a reduction in the total overall share of total CCG budget. How is "parity of esteem" possible without addressing the discrepancy between demand and resources and disadvantage that a block contract creates*? We will need to source some further information from the coordinating commissioner in order to be able to provide a detailed response. This will be provided to Cllr Corlett in writing and shared with Governing Body members. It was highlighted that NHS Norwich CCG not only meets but exceeds the financial investment standard for mental health services.	
7.	**Commissioning Case Study**	
	Euan Williamson (EW) provided an update on how the public have been engaged with the development of the Mental Health Crisis Hub to date. In terms of the hub, it started life as a community wellbeing hub. It is intended to be a multi-faceted service based on best practice examples from around the country. Lots of different types of models have been considered, and the pre-engagement process has been fundamental in refining the Business Case. If the project is signed off by the three central Norfolk CCGs then a formal engagement and consultation process will take place. There are two workstreams. The first being the Project Group leading the project. This Project Group was tasked to develop the Business Case and present it to the STP workstream and the three central Norfolk CCGs. The stakeholders include three service user representatives, the mental health trust, 3rd sector and EW. The Project Group has visited other locations to look at their models i.e. Bradford and Leeds and reported back to the STP Mental Health forum and the Mental Health Clinical Commissioning Network run by CCGs. They also took a range of ideas and findings to the service user reference group which is facilitated by Norfolk County Council on a monthly basis. EW and Clive Rennie (CR) have liaised with the Mental Health Provider Forum and attended monthly meetings. They provided a presentation in July 2017 to share the information to date. The Project Group engaged with the STP Stakeholder Group	

	which is run by the 3rd sector. The Vice Chair is a member of both groups. The Project ran a pre-engagement consultation over December and January and received over 120 responses. The reaction has been mainly positive; however concerns were raised about how people in rural communities would access the hub. The second workstream is about decisions concerning the building / physical hub which is an essential part of the Business Case. The Project Group created an evaluation panel to identify the criteria of the search. This group was made up of service users, primary care, clinicians, management, the 3rd sector, and estates from both STP and NSFT. A search was carried out with was narrowed down to two buildings. The Project Group visited both shortlisted buildings and identified their preferred option which had been through an evaluation by NHS Property Services. The question was raised as a user, what might the pathway look like in terms of rurality and virtual spokes based on this model. The final model needs to come out of the formal engagement process, workshops and surveys to understand the needs of the population. To date the Project Group has reviewed other models and it is anticipated that people could use it as a drop in, a triage line and professionals could refer patients in. Through the pre-engagement process with service users in North Norfolk, it has been identified that there are plenty of cafés and other community facilities that could form a network. Concerns were raised as from previous experience of IAPT, there were pros and cons of the engagement process. It was acknowledged that engagement is tricky and wide ranging. It is recognised that stakeholders will have a range of views. With regards to the Wellbeing/IAPT experience the biggest challenge was the core group who wanted to be part of it and challenged the processes and ideas. However this was also the best part as we were able to take ideas on and listen to the needs of the service users. For example, the support line wouldn't have happened without the service users' input. It is important that the hub is community owned.	
8.	**Patient Engagement Update**	
	IM presented the patient and public engagement update. NHSE carried out a desktop exercise during the summer on all CCGs regarding their engagement and equalities pages on their website. NCCG were rated amber and ten key actions were identified. An improvement plan is in a place. It was acknowledged that there is already a significant amount of work taking place in Norwich CCG and this may not be fully visible on the CCG's website. The website could be updated to enable greater visibility and easier access to the engagement work that the CCG does. LMG requested that a report comes to Governing Body annually (July) for discussion. This was agreed. It was suggested that once NHSE have carried out their desktop exercise they be invited to talk to NCCG about their findings before they finalise their report. **Action: LMG to feedback this suggestion to NHSE.**	**LMG**

9.	**Chair's Report and Consolidated Quality Committee Report**	
	Quality and Patient Safety Chair's Report PFe provided a summary of assurance in relation to key providers and key areas of focus within the local system. It is recognised that the whole system is under a huge amount of pressure and that this is a national issue. Some of the reporting is based on information from the latter part of last year and therefore with regards to the correlation between the performance and quality reports there are some differences in reporting periods. **Consolidated Quality and Patient Safety Report** CD raised a concern about the NHSE approach to funding contingencies and winter pressures plans where Commissioners were given 24 hours to come up with ways of spending extra monies. This doesn't allow for CCG's to plan for winter pressures and it is alarming that NHSE feels that this is a reasonable way to behave. Is that story correct and what can we do as a Governing Body to say it isn't good enough. We have received notification that funding is available and there are often short turnaround times. Concerns about the process have been fed back on numerous occasions. With GB backing we need to try to work around this process and be prepared for short notification in the future. Work takes place to learn from each winter what we can do for the coming winter. The A&E Delivery Board is learning what we could do better to inform future decisions. NCCG has prepared contingencies plans but capacity and workforce also has to be taken into consideration. Concerns were raised about the ambulance queuing situation at NNUHFT and whether there are alternatives to having patients waiting in ambulances, for example could some patients walk into the hospital unless they need clinical supervision. The delays are due to the clinical handover issues from one organisation to another and when clinical handover and therefore risk handover, takes place. There are also issues around staffing and patient volumes in A&E and therefore it is not always safe for that person to be handed over to the hospital. Is there any reason why patients who don't need clinical supervision can't be released? The A&E Delivery Board covering central Norfolk meets every two weeks and looks at the pressures on the system and ways to improve the performance. A recent example of a new service was where a GP identifies a patient that needs to be brought into hospital there is an initiative in place where the hospital takes on responsibility for organising transport for that patient. Conversations take place around whether the patient could get to the hospital on their own or by taxi and an ambulance is only dispatched when they need clinical supervision. The hospital makes this decision. Within the same conversation CD outlined above, it was suggested that the clock starts 20 mins after an ambulance arrives at A&E and therefore there is no reverse incentive to keep the patients waiting in an ambulance. This is not thought to be the case and the clock starts when the ambulance arrives outside the Emergency	

	Department. NSFT have created a role for a designated member of staff to manage out of area placements. There is some learning that could come from the experience of this member of staff that could inform future planning. A deep dive has taken place at Finance Committee on out of trust MH placements and questions have been raised with the Mental Health Commissioners. A response is expected by the next Finance Committee meeting in March and will also be taken to Executive Committee. The number of medicines management incidents at NNUH is increasing. Are we confident that action is being taken and will we monitor progress? This is picked up at CQRM. There was one incident of serious harm last May and work is ongoing with the trust. There is additional training for junior members of staff around the administration of medicines. With regards to NCH&C Looked After Children (LAC), GB asked the Quality Team to monitor the impact of the additional resource. An initial review meeting has taken place and it was confirmed that the Quality Team will continue to monitor this closely.	
10.	**Provider and System Performance Report**	
	FH presented the Performance Report. With regards to pressures on the system, he highlighted that the November data doesn't reflect the true winter pressures. GB were asked to note that the December A&E performance data is un-validated and there has been slippage due to winter pressures With regards to Dementia NCCG are behind the national target of 66.7%. The reported figures do not include the impact of Bowthorpe Care Village, when it is included the figure raises to 64.5% Dementia care is a huge priority for NHSE. At the last CRG meeting it was agreed that all practices would receive individual numbers indicative of diagnosis rates. This information will be customised for practices to help identify patients with dementia.	
11.	**Activity and Demand Management Report**	
	JIn presented the Activity and Demand Management Report and provided a summary of progress to date. The Demand Management Plan consists of specific schemes; there are a few behind schedule. There are areas of pathway redesign which are led by each CCG. Work that has taken place to change pathways are starting to show an impact albeit later than we had planned for. The report has been reviewed in detail by the Finance Committee. The question was raised about the more recent impact of Christmas Winter Pressures. JIn was asked whether he was able to provide some un-validated assurance.	

	JIn advised that the plan is based on capacity of the trust and the number of days in the month. The Finance Report has allowed for increased costs coming in December due to higher than anticipated levels of emergency admissions but December data hasn't been received. Although un-validated the hospital has quoted that during December attendances were up 10% on what was planned.	
12.	**Finance Committee Chair's Report**	
	RB provided an update from the meeting that took place last Thursday (18th January). A report has been drafted and will be shared in due course. One key point is that as at 31st December 2017, there was an underspend of £1.3m and we are projecting that it will increase towards the end of financial year and there will be a higher than budgeted surplus. A number of these budgets are volatile and therefore the picture will become clearer as we near the end of the financial year With regards to pressures, these consist of prescribing costs, shortages of certain drugs and an increased spend as a consequence. This is a national issue and there is no control locally. With regards to mental health overspending on out of trust placements, questions have been raised and there will be an update at March meeting. The Finance Committee reviewed the QIPP report and this is behind plan at the end of December. However, the results are encouraging and there is a good basis for the plan for the next financial year. The Demand management report provides a good picture overall and this was scrutinised in detail. The budget assumptions for next year were reviewed and these were underlined by a series of assumptions around activity. The Finance Committee are content with the assumptions. Two deep dives were carried out; one around pathway redesign and areas in the QIPP programme around slippage. The progress to date has been slower than anticipated and work continues. Some impact is starting to show. The second deep drive was around MCP (new models of care) financial arrangements. The new model of care will be translated into commissioning intentions with the incentive of a long term contract. The Committee would like to see incentives take account of quality and not just numbers. Work is being carried out to develop a programme of work for the next 12 months and this will come to the Governing Body in March.	
13.	**Finance Report Month 9**	
	JIn presented the Finance Report as at Month 9, reporting a positive year to date as at end December. The question was raised about how NCCG has contained costs for CHC, whether	

	there are fewer patients with complex needs or whether there are patients who are eligible and failing to access the service. CHC is not just about the volume of patients but the cost of care. The number of patients has gone down but that is because of closer monitoring and case management of patients to ensure that they have the most appropriate package of care. There are better controls in place and money is used in a better way. From a quality perspective there are robust processes in place and sometimes when patients are reviewed their need changes which leads to changes in the level of care provided. With regards to quality processes, we have implemented a 'discharge to assess' model from NNUH and therefore the majority of CHC assessments are carried out outside of an acute hospital setting. The eligibility criteria haven't change but the patients are better rehabilitated. The question was raised as to whether the overall CCG budget could have been managed so that there will be a smaller surplus. Concerns were raised around what happens if the CCG ends the year with a surplus against plan. There are many organisations especially amongst providers who are under pressure; there is the feeling that savings may be moved across CCGs in order to make the system work. JIn asked Governing Body to note that as a separate Statutory Organisation, there is no suggestion that we give money to other CCGs or any other organisation. An improved NCCG financial position will benefit the system as a whole. NCCG intends to declare the extra surplus, however recognises that there are no guarantees about when that extra surplus will be made available to the CCG in future years. NCCG believes it has invested in services based on the merits of each business case.	
14.	**QIPP Report Month 9**	
	JIn presented the QIPP Report as at Month 9. Demand management is a big part of the QIPP plan. There has been 85% delivery of plan to date which benchmarks positively against other CCGs. Some of the QIPP projects cover more than one CCG and are run jointly. The delivery during 2017/18 will inform the planning of the QIPP programme for next year.	
15.	**Commissioning Report**	
	JE presented the Commissioning Report and provided an update on the arrangements of the development and implementation of the Norwich New Model of Care. The governance chart was tabled and JE explained the meaning behind it. Anything "blue" is part of the commissioning cycle and anything "pink" is solely with NCCG i.e. contracting and procurement. Work needs to be carried out in order to understand the impact on other providers, existing structure of current providers and this needs to be done in context of the wider STP as providers do not solely provide services for Norwich. The Provider Board is within the "blue" area and two areas of focus for the Provider Board are the establishment of the provider entity and to work with providers who	

	may support the development and implementation of the New Model of Care. There will be a full formal paper to the March GB meeting which will include a timetable of action. **ACTION: New Models of Care to be an Agenda Item for March GB** Estates should be RAG rated amber. The Greater Norwich local plan has been published and we have been asked to respond to it. It sets out the local strategic picture for the longer term. It includes details of planned housing developments for Greater Norwich. It will have an implication for NCCG and the New Model of Care in terms of planning. There will be a major increase in housing and therefore an influx of patients putting a strain on existing primary care and other services. Planning needs to be put in place both for the short term and long term both for estates as well as services going forward. It was confirmed that the majority of gaps around staff sickness have been addressed, although there are a few that are presenting a challenge to delivery of the commissioning plan. Governing Body were asked to confirm that they were happy with the direction of travel to ensure that it remains consistent with what the Governing Body wants and the strategic plans. Concerns were raised around whether there was primary care involvement and patient engagement in respect of Norwich Integrated Neighbourhood Care as there hasn't been any mention of involvement from those areas. The working group has been in communication through those local practices and is linking back to their patient groups. **ACTION: JE to check if there are any specific groups which have not been involved.**	**JE** **JE**
16.	**Primary Care Committee Chair's Report**	
	All those working in Primary Care have a CoI – TW, VS, CD, JeS, AD and JIs. RB presented the Chair's Report and outlined a few key areas. A discussion took place about where we will be financially at year end specifically about the shortfall we started the year with and despite best attempts with NHSE we are yet to receive a response. JIn confirmed that last week it was agreed that they would give us transitional relief. With regards to the proposed practice merger, at the last meeting the Committee considered and approved this. Business Cases for use of PMS monies were considered and also what primary care engagement there was over the previous two years money and utilising the PMS monies. GB were informed that there is action on moving projects forward. The Assistant Director of Contracts and Performance – Primary Care has been invited to the next meeting.	
17	**STP Report**	
	JoS presented the STP report which was provided through the Communications Lead from the STP Team.	

	NCCG are carrying out a piece of work to look at the existing STP forums to ensure that we have a representative on each group. JC has created a matrix and is trying to ensure coverage on all programmes, but this is work in progress and is still evolving. From the update at November's meeting there is an outstanding action. GB wanted to see an improved format of the report, in particular highlighting progress on delivery workstreams. It is felt that the report doesn't provide any assurance and RAG ratings are required, in a similar format as the Commissioning Report. Although this report does include key risks and challenges, it is thought that there are a lot more key risks and challenges and in particular funding is not mentioned. **ACTION: JoS to pick this up as a risk.** With regards to 2.2 'Links with Waveney', concerns were raised as there is no representation from GP Provider Groups but Suffolk County Council have been invited. **ACTION: JoS to feedback this comment.** The paper asked Governing Body to identify actions that they could take to accelerate progress on delivering the changes necessary to deliver sustainable services. It was suggested that a representation from a specific workstream e.g. Prevention, could be invited to a future development session to discuss in detail to allow GB to develop their understanding and how they can provide support in the future. JoS confirmed that Rachel Hunt has been nominated to be on this STP workstream as it ties in with Healthy Norwich.	**JoS** **JoS**
18.	**Strategic Commissioning**	
	The membership of the JSCC was concluded last week. There are three individuals from each CCG making up a body of 15. It is made up of five Chairs, four Accountable Officer's, Chief Finance Officer, Secondary Care Doctor, Registered Nurse, Lay Member – Governance, Lay Member – PPI and third Lay Member. John Ingham was appointed as the CFO which meant that there were no remaining places for NCCG. Other GBs were contacted and over 50% of members were interested. The first meeting with the new membership is taking place on 1st February 2018. **ADHD** Service – A proposed was received for the ADHD service to address the service going forward and the backlog. This proposal was not agreed at JSCC but there will be further discussions to move it forward as there are concerns about the backlog of patients waiting. **Research** Strategy – There was a presentation from Amanda Howe from the UEA about the research strategy and link to UEA research. It was agreed that they should have a seat at the CEPN, network workforce development group. A request was received to extend the **Enteral Feeds** contract by one year after	

	which time there were be a wider EoE procurement process. This was debated and it was concluded that this was appropriate and there would be benefits of a wider procurement. **CAHMS redesign** – There will be a lot happening going forward. The redesign project is underway and this will be going to the March JSCC meeting for a decision on the procurement process going forward. JSCC also discussed the need for shared Governance between Norfolk County Council and the CCGs as the plan is for integrated services going forward. The Director of Children's Social Care will be invited to attend the JSCC discussions. **Short Breaks** – All CCGs have a duty to provide respite for children with complex needs. Options were discussed and it was agreed to extend the NCH&C contract until March 2019 in order to carry out an aligned procurement with Norfolk County Council if possible for respite for children with complex needs. **Clinical Policies** – JSCC discussed a response letter to NHSE about some of the components of clinical policies and thresholds. Further clinical work is needed and there will be a paper to the April meeting. Dr Chris Dent chairs the NCCG Clinical Reference Group. JSCC has not finalised the issue of governance and delegated authority and how this will be incorporated into the Constitution. CoM agreed the ToR and a further piece of work will be carried out by the Task and Finish Group within the next few weeks about changes to the Scheme of Reservation and Delegation. The Task and Finish Group consists of representatives from each CCG and a mechanism and infrastructure need to be in place to support JSCC. The proposals will need to be approved by CoM in order to put formal delegation in place with appropriately defined scope of those delegations. Work will be carried out to scope the impact on GB. The question was raised around the JSCC agreeing to extend a contract and what authority does the committee have to do this. It was confirmed that it is the management responsibility to make decisions and report back through the Audit Committee. The decision was made as it was felt that all CCGs need to go in same direction and therefore take a common approach. JoS and JIn were operating under their delegated authority. JSCC are looking to establish a work programme which will come back to GB in either February or March. It is planned that JSCC will have the same reporting process to all GBs. **ACTION: JSCC work programme to be an agenda item for February / March**	**JoS**
19.	**Mental Health Crisis Hub**	
	Euan Williamson (EW), Mental Health Commissioning Programme Manager attended the meeting to present a proposal for a development and implementation process so that members could consider and make a final decision to proceed on the procurement. A query was raised with regards to funding and cost sharing. It was confirmed that each CCG would be asked to cover the cost of revenue and work will be carried out	

	to look at how it will be divided between each CCG. With regards to the Capital Bid it is hoped that we will have a response within 4-6 weeks and by the beginning of April at the latest. It was felt that unless we know whether we have this funding it would be difficult to make a decision. JIn provided assurance that the co-ordinating commissioner has looked at the proposed costs contained with the paper and carried out an affordability test. From the proposal it is anticipated that there would a reduction in out of trust placements and therefore reduced spend in that area. There is uncertainty about dates and therefore there needs to be a realistic timetable rather than one that is overly optimistic. EW confirmed that we are looking at an end date of January 2019 for building works with the service partially up and running by November 2018. There would be some building work being completed while the service is being implemented. Meetings have taken place with Norwich City Council who are fully committed and have offered to explore if we can draw down on some monies to firm up the process. They see it as an important part of their estate and are excited at the idea of creating a community hub. It will be of benefit for tenants of the city council. With regards to the services provided this is something that will need to be worked up through the engagement and planning processes as there are various options. It is felt that Option 3 provides what is missing at the moment and is the core provision which needs to be concentrated on. It is suspected that the first two options were created for reassurance that it would fit the rest of system. There are some reservations as more information is required around how funding will be arranged and whether NCCG has sufficient capacity to absorb the risk if this is not delivered. There needs to be a continuing evaluation process or smart targets and continuous review. **Recommendations** Governing Body agreed to proceed with the development of a community wellbeing hub in Norwich. Governing Body agreed to the preferred Option 3.	
20.	**SIRO Report**	
	For the past six months the focus has been on GDPR and the paper is in response to that. NCCG are well aware of what is required in order to implement the GDPR. This is overseen by the IG working group and GB received assurance from the report which will be going to Audit Committee for further scrutiny. Chrissy Jackson (CJ) was thanked for her hard work.	
21.	**Conflicts of Interest Committee Chair's Report**	
	PFi presented the CoI Committee Chairs Report. There is one item of interest which is the New Models of Care and how the process and decisions will be made. The Committee agreed that the Primary Care Delegated Commissioning Committee is the most appropriate decision making committee for this.	

22.	**Governing Body Assurance Framework (GBAF)**	
	JC presented the GBAF. There has been a lot of movement around winter pressures discussions. There have been discussions at Exec Committee about elevating the financial risk around Mental Health onto the main GBAF, work will be carried out on the next iteration.	
23.	**Internal Audit Procurement**	
	Following the successful External Audit procurement, the CCG's followed the joint process with one panel for all CCGs and this paper offers assurance that we followed due process. Bidder A was the successful bidder for both Internal Audit and Counter Fraud services. As the scores were close, the question was raised as to whether they could be challenged. It is believed that it is unlikely as there is a lot of scrutiny as to how the scores are made up. There will be a full report to Audit Committee and the full procurement from CSU will be up for scrutiny. This was agreed by Governing Body.	
FOR INFORMATION ONLY		
	Health & Wellbeing Board	
	The link to the Health & Wellbeing Board papers was shared for information.	

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair (on behalf of NHS Norwich CCG Governing Body)