Present:
Ailsa Claire  Chief Executive (Chair)  NHS Barnsley
Steve Wainwright  Director of Strategy & Contracting  NHS Barnsley
Steve Hackett  Director of Finance  NHS Barnsley
Annette Laban  Chief Executive  NHS Doncaster
Andy Buck  Chief Executive  NHS Rotherham
Jan Sobieraj  Chief Executive  NHS Sheffield
Ann Ballarini  Director of Strategy & Commissioning  NHS Wakefield
Carol McKenna  Director of Commissioning  NHS Kirklees
Jayne Brown  Chief Executive  NHS North Yorkshire & York
Simon Morriss  Chief Executive  NHS Bradford & Airedale
John Lawlor  Chief Executive  NHS Leeds
Debbie Graham  Director of Business Intelligence  NHS Calderdale
Ivan Ellul  Chief Executive  NHS East Riding
Julia Mizon  Assistant Director – Contracting and Performance  NHS Hull
Caroline Briggs  Director of Strategic Commissioning & Development  NHS North Lincolnshire
Sue Rogerson  Director of Collaborative Commissioning  North East Lincolnshire Care Trust Plus

In Attendance:
Cathy Edwards  Director  Yorkshire & the Humber SCG
Kevin Smith  Medical Advisor  Yorkshire & the Humber SCG
Lisa Marriott  Assistant Director of Commissioning  Yorkshire & the Humber SCG
Frances Carey  Deputy Director of Finance  Yorkshire & the Humber SCG
Paul McManus  Lead Pharmacy Advisor  Yorkshire & the Humber SCG
Laura Sherburn  Deputy Director of Commissioning – Specialised Services  Yorkshire & the Humber SCG
Pia Clinton-Tarestad  Asst Director of Commissioning – Specialised Services  Yorkshire & the Humber SCG
Ged McCann  Associate Director of Commissioning – Specialist Mental Health  Yorkshire & the Humber SCG
Paul Crompton  Business Manager  Yorkshire & the Humber SCG

SCG  Apologies
62/10
Maddy Ruff  Director of Commissioning  NHS Hull
Graham Wardman  Director of Performance  NHS Calderdale
Action

SCG 63/10  Declarations of Interest
There were no declarations of interest.

SCG 64/10  Minutes of the Meeting held on Friday 23rd July 2010
The minutes of the meeting held on the 23rd July 2010 were accepted as a true and accurate record.

SCG 65/10  Matters Arising
(a)  Paediatric Critical Care Services
The meeting was informed that there was an improving position with regard to this matter. The five PICU beds at Sheffield had re-opened on the 2nd August and the middle grade training staff rota was much improved. EMBRACE was now providing full cover with effect from the beginning of September. However, there was still some risk in the system with regard to consultant staffing.

(b)  Paediatric Standards
The exercise for undertaking a stock-take against the standards was now in progress and due to be completed by the 31st October. Mid Yorkshire and Harrogate hospitals had yet to nominate a representative for this. The results from the exercise would be reported to the SCG Board meeting in November.

(c)  Paediatric Cardiac Surgery Update
Cathy Edwards gave a briefing on the background to the article which had appeared in last week’s ‘Sunday Telegraph’ newspaper in relation to paediatric cardiac surgery. The article had been developed following a statistical analysis of the Central Cardiac Audit Database (CCAD) information looking at the expected and actual deaths at Oxford between 2000 and 2008. Using similar data from across the country, three other centres were identified as potential areas for concern, one of which was Leeds.


There had been problems at Leeds in the middle period with regard to one particular procedure, but these had been addressed, and the latter period clearly evidenced an improvement.

The national SCT in conjunction with Sir Ian Kennedy were now
considering requesting further information from each of the three providers regarding their mortality and morbidity meetings; both the process and the clinical outcomes. This information would enable assurance to be provided to both the public and the NHS about the standard of current services. This information would also feed into the ongoing review of paediatric cardiac surgery.

Kevin Smith stated that he had reviewed the Leeds data from 2008 onwards and the processes that were now in place. He had been able to provide the national SCT with reassurance that Leeds had very good processes in place that would immediately register any abnormalities in outcomes. Leeds was not in the same position as Oxford.

Cathy Edwards highlighted that the matter needed very careful management.

It was noted that public consultation on the full review would not start until early 2011.

It was agreed that a position statement and briefing note be circulated to PCTs for information and to ensure a consistent position. Enquiries regarding the matter should be directed to Cathy Edwards.

(d) Neonatal Task Force Implementation

It was reported that progress was being made with regard to neonatal surgery and intensive care in Sheffield where currently there were two Trusts involved with provision. There had been a discussion involving the two Trusts where it had been agreed that it was not practical or deliverable to consider moving one of the services to colocate with the other. However it had been agreed to review the standard of care provided in neonatal surgery at Sheffield Children’s Hospital to ensure consistency with the main neonatal services in Sheffield Teaching Hospitals Foundation Trust.

Financial Plan 2010/11 – 2011/12 Update on Progress

Frances Carey presented a summary of the report to the meeting.

The last 2010/2011 financial plan paper presented to the Board was in May 2010 at which point the financial plan was signed off subject to finalisation and agreement of contract values.

The financial plan was split into 2 elements, financial values for those elements that needed to be placed into contracts from the 1 April 2010 and financial values for those elements where the cost related to in year growth predictions.

The SCT recommendation was that the growth horizon scanning funding
would be required in 2010/2011 however as the timing of these investments were not known this was at the discretion and risk of the PCTs as to whether funding was set aside for these elements.

At the time of writing the report all secure services and all but a few of the national contracts were signed. A number of local contracts were agreed and contract documentation sent out for signature. An update on the main local contracts was attached. The situation with regards the SCG element mirrored the issues facing PCTs for the non specialised elements of the contracts.

A reconciliation of the original financial plan to the 2010/11 actual financial plan would be presented to the SCG Board meeting in October.

With regard to the 2011/12 financial plan, baseline information and horizon scanning information would be forwarded to PCTs next week.

A confirm and challenge event was being held with PCTs in October. There was a discussion on the correct percentage to include for efficiency savings, the SHA figure of 3.5% appeared to have been modified and the actual figure being used by PCTs was above this figure.

It was reported that providers of services had been forwarded a letter in August 2010, requesting that they use the correct YDD2 codes when recording SCG activity and costs. Only one provider to date was complying fully. It was the intention to forward a further letter indicating that PCTs/SCG would use the appropriate clauses in the contract to withhold part of the contract payments if the correct coding for SCG activity was not used.

It was agreed that the contents of the report be noted and the proposed actions with regard to ensuring that providers used the correct coding system be approved.

**SCG 67/10 QIPP Programme Report**

Laura Sherburn presented a summary of the QIPP programme and the first set of reports.

The SCG QIPP Programme was signed off in May 2010. The SHA undertook a subsequent review of the QIPP Programme in July 2010, and it was agreed that monitoring reports should be in place from September onwards. An SCG Programme Manager role has been sourced from the Commercial Procurement Collaborative. The reporting format was based on the salient elements of the SHA QIPP tracker used by PCTs. The Chief Executive sponsors for each project identified in May continued in these roles, and receive detailed briefings on the progress of their project from the SCT on a regular basis.

This first report contained details of all risks and milestones identified for the
19 SCG QIPP Projects, and an overall financial summary by project.

The original SHA reports were completed in May 2010 and since then there had been various events that had changed the scope and outcome of some of the QIPP Projects, these changes were identified in the milestones and risks in the report.

A brief summary of the most significant changes & risks were as follows:

(i) The morbid obesity surgical services project originally identified that a saving between £0-800k would be made in 2010/11. This would now not be achieved, as it was based on 7 PCTs currently operating different criteria to move to the current regional criteria in-year. These PCTs were now opting to make one move to the new regional criteria which were being developed within this overall project over a longer time frame.

(ii) The fertility project price negotiations had been completed however, the restrictions surrounding the agreement within the LTHT contract not to re-visit non-PbR prices in 2010-11, meant that the savings of £470k could not be realised in 2010/11.

(iii) The specialist mental health project had been delayed due to recruitment issues with NHS Barnsley host.

(iv) The finance resource to support the QIPP Programme agreed by SCG Board in July had not yet been identified, and as a result, the financial input to the projects to date had been compromised. This would not be sustainable as the projects were taken forward.

The principle for calculating individual monthly savings per PCT per project had been circulated for comment to the SCG Finance Network Group and Performance Monitoring Sub Group. The figures would be submitted via the individual PCT trackers to the SHA.

Concern was expressed about the slippage in the QIPP projects. It was agreed that there was a need to review the overall QIPP Programme, from a strategic perspective, to ensure appropriate focus and priorities. North Yorkshire and York PCT volunteered to assist in the review process.

It was agreed that:

(a) The QIPP programme summary, financial summary and 19 project highlight reports be noted

(b) The reports for submission to the SHA be approved

(c) A report be submitted to the October SCG Board following a further review of the programme to reduce/eliminate the slippage.

Laura Sherburn /
**Low Secure Services Update**

Ged McCann presented a report on low secure services and the activity commissioned on behalf of the Yorkshire & the Humber SCG. Information was provided for each PCT. The focus of the report was to draw attention to the patient pathway specifically at the interface between secure care and local mental health services. The information in the report was to assist individual PCTs in identifying opportunities to reduce the need for secure care, or reduce length of stay.

The secure services pathway was dependent on the whole patient pathway for it to work efficiently as a lack of local services would cause delays and extend the length of stay in secure care. To monitor the patient pathway the SCT had introduced standard pathway criteria which was in use across the secure services and case managers with Yorkshire & the Humber. The criteria attempted to classify a patient at all stages along their pathway and monthly reviews of all patient allowed the SCT to quantify delays and identify areas to improve efficiency.

A number of ‘bottlenecks’ in the pathway were identified in the report.

The report also went on to identify the specific issues in individual PCTs relating to the pathway.

It was agreed that the report be noted and that individual PCTs use the information to inform the approach to low secure services.

**Low Secure Risk Share Update**

It was agreed that this item be deferred to the next SCG Board meeting in October.

**Pilot PIPE at HMP Hull**

Ged McCann presented a report on the establishment of a pilot scheme at HMP Hull.

The National Personality Disorder Policy Team, which works cross departmentally between the DH and the Ministry of Justice (MoJ), had published a draft strategy for individuals with Personality Disorder (PD) and ‘high harm’ behaviour. The strategy proposed two parallel pathways for this population; one in health the other in the criminal justice system. The central tenet of the strategy was that those individuals with PD and ‘high harm behaviour’ should be treated within the prison system and only be transferred into the health system when there were co-morbidities (such as psychotic illness, autistic spectrum disorder or learning disability).
The strategy proposed the establishment of PD treatment centres within the prison estate within each region to underpin existing dangerous and severe PD (DSPD) provision and that those treatment centres should be supported by Psychologically Informed Planned Environments (PIPEs) within each region. Action was now being taken to establish a small number of pilots on both the male and female prison estate. The Secure Services Team had submitted an expression of interest. The application had been successful and HMP Hull would be establishing one of these pilot sites by the end of the year.

The development was essentially a prison venture but SCG would have oversight and would ensure that the service linked with the programme of PD focussed services in the region. The successful establishment of regional treatment centres and PIPEs within the prison estate would have significant implications for the secure hospital system which could see a substantial reduction in the number of men referred for specialist treatment.

It was agreed that the report and developments be noted.

General Commissioning Policies for Medicines and Treatments

The following four policies were proposed for adoption by the SCG:-

(a) **Imatinib** for the adjuvant treatment of gastrointestinal stromal tumours - To be not routinely funded, in accordance with **NICE TA 196**

(b) **Capecitabine** for the treatment of advanced gastric cancer - To be routinely funded in accordance with **NICE TA191**

(c) **Rituximab** for the treatment of relapsed or refractory chronic lymphocytic leukaemia - To be routinely funded in accordance with **NICE TA193**

(d) **Gefitinib** for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer - Update to regional policy 08/10 to reflect recently published **NICE TA192**

The following notes for commissioners were provided:-

(a) **Clarification of NICE TA 190** – pemetrexed for maintenance treatment of non-small cell lung cancer

The three cancer networks had identified different levels of use of pemetrexed in line with NICE TA 190.

These differences would be explored in an on-going review of cancer network treatment regimens being undertaken by the SCG Pharmacist Advisor and lead pharmacists for the three cancer networks.
(b) **Review of regional policy 10/09 (rituximab for severe (refractory) rheumatoid arthritis)**

In view of changes to national policy in accordance with NICE TA 195, a review of regional policy 10/09 was proposed, to be facilitated by the Regional Policy Sub-Group.

Commissioners would need to be aware of the implications of NICE TA 195, which increased treatment options for patients with severe rheumatoid arthritis, and, in particular, recommended that abatement, which had previously not been supported by NICE, may be used in certain circumstances.

(c) **Imatinib for adjuvant treatment of gastrointestinal stromal tumours**

Commissioners were reminded that Imatinib was already funded, in accordance with NICE TA 86 (October 2004) for gastrointestinal tumours that could not be removed surgically. This more recent appraisal related to use after surgery, which should not be funded.

(d) **Patient access scheme for gefitinib**

Commissioners were asked to note the patient access scheme for gefitinib and ensure that systems were in place to avoid payment for patients who discontinue therapy within the first 3 months.

It was agreed that:

(i) the key points for commissioners be noted;

(ii) the general policies for Imatinib, Capecitabine, Rituximab and Gefitinib as detailed in the report be approved for adoption; and

(iii) These policies be made available to the public in accordance with directions from the Secretary of State

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**Evidenced-Based Commissioning (EBC)**

The Evidence-Based Commissioning programme aims to support collaborative development by PCTs, using the SCG mechanisms. In conjunction with providers and clinical networks, a single process to quality assure, implement and monitor Evidence Based Commissioning policies for non-specialised drugs and interventions had been developed. It aims to deliver consistent written statements and policies, in accordance with directions from the Secretary of State (April 2009), for publication by PCTs. The group also horizon scans for potential future topics. By utilising this collaborative approach, it aims to ensure transparency and consistency, while sharing capacity and cost saving across the region.
The EBC programme links closely to the aims and objectives of the Regional Policy Sub-Group, and shares the same decision-making framework. However, it has a different focus, both in terms of the range of treatments considered, and the process for policy development. While the RPSG looks to prospectively develop policies for specialised or cancer medicines (and other areas of collaboration subject to agreement of SCG), EBC focuses on non-specialised treatments and, in its initial stages, provides a mechanism for PCTs to share existing commissioning policies that have been developed elsewhere in the region.

In the medium to long term, EBC will link with the RPSG to provide quality assurance. Until the RPSG is fully functional, SCG had asked that the first wave of EBC policies are developed using the regional policy template which will then be reviewed by a sub-group of the RPSG, and proposed to SCG via the Clinical Standards Sub-Group.

The EBC programme was divided into a number of waves of policy.

Wave one started with a stock-take of all PCT commissioning policies in the region. The author PCT was invited to review their policy, to ensure that it was still relevant, accurate, and reflected current evidence, and convert it into the regional policy template. These standardised policies were then submitted to the project team for review.

Policies were then scrutinised by a sub-group of the RPSG, who sought assurance that there had been the clinical input to the development of policies and they had been equality impact assessed.

The report set out a list of policies which were categorised as follows:

- Policies previously agreed by the SCG
- Policies recommended for adoption by SCG
- Policies recommended for the SCG – Primary Care Interface
- Policies requiring further work prior to recommendation
- Policies that were not recommended for adoption

In terms of the implementation much of this would be via local PCT processes, excepting those that relate to cancer drugs. The critical element was the need for consistency across the region and the need to avoid inappropriate use of the Individual Funding request (IFR) process.

It was agreed:

(a) In respect of the policies set out in the first two categories (pages 5-9 of the report), excepting the policies for Functional Electrical Stimulation (FES), hyperbaric oxygen therapy (HBOT) and occipital nerve stimulation (ONS) be approved for adoption as regional policies;
(b) In respect of the policies set out in category three (pages 10-12 of the report) that these be adopted by the constituent PCTs of the Yorkshire & the Humber SCG, unless a PCT was able to inform the SCG why they should not adopt a specific policy;

(c) That SCG Board members be circulated a note on the implementation procedures, including the uses of comparative information and benchmarking; and

(d) That appreciation be expressed to Paul McManus and the PCTs who had assisted in the development of the policies.

SCG 73/10

Interim Cancer Drugs Fund

The Secretary of State for Health had recently announced plans to establish a Cancer Drugs Fund from April 2011 to improve patient access to cancer drugs prior to the anticipated reform of arrangements for the pricing of branded medicines from 2014. Further details on this fund would be available in October following publication of the Comprehensive Spending Review. However, an interim fund of £50M had been identified from DH central budgets to provide in-year funding for cancer drugs from October 2010 to March 2011. This interim funding would be allocated at a regional level, based on weighted capitation, and made available through Strategic Health Authorities (SHA). The allocation for Yorkshire and the Humber SHA was expected to be around £5.3M.

The SHA Medical Director, Professor Chris Welsh, was leading arrangements for the distribution of the Interim Cancer Drugs Fund in Yorkshire and the Humber, in collaboration with YHSCG and the three cancer networks in the region. The SHA was proposing that operational management of the fund was undertaken by the Specialised Commissioning Team, with an appropriate increase in capacity.

Early estimates of the potential demands on the interim fund suggested that there may not be sufficient to fund all patients whose clinician was recommending treatment with a medicine that was not currently funded by the local NHS. The SHA therefore intended to work with local cancer clinicians to agree which treatments, not currently funded by the local NHS, should be priorities for the fund. Some contingency would also need to be agreed to fund treatments for rarer cancers and ‘off-label’ use of cancer medicines that were less easy to anticipate.

Professor Welsh had written to all cancer clinicians in the region explaining the fund and asking for support in its administration. In addition representatives from YHSHA, YHSCG and the three cancer networks had recently met to agree clinical involvement in deciding which treatments would be covered by the fund.

The Chair advised the meeting that the national Specialised Commissioning
Team had identified an underspend in 2010 and the share for Yorkshire and Humber would be £2m. It was felt appropriate that this be kept in reserve to help mitigate against the risks associated with the fund; particularly the associated treatment costs which were not covered by the Cancer Drug Fund.

It was anticipated that the clinical panel would take 6 weeks to identify the priority list, including patient numbers and activity.

Discussion identified that communication issues were critical to this matter. It was suggested that training for PCT chairs and Non-Executive Directors regarding the Interim Cancer Drug Fund would be required.

It was agreed:

(a) To note the proposed draft regional arrangements for the Interim Cancer Drug Fund and to support the direction of travel set out; and

(b) To endorse the need for PCTs and acute Trusts to establish procedures for the monitoring of the use of the fund and associated activity costs.

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SCG 74/10

Reimbursement of Living Donor Expenses Policy

A report was presented to the meeting which advised that Department of Health Guidance states that reimbursement of living donor expenses is permitted, although the NHS is not legally obliged to do so. However, as renal transplantation is the most cost effective treatment for end stage renal failure (ESRF), payment of donor expenses incurred was justified.

The purpose of the discretionary reimbursement was to ensure that loss of earnings or other financial disincentives did not act as a constraint on individuals wishing to act as a live transplant donor.

Currently there were inconsistencies within the Yorkshire & the Humber region regarding reimbursement of living donor expenses.

The Yorkshire & the Humber Renal Network were therefore recommending the following:

(i) Consistency across NHS Trusts and Primary Care Trusts in the reimbursement of living donor expenses

(ii) Reimbursement of reasonable individual claims as outlined in the policy document

(iii) An agreed policy for reimbursement

(iv) An agreed claims process

It was agreed that the recommendation of the Renal Network relating to the

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Jackie Parr

Paul McManus/ PCTs
reimbursement of Living Donor Expenses be approved.

**SCG 75/10**

**Yorkshire & the Humber SCG Annual Report 2009/10**

The final version of the Yorkshire & the Humber SCG Annual Report 2009/10 was presented to the meeting. A copy of the report would be put on the Y&H SCG website. PCTs were required to present the report to their Board meetings.

It was agreed that:-

(a) The final version of the Y&H SCG Annual Report be approved and that this be placed on the web-site. **Paul Crompton**

(b) The report be presented to PCTs Boards **PCTs**

**SCG 76/10**

**SHA Review of SCG**

A letter from the Yorkshire and Humber Strategic Health Authority was presented to the meeting. The review took place on the 15th July 2010 and the main focus of the review had been the SCG commissioning strategy and the proposed SCG QIPP programme.

The letter highlighted that the SCG had made many improvements over the last year and that the SCG QIPP programme would only be delivered if PCTs were actively involved in the process.

It was agreed that the letter from the Y&H SHA regarding the review of the SCG be noted.

**SCG 77/10**

**Exception Performance Report (to June 30th 2010)**

The exception performance report for the period up to the 30th June 2010 was presented to the meeting.

The position at the end of June showed an underspend of £1.2m but there were a number of outstanding issues relating to contract baselines which needed to be resolved. The year end forecast was showing an overspend of £5.5m. Work was already in progress on challenging the position and obtaining a more accurate forecast.

It was agreed that the exception report for the period up to the 30th June 2010 be noted.

**SCG 78/10**

**Risk Management of the Sheffield Teaching Hospitals Contract 2010/11**

Further to the Performance Monitoring Sub Group meeting on 16th August 2010, a report was presented to the meeting setting out the issues that caused a significant variance from the projected spend for 2009/10 and the
additional risks to the contract identified in respect of the Sheffield Teaching Hospitals contract. The report went on to set out the agreed actions to mitigate against a recurrence of the problem in 2010/11.

It was agreed that the contents of the report be noted and the proposed actions were endorsed.

**SCG Acute CQUINs Scheme Quarter 1 Results**

The SCG Acute CQUINs Scheme 2010-11 was endorsed by SCG at Board on 26th March 2010 and subsequently approved by the YHSHA. Following discussion with providers in an open Clinical Standards Sub-Group (CSSG) meeting a consensus version of the scheme, agreed by CSSG members, was endorsed by SCG on 28th May 2010.

There had been considerable work done in Q1 to ensure the indicators were fit for purpose, leading to some revisions to the schedule. Given these changes, and to ensure that improvement trajectories were based on the most robust data, it was therefore proposed that Q2 submissions would set baselines for all 7 indicators.

A revised schedule of the indicators was attached to the report setting out the changes.

It was made clear where narrative reports would be submitted to supplement the raw data.

It was also made clear that for those indicators where Q1 submission was not required, the principle of payment in Q1 was agreed only subject to submission in Q2; should submission of Q2 not be achieved, then Q1 payment would be repaid to commissioners.

The following revisions to indicators were proposed:-

- **Indicator 1 (Lung Cancer):** it was proposed to go back to quarterly reporting of real-time data, instead of using published annual reports

- **Indicator 2 (BMT):** emphasis on learning from significant events rather than accrued rates

- **Indicators 3 & 4 (NIC & PIC):** improved definitions of indicators 3a and 3b were proposed, together with an agreed comprehensive indicator for both 3c and 4 which recognised the importance of network-level action

- **Indicator 5 (Cardiac):** improved definitions were proposed

The CSSG would continue work on the approval of baselines and setting of trajectories, throughout the coming months.
Learning from the experience of the short lead-in time for the 2010-11 scheme, it was recognised that work on the SCG Acute CQUINS scheme for 2011-12 must begin early. Therefore it was proposed that the CSSG would start to consider the priority areas for 2011-12 at their meeting in October, and, using the learning from this year, start to build up next year’s scheme.

It was agreed that:

(a) The recommendations and revisions proposed by the CSSG in relation to the SCG Acute CQUIN scheme be approved;

(b) Q1 payments to all providers in respect of all indicators as per the schedule of CQUIN indicators be approved; and

(c) The planned work of the CSSG be noted.

Kevin Smith

SCG 80/10

Strengthening SCG Board Governance Arrangements

A report was presented to the meeting which set out the following information:

At the SCG Board meeting on 28 May it was agreed that a range of proposals to strengthen the SCG Board governance would be circulated for consideration by PCT Boards and PCT Executive Teams. The proposals included:

- Updating the Establishment Agreement to incorporate Version 3 of the Specialised Services National Definition Set (SSNDS), and an appendix clearly listing non-specialised areas for SCG Board collaboration
- Amending the Scheme of Delegation to delegate decisions relating to commissioning policy to SCG Board
- Strengthening the role of the SCG Patient and Public Involvement (PPI) Steering Group in providing assurance to SCG Board
- Incorporating non-executive challenge to SCG Board
- Changing the Chair of the Clinical Standards Sub-Group (CSSG)

Feedback had been received from the constituent PCT Boards on the proposals and these were sent out in an appendix to the report. The feedback had been incorporated in the recommendations and revised documentation that was presented for approval:

- Yorkshire and the Humber SCG Establishment Agreement
- Yorkshire and the Humber SCG Scheme of Reservation and Delegation
- Development/Adoption of Commissioning Policies – Clarification on level of Delegation
A discussion followed on the issue of transparency in the decision making process and the need for PCTs to adopt the SCG minutes at their Board meetings.

In conclusion it was agreed that:

(a) The revised Establishment Agreement which incorporated SSNDS version 3 and a list of non-specialised areas for collaboration be approved;

(b) The revised Scheme of Delegation incorporating the development/adoption of commissioning policies – clarification on the level of delegation, be approved;

(c) The PPI Steering Group terms of reference be amended as recommended in the report;

(d) Implementation of non-executive involvement be suspended;

(e) Nominations for a new Chair of the CSSG be considered later in the agenda;

(f) The revised terms of reference of the Sub-Groups be considered; and

(g) The minutes from the SCG Board meetings be presented to PCT Board meetings for adoption and that these minutes would be prefixed by a summary of the decisions.

**SCG 81/10 Specialised Services National Definition Set – Update**

A report was presented to the meeting setting out the implications of adopting the use of the Specialised Services National Definitions Set (SSNDS) 3rd Edition. The report summarised the major changes from the 2nd Edition:

- Removal of four definitions (14 HIV; 21 Learning Disabilities; 25 Pathology; 20 Hyperbaric Oxygen);

- Addition of three definitions (36 Metabolic Disorders; 37 Ophthalmology; 38 Haemoglobinopathy);

- Updates of other definitions with clearer descriptions of what elements of service require specialised commissioning;

- Removes elements of four definitions where number of providers exceeds 50 nationally (4 Fertility Treatments; 14 Angioplasty; 26 Almost all Adult Rheumatology; 30 much Vascular Surgery).

The report outlined key areas where the SCG currently commissions
services, which have been removed from the 3rd Edition definitions, but still merit regional commissioning.

It was agreed that:-

- The 3rd Edition of the Specialised Services National Definition Set be adopted as part of the Y&H SCG Establishment Agreement;

- The Y&H SCG continues to commission services which have been removed from the SSNDS which continue to merit regional commissioning (IVF Treatments; HIV, Principal Treatment Centres only; and Vascular Surgery & Interventional Radiology).

SCG 82/10 Revised/Update Terms of Reference

The following revised/updated terms of reference were presented to the meeting:-

(a) Clinical Standards Sub Group
(b) Designation Sub Group
(c) Performance Monitoring Sub Group
(d) Regional Policy Sub Group

It was noted that a new chair of the Clinical Standards Sub Group was required.

It was agreed that:-

(a) The revised terms of reference for the Clinical Standards, Designation, Performance Monitoring and Regional Policy Sub Groups be approved; and

(b) John Lawlor be appointed as the Chair of the Clinical Standards Sub Group.

SCG 83/10 Minutes of the Designation Sub Group

The minutes of the Designation Sub Group meeting held on the 3rd August 2010 were presented to the meeting.

It was agreed that the minutes of the Designation Sub Group meeting held on the 3rd August 2010 be received.

SCG 84/10 Minutes of the Performance Monitoring Sub Group

The minutes of the Performance Monitoring Sub Group meeting held on the 16th August 2010 were presented to the meeting.

It was agreed that the minutes of the Performance Monitoring Sub Group
meeting held on the 16th August 2010 be received.

**SCG 85/10 Minutes of the Yorkshire Neonatal Network Board**

The minutes of the Yorkshire Neonatal Network Board meeting held on the 15th April were presented to the meeting.

It was agreed that the minutes of the Yorkshire Neonatal Network Board meeting held on the 15th April 2010 be received.

**SCG 86/10 Minutes of the North Trent Neonatal Network Steering Group**

The minutes of the North Trent Neonatal Network Steering Group meetings held on the 21st April and 16th June 2010 were presented to the meeting.

It was agreed that the minutes of the North Trent Neonatal Network Steering Group meetings held on the 21st April and 16th June 2010 be received.

**SCG 87/10 Minutes of the North Trent Neonatal Clinical Sub Group**

The minutes of the North Trent Neonatal Clinical Sub Group meetings held on the 11th May and 9th July 2010 were presented to the meeting.

It was agreed that the minutes of the North Trent Neonatal Clinical Sub Group meetings held on the 11th May and 9th July 2010 be received.

**SCG 88/10 Minutes of the Yorkshire & Humber Renal Strategy Group**

The minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 28th June 2010 were presented to the meeting.

It was agreed that the minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 28th June 2010 be received.

**SCG 89/10 Draft Minutes of the Congenital Cardiac Network Board**

The draft minutes of the Congenital Cardiac Network Board meeting held on the 8th September 2010 were presented to the meeting.

It was agreed that the draft minutes of the Congenital Cardiac Network Board meeting held on the 8th September 2010 be received.

The meeting was advised that a Chair of the Congenital Cardiac Network was required.

It was agreed that Jayne Brown be appointed as the Chair of the Congenital Cardiac Network.
SCG
90/10  Y&H SCG Board Meeting Dates 2011
The proposed dates for the Y&H SCG Board meetings in 2011 were presented to the meeting.

It was agreed that the dates and times set out for the SCG Board meetings in 2011 be approved.

SCG
91/10  Any Other Business
There were no other items of business.

SCG
92/10  Date and Time of Next Meeting
Friday 22\textsuperscript{nd} October 2010, 9am – 12:30pm at Sandal Rugby Club, Wakefield