Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

7 March 2019 9.30am to 12.30pm

The Snow Room, West Offices, Station Rise, York YO1 6GA

Prior to the commencement of the meeting a period of up to 20 minutes, starting at 9.30am, will be set aside for questions or comments from members of the public who have registered in advance their wish to participate.

The agenda and associated papers will be available at:
www.valeofyorkccg.nhs.uk

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 5 to 20	Minutes of the meeting held on 3 January 2019	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 21 to 29	Accountable Officer's Report	To Receive	Phil Mettam Accountable Officer
6.	Pages 31 to 39	Risk Update Report	To Receive	Phil Mettam Accountable Officer

STRATEGIC – 10.20am				
7.	Pages 41 to 42	Back to the Future: Annual Report of the Director of Public Health for North Yorkshire 2018 Full report available at: http://www.nypartnerships.org.uk/dphreport2018	To Receive	Dr Lincoln Sargeant Director of Public Health for North Yorkshire
8.	Pages 43 to 46	Commissioning Intentions 2019/20	To Approve	Phil Mettam Accountable Officer
9.	Pages 47 to 75	Services in the Community; Improving Health and Tackling Inequalities	To Approve	Lisa Marriott Head of Community Strategy
FINANCE AND PERFORMANCE – 11.20am				
10.	Pages 77 to 96	Financial Performance Report 2018/19 Month 10	To Receive	Michael Ash-McMahon Deputy Chief Finance Officer
11.	Pages 97 to 104	Quarter 3 Financial control, planning and governance assessment	To Receive	Michael Ash-McMahon Deputy Chief Finance Officer
12.	Pages 105 to 149	Integrated Performance Report Month 9	To Receive	Caroline Alexander Assistant Director of Delivery and Performance
ASSURANCE – 12.10pm				
13.	Pages 151 to 199	Quality and Patient Experience Report	To Receive	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse

RECEIVED ITEMS – 12.25pm **Committee minutes are published as separate documents**				
14.	Page 201 to 202	Chair's Report Executive Committee: 5 December 2018, 2 and 16 January and 6 February 2019		
15.	Pages 203 to 204	Chair's Report Finance and Performance Committee: 20 December 2018 and 24 January 2019		
16.	Page 205	Chair's Report Primary Care Commissioning Committee: 24 January 2019		
17.	Pages 207 to 222	Medicines Commissioning Committee: 12 December 2018 and 9 January 2019		
18.	Pages 223 to 226	Joint Acute Commissioning Committee: 24 October and 28 November 2018		
NEXT MEETING				
19.	Verbal	9.30am on 4 April 2019 at West Offices, Station Rise, York YO1 6GA	To Note	All
CLOSE – 12.30pm				

EXCLUSION OF PRESS AND PUBLIC

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it is considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted as it contains commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.

A glossary of commonly used terms is available at

http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/governing-body-glossary.pdf

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Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 3 January 2019 at West Offices, York

Present

Dr Nigel Wells (NW)	Clinical Chair
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Dr Helena Ebbs (HE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member and Audit Committee Chair
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Keith Ramsay (KR)	Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Caroline Alexander (CA) –item 8	Assistant Director of Performance and Delivery
Abigail Combes (AC) – items 1-6	Head of Legal and Governance
Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Michèle Saidman (MS)	Executive Assistant

Apologies

Sharon Stoltz (SS)	Director of Public Health, City of York Council

There were four members of the public present.

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

Fiona Benson on behalf of York Ambassadors for the Public Health Collaboration

Management and treatment of metabolic disorders, including Diabetes and obesity, continues to be a major challenge. In December 2018 NHS Digital added The Diabetes.co.uk Low Carb Program (@LowCarbProgram) for diabetes

management to their Apps Library (#NHSAppLibrary) with access free for patients with a voucher from their GP. The Royal College of General Practitioners also have an e-learning module for GPs 'Type 2 diabetes and Low GI Diet' available in their metabolic disorders e-learning section.

Those, both here in the UK and internationally, who have adopted this approach are achieving positive outcomes in weight loss and improved metabolic health with many diabetic patients putting their condition into remission and coming off all medication.

What plans does The Vale of York CCG have to support Primary Care Teams to offer the option of the effective low carbohydrate/glycaemic index approach?

NW responded that there was a rolling education programme, mostly evening sessions, within the CCG for GPs and Practice Nurses which included diabetes. He emphasised that the CCG understands the importance of both prevention and preventing progression of diabetes.

NW advised that the CCG was developing a programme of peer-led protected learning time events for GPs and Practice Nurses over the coming two years. The areas for inclusion would be discussed with them and may include diabetes.

AGENDA

STANDING ITEMS

1. Apologies

As noted above.

2. Declaration of Members' Interests in Relation to the Business of the Meeting

There were no declarations of interest in the business of the meeting. All declarations were as per the Register of Interests.

3. Minutes of the Meeting held on 6 December 2018

In seeking approval of the minutes of 6 December NW noted that a question had been received about communication of this additional meeting; a response would be provided in this regard. *Post meeting note: A response was provided on 9 January.*

The Governing Body:

Approved the minutes of the meeting held on 6 December 2018.

4. Matters Arising from the Minutes

There were no matters arising.

5. Accountable Officer's Report

PM presented the report which provided an update on turnaround, local financial position and system recovery; acute service transformation; operational planning; continuing healthcare; joint commissioning; Care Quality Commission Local System Review; winter resilience; Better Care Fund; Humber, Coast and Vale Health and Care Partnership; planning for the UK's exit from the European Union; and strategic and national issues.

PM explained that the financial position was in line with that reported in November 2018, a forecast deficit for the end of the year of £18.6million, with Quality, Innovation, Productivity and Prevention (QIPP) forecasts and additional financial recovery actions remaining on plan. Whilst stabilisation was continuing PM noted areas of concern: aspects of the Aligned Incentive Contract with York Teaching Hospital NHS Foundation Trust and the completion of the continuing healthcare reconciliation position by NHS Scarborough and Ryedale CCG. With regard to the former PM reported that increased demand for urgent and emergency care at York Teaching Hospital NHS Foundation Trust, in line with the national position, was having a financial impact on partner organisations; the impact of the historic cost pressure from the latter was being assessed.

PM noted that publication of the NHS 10-Year Plan had been delayed due to national issues including Brexit. This meant that financial resources to support the CCG's priorities in 2019/20 had not yet been confirmed. PM advised that CCGs and providers were required to submit to their respective regulators joint activity plans aligning resources for 2019/20 from planning assumptions based on historic activity. PM however emphasised anticipation of being able to report another year of stabilisation of the CCG's financial position and delivery of a modest improvement on the 2017/18 position.

With regard to operational planning for 2019/20 PM commended the developing clinical networks. He explained the aim of moving to a non activity based pay framework, other than where required for national performance areas, and for future services within available resources through working jointly with primary and secondary care clinicians. PM highlighted that the progress in clinical leadership was an important milestone for the system and added that the Chief Executives and Directors of Finance of partner commissioners and providers across North Yorkshire and York were meeting on 15 January to discuss alignment of priorities from 2019/20 onwards within financial resources.

PM referred to the CCG's commissioning intentions for 2019/20 which continued to describe the priorities emanating from the public engagement that had informed the 2018/19 commissioning intentions and the national priorities including cancer. He explained that available resources would not be sufficient therefore a system, instead of an organisational, approach would be sought with a request to boards that health priorities should take precedence.

PM commended DN and her team for the implementation of the iQA+ Health system for effective management of continuing healthcare, funded nursing care, personal health budgets, mental health aftercare and neurological rehabilitation.

He noted that, while there were still risks in this area, the new system would provide greatly improved assurance.

PM advised that the final report from the Care Quality Commission Local System Follow-up Review in December 2018 was still awaited but verbal feedback and the draft report included concern that more progress had not been made in response to their encouragement for the organisations to work more collaboratively. A further concern, not relating to the CCG, was of senior leadership turnover and vacancies. PM hoped that the report would be available for the March Governing Body meeting and emphasised the CCG's commitment to joint working at pace.

With regard to winter resilience PM reported that the Christmas and New Year period across the CCG had been busy but not at crisis level and the position had in the main been similar in the North of England. GP members advised that 'flu and respiratory viruses had now begun to have an impact.

PM noted that ambulance turnaround had been a concern on a number of days from the York Hospital perspective and at national level 'corridor care' had been a concern however this was not the case locally.

In response to DB enquiring about a 'flu review KS explained that the vaccine had been a good match but uptake had been low due to supply issues earlier in the year; a national and international review would take place at the end of the season. KS referred to the support provided through additional capacity within primary care for the first two working weeks of January and highlighted for the longer term potential impact from staff illness noting that not all staff were able to be vaccinated. KS confirmed that the CCG had made all possible preparations for the winter period.

PM referred to the Brexit information in his report advising that all NHS organisations were being encouraged to develop contingency plans and noting the expectation for the requirement of a named Executive Director lead in this regard. PM noted that the main impact was expected to be in respect of medication and specialist devices and advised that planning was also taking place with partner organisations to prepare for a potential no deal Brexit. PM assured members that in the event of the need for any Governing Body involvement before the scheduled March meeting the appropriate arrangements would be made. In response to HE noting that she had received and refused a number of requests from patients for stockpiling medication PM agreed to arrange for a communication to be circulated to Practices confirming that the CCG did not support such stockpiling.

KR welcomed PM's response to the Care Quality Commission Local System Review Follow-up report but, as the Health and Wellbeing Board workshop was not held in private, enquired when the report may be discussed in a public forum. KR also referred to discussion at the Quality and Patient Experience Committee regarding development of the CCG's Community Strategy in the context of collaborative working. In response KS advised that work was taking place to develop a holistic approach to replace the separate community services for

physical and mental health and based on a locality model incorporating services provided by the three Local Authorities as well as primary care. Services would be in response to population need initially working with current providers but with potential for alternatives, such as procurement, to be considered in the future. KS emphasised that the community services model must not be disease specific but a strategy for the appropriate management of patients and maximising available resources. He advised that meetings were taking place to identify health priorities in each area to inform consideration of addressing identified gaps.

In response to DB referring to the potential £510k over three years from the recently launched Voluntary, Community and Social Enterprise Health and Wellbeing Fund 2019/20 on Children and Young People's Mental Health, HE noted opportunities to learn from existing projects, including one on adverse childhood experiences in Bristol. The context of the earlier discussion about joint working ensued and DN agreed to discuss with Public Health colleagues potential for joint application to the fund for low cost transferable initiatives. DB additionally advised that, as he had reported at the recent Finance and Performance Committee, he was seeking information relating to potential opportunities for Dr Barnardo's to work with Child and Adolescent Mental Health Services which had the potential for inclusion in a bid. This partnership approach in Birmingham had resulted in waiting lists being reduced from 40 weeks to six weeks.

The Governing Body:

1. Received the Accountable Officer's report.
2. Noted that PM would arrange for a communication to be sent to Practices advising that medication should not be stockpiled.
3. Requested that DN explore the potential for a bid to the Voluntary, Community and Social Enterprise Health and Wellbeing Fund 2019/20 on Children and Young People's Mental Health

6. Risk Update Report

AC referred to the report presented to provide assurance that risks were being strategically managed, monitored and mitigated. It described details of current events and risks escalated to Governing Body by the Governing Body Committees for consideration regarding effectiveness of risk management approach. AC advised that all events had been reviewed by the relevant lead since the last Governing Body meeting.

AC highlighted that the RAG (Red, Amber, Green) rating for Event PC.02 - *Primary Care: capacity over winter* had reduced from 15 to 12 and sought members' views as to whether this should remain on the Governing Body Risk Register or be delegated elsewhere. KS responded that this was a significant risk that required regular monitoring.

Detailed discussion included the context of the CCG's investment in primary care to provide additional winter capacity but recognition that this created further

pressure on GPs as very few locums wished to take on short term work; diversification of the workforce in response to the GP Forward View had resulted in a model of fewer GPs in some Practices which was an issue in time of crisis; impact from Brexit; and the need for a longer term approach to develop models to address the vulnerability of Practices.

Members agreed that monitoring of PC.02 - *Primary Care: capacity over winter* be delegated to the Executive Committee.

AC explained that the ratings for the other events reported were unchanged and proposed amending the format of the report to provide greater assurance about mitigating actions. She also noted discussion at the Audit Committee in the context of reporting risks to the Governing Body only in the event of officers or Executive Directors being unable to manage them. SB highlighted the need for a more graphic presentation to help Committee and Governing Body members more easily identify areas for concern, e.g. gaps in controls and/or assurance around them.

Discussion ensued regarding how to provide clear and meaningful assurance to the Governing Body that controls were in place to manage risk. HE and RW highlighted that they welcomed the opportunity provided by the Risk Report to challenge RAG ratings that had not changed in the context of understanding the previous position, the present ambition and actions for its achievement. They also noted that the Governing Body was a clinically led forum for this challenge.

AC explained that opportunity for GPs to challenge was different from risks to the organisation. She advised that work was currently taking place with the Executive Directors and PG on development of a Board Assurance Framework. This would provide clarification and differentiation. AC noted that the Risk Update Report to the next Governing Body meeting would be in a revised format to inform discussion around assurance. Members also required assurance that the majority of risk monitoring was taking place in other forums, including the Committee structure, but with an opportunity remaining to challenge the status quo.

It was agreed that Brexit be added to the Executive Committee Risk Register in the context of the discussion at the previous agenda item.

AC reported that the CCG did not currently have resilience or emergency plans for primary care / GP Practices to provide timely support. Whilst noting their private business status, it would be helpful in the event of such as a repeat of the IT crisis or flooding for the CCG to hold this information which had not been forthcoming when previously requested. PM noted that KS would be the responsible Executive Director but advised AC to escalate the risk to NW and himself to write again to Practices. AC advised that this risk would be added to the Primary Care Commissioning Committee Risk Register.

The Governing Body:

1. Agreed that Event PC.02 *Primary Care: capacity over winter. Increasing signs that workforce numbers in primary care are impacting on capacity* be delegated to the Executive Committee.

2. Requested that Brexit be added to the Executive Committee Risk Register.
3. PM and NW to write to Practices requesting resilience and emergency plans.

AC left the meeting

Post Meeting Note

Following discussion with PM and SB after the meeting, a comprehensive review of the method by which risks are recorded and managed aligned to the creation of a new Board Assurance Framework will be undertaken. This means that the next risk register will remain in the current format with a view to changes being in late Spring / early Summer 2019.

FINANCE AND PERFORMANCE

7. Financial Performance Report 2018/19 Month 8

In presenting this report SB referred to the discussion at agenda item 5 and noted the reported year to date position and year end forecast remained respectively at £13.2m deficit and £18.6m deficit. The forecast position represented a £6.0m adverse variance against the CCG's financial plan and included the anticipated effect of the additional financial recovery actions as previously reported. SB emphasised that continued stabilisation of the financial recovery was as part of the locally agreed multi-year planning framework and assured members that issues were being closely monitored and managed as detailed.

SB reported that a meeting was taking place on 7 January with colleagues from NHS Scarborough and Ryedale CCG to discuss their continued invoicing for outstanding continuing healthcare payments over and above the agreed reconciliation exercise and £1m impact built in to NHS Vale of York CCG's position. SB confirmed that despite the continued charging there was no change to the CCG's forecast financial position. DB added that a key message from the December Finance and Performance Committee had related to the apparent lack of confidence around quality of the data and financial implications in the management of continuing healthcare by NHS Scarborough and Ryedale CCG. The Committee had requested that SB work with Scarborough and Ryedale CCG to establish a clear, agreed position. SB confirmed that work was underway and meetings to agree a way forward would take place in the second week of January.

SB reiterated the importance of establishing a system trajectory with development of meaningful, achievable plans at the start of quarter 4 of 2018/19. An agreed system approach to managing within fixed resource would enable investment in the CCG's priority areas. SB noted that despite the delay in publication of detailed planning guidance, allocations and control totals, planning locally had begun last year and the principle remained that all the organisations – NHS Vale of York and NHS Scarborough and Ryedale CCGs and York Teaching Hospital NHS Foundation Trust – should return to financial balance over the four years 2019/20 to 2022/23. This would enable the CCG to invest in the priority areas of primary care and in mental health.

With regard to the planning guidance SB expressed specific concern about the expectation that CCGs would be expected to reduce running costs by 20% by 2021. He explained that the £6.8m forecast spend in this regard was already £0.8m less than permitted currently by national rules. SB reported on discussion with the Executive Directors in the context of the need for additional staff resources in key areas, such as acute commissioning and clinical capacity for continuing healthcare, but with awareness of the c£1m running costs reduction target in 2020/21. He emphasised that reducing staffing costs could increase strategic risk and decrease ability to deliver expected improvements in value..

In response to NW enquiring about potential opportunities to address issues where partners may be less supportive in developing a system approach to working within the fixed financial resource, SB agreed that in his view there was a tension between the national direction of travel for organisations to work more closely together to deliver improvement, and a continuation of a tariff approach to paying for acute services. He commended the fact that from the local perspective system partners had recognised the need to work collaboratively over time within an overall fixed resource and noted that any organisation not working as part of the system would become increasingly isolated. SB assured members that alternatives, such as procurement, were available if appropriate and emphasised that informed discussions were taking place pending publication of the planning guidance. PM added that, prior to submission of the CCG's plans in March, members would be given the opportunity to identify any "red lines".

Discussion ensued in the context of the CCG being the largest commissioning organisation in the area, the need to ensure partner organisations had realistic expectations and the ambition that attendees at the meeting on 15 January were there as system, not organisation, representatives.

In response to RW and HE referring to the continuing underspend in primary care and the complexity of the requirements for localities to access the funding set aside by the CCG, KS emphasised that the ambition had always been for this to be distributed. In response to concerns about the complexity of the process to apply for funding, KS commented that this was now much more straightforward, but that appropriate governance was essential for the good use of public money. KS also noted that in addition to offering funding the CCG provided associated support. HE highlighted that Practice members did have ideas but there was not always the resilience to release clinicians to develop projects. NW added that primary care must develop a "one voice" approach for the local population and PM emphasised that a different way of working was required which may vary in each locality. A meeting later in the day would offer an opportunity to progress this discussion.

In conclusion SB emphasised the requirement of a system commitment to work within fixed financial resources.

The Governing Body:

Received the month 8 Financial Performance Report.

CA joined the meeting

8. Integrated Performance Report Month 7

CA advised that the report represented the pre-winter position for NHS Vale of York and NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust as updated for presentation to regulators and noted that this was a comparatively stable position. CA also referred to the awaited national planning guidance highlighting that in the meantime emerging planning priorities were being informed by greater availability of performance and activity information and analysis from providers and partners than previously under the Aligned Incentive Contract. She noted that performance aspirations would augment these plans when operational planning targets were clarified.

CA reported that the cancer two week wait target of 93% had deteriorated in September mainly due to the on-going clinical capacity shortfalls in dermatology. There had been a significant improvement in October largely due to closure of two week wait referral slots at Scarborough Hospital at the request of NHS Scarborough and Ryedale CCG. CA advised that work to address the shortage of dermatology clinical capacity included potential for scoping the GP with a Special Interest model. NHS Scarborough and Ryedale CCG were also considering whether issuing of a Prior Information Notice to test the market for dermatology provider capacity in February would be helpful in understanding the capacity available locally and regionally to support the shortfalls in local capacity.

CA noted that the two week breaches in lower gastrointestinal cancer were mainly due to patient choice. Engagement work was taking place in this regard through the CCG Clinical Lead for Cancer.

CA advised that performance for cancer 62 day treatment was 78% in October against the 85% target. A new programme director had been appointed to the Cancer Alliance which had been undertaking a refresh of the work programme, including confirmation they would be progressing rapid diagnostic pathways, with a focus on the lung pathway. The additional patient care co-ordinators were also now in post.

CA explained aspects of the diagnostics performance improvement priorities being explored by providers and commissioners for 2019/20. This included establishment of a refreshed diagnostics workstream across the Sustainability and Transformation Partnership bringing together the diagnostics demand and capacity work undertaken by the Cancer Alliance to date with the non-cancer all local diagnostics pressures. Work was also taking place with York Teaching Hospital NHS Foundation Trust to progress jointly in future to understand the current demand and capacity position for all radiology modalities and direct access pathology services.

CA noted that MRI continued to be the specialty with the highest number of breaches for CCG patients in September, also noting that concern had been raised in August from local GPs in relation to long routine reporting timescales. The latter had since improved, with 91% of reports being within 21 days although

there were some outliers. The Governing Body welcomed this performance improvement but still had some concerns around the impact on patients deteriorating within that 21 day timeline for routine reporting. CA advised that, while the CCG monitored against national performance targets of six weeks for diagnostics, there was an opportunity from working under Aligned Incentives and as a more integrated provider commissioner framework for clinicians to work jointly to define the appropriate and deliverable local targets for reporting they required and within the capacity available. NW additionally noted the intention of further clinical discussion with secondary care colleagues at the next Council of Representatives to ensure that GPs had the information they required to manage patients.

In respect of 18 week referral to treatment performance CA reported that York Teaching Hospital NHS Foundation Trust was working on a recovery plan to meet the NHS England target for the waiting list recovery so that at March 2019 the total waiting list would be no larger than at March 2018. She also noted that they had agreed to transfer spend from planned elective care to fund potential increased ophthalmology capacity.

CA reported with regard to the breaches relating to the complex spinal patients waiting for their operations at Leeds Teaching Hospitals NHS Trust that she had been assured there was no clinical risk and that additional capacity was slowly being developed. The capacity constraints locally were mirrored nationally and there appeared to be little opportunity to transfer patients out of the region as there was limited capacity there too. Two of the seven patients now had January treatment dates and dates were being sought for the others.

In response to concerns raised about timescales for Child and Adolescent Mental Health Services, DN explained the need to consider the emotional and the health and wellbeing pathways separately. As reported to the December Quality and Patient Experience Committee work was taking place to ensure initial triage. The long waits had been between this and second appointments. This was now being addressed by Tees, Esk and Wear Valleys NHS Foundation Trust through adopting a flexible approach to skill mix, e.g. a trainee psychologist. In addition 'keep in touch' support was being developed. DN also assured members that there was access to crisis support if required.

DN reported that investment by the CCG and Tees, Esk and Wear Valleys NHS Foundation Trust had resulted in some improvements in the current year but not to a level that enable capacity to match demand in Child and Adolescent Mental Health Services.

In response to RW enquiring about the appropriate forum to raise concerns about crisis support, DN advised that Tees, Esk and Wear Valleys NHS Foundation Trust was aware of concerns in this regard. Such matters could be raised through DN or directly with the provider. DN also noted that Child and Adolescent Mental Health Services was a topic at the Protected Learning Time event at the end of the month.

DN highlighted that, while improvements had been achieved through the limited investment, more were required.

AB noted that the Local Medical Committee collated themes of concerns raised by GPs and offered to work with DN in this regard.

In conclusion of this item PM noted that impact on the CCG from the new guidance relating to delayed transfers of care would be assessed and presented at the Finance and Performance Committee. CA also noted that the clinical priorities of the Improvement Assessment Framework would be presented to the Committee once released.

The Governing Body:

Received the month 7 Integrated Performance Report.

CA left the meeting

ASSURANCE

9. Quality and Patient Experience Report

MC presented the report which provided an overview of the quality of services across the CCG's main providers and an update on the quality improvement work of the CCG's Quality Team relating to quality improvements affecting the wider health and care economy. Key pieces of improvement work included: Special School Nursing Review as part of review of the 0 – 19 pathway, Care Home Strategy development, maternity services transformation and workforce transformation. MC also referred to the key messages from the December meeting of the Quality and Patient Experience Committee.

MC welcomed the recently appointed City of York Council Corporate Director for Children, Education and Communities and reported on discussions which would aid opportunities for joint working.

MC highlighted positive feedback from GP Practices following the CCG's support for readiness for Care Quality Commission inspections. Early themes emerging were being monitored and incorporated in an improvement plan to address any identified gaps. MC noted that sepsis training had taken place across Practices that had done the self assessment. Additionally, sepsis was included in the Improvement and Assessment Framework, the inaugural Protected Learning Time event included a session on sepsis and the CCG had secured 100% funding for a Clinical Fellow to develop a programme of work to offer primary care in this regard.

MC reported on improvements in Serious Incident reporting, transparency and collaborative working with York Teaching Hospital NHS Foundation Trust since the appointment of the Deputy Director of Patient Safety.

MC explained that since the report had been written a Never Event had been declared following a shared investigation relating to management of methotrexate in treatment of a Vale of York patient She noted that, although the CCG believed the investigation pointed to the fact that this was attributable to secondary care,

there was also an opportunity for learning for primary care which would be included in the CCG's regular Practice briefing. There had also been a further possible Never Event affecting a Vale of York patient in an out of area provider and the investigation was underway.

In response to PM enquiring about discussion of Serious Incidents by York Teaching Hospital NHS Foundation Trust's Board, MC explained that the Board's remit had recently changed in this regard to an approach which provided increased transparency and assurance. She also confirmed that the Yorkshire and Humber Quality Surveillance Group was cited on issues relating to Scarborough Hospital.

MC highlighted publication of new guidance by the Parliamentary and Health Service Ombudsman which could include financial redress of up to £10k for patients. The potential impact was not yet known.

MC noted the priorities for the three local Healthwatch groups: York, North Yorkshire and East Riding of Yorkshire.

In referring to the summary of patient stories at the Quality and Patient Experience Committee MC explained that consideration was being given to their presentation at Governing Body meetings to demonstrate both resulting impact on the CCG's commissioning decisions and impact for patients.

MC highlighted aspects of work relating to quality in care homes, noting in particular the pilot relating to identification of deteriorating residents which had been nationally recognised and resulted in £30k from the Health Foundation to roll out the project across the Vale of York. This resulted from relationship building by the CCG's Care Home Team.

MC explained that the CCG had a statutory responsibility to support research and development work noting that the Research and Development Manager's hours had been increased to four days a week. Research and development were carried out through working with partner organisations, including University of York, and formed a sub group of the Clinical Effectiveness Advisory Group.

MC referred to the overview of Quality Impact Assessments which were a statutory responsibility for any service changes. She commended the process described and offered to provide support to primary care in this regard if required.

MC explained that a holistic review of commissioned services for children and young people had recently begun. This included continence provision, Special Education Needs and Disability (SEND), short breaks for disabled children and Special School Nursing and Community Children's Nursing. Areas of duplication and gaps would be identified and addressed accordingly.

In response to DB seeking clarification about care home provision MC advised that a robust market management strategy was required. Issues in care provision included recruitment, the fact that nursing homes were converting to residential homes, the need for wrap around care and insufficient complex

dementia beds. These could only be addressed through a total health and social care approach.

The Governing Body:

Received the Quality and Patient Experience Report.

10. Internal Audit Report 'Quality Assurance: Compliance with National Guidance for Mental Health and Learning Disabilities'

DN referred to the report presented in accordance with an internal audit report recommendation that the Governing Body should receive an annual report on delivery of the *Five Year Forward View for Mental Health Services* (2016). The report provided an update on key themes against the *Five Year Forward View* under the headings: Background: the *Mental Health Five Year Forward View 2015-2020;* Implementation of the *Mental Health Five Year Forward View* in Vale of York; and Future Priorities for Delivering the *Mental Health Five Year Forward View.*

DN emphasised that the *Five Year Forward View for Mental Health Services* specifically recognised that mental health delivery aims were wider than health services incorporating such as prevention, diagnostics and pathways for specialist services. Partnerships were required across health, schools, primary care, the voluntary sector and NHS England in respect of specialist care. Mental illness could be a lifelong condition requiring multi faceted organisational approach.

DN noted that, whilst recognising the issues discussed at earlier agenda items, progress against national mental health targets, as described in the report, should be recognised. With regard to the increase in dementia diagnosis rates recorded on GP registers, DN explained that this also included services provided by the memory clinic. She noted that wider clinical discussion was required about the pathway as a whole and that, although significant effort had resulted in this progress, further work was required.

DN also referred to the progress achieved through further work with partner organisations, including local authorities, and areas where the CCG was an active participant in the strategic development of mental health support across City of York and North Yorkshire. DN also highlighted ongoing challenges around access to support but emphasised the strong commitment across the area to meet and address these challenges with recognition that investment and activity needed focus on all elements of the pathway from prevention, diagnosis, maintenance and access to specialist services.

DN additionally referred to the opportunity at the meeting on 15 January, discussed at previous agenda items, to align both acute and mental health priorities across the system.

In response to DN noting that the primary care clinical voice was missing from discussions on pathway development PM advised that this was the challenge for

Health and Wellbeing Boards as they all had Mental Health Strategies and working groups but there was no clinical voice at either City of York or North Yorkshire health and Wellbeing Boards. HE additionally noted that primary care needed strategic priorities for mental health.

RW sought clarification about the model of mental health services being proposed by Harrogate and District NHS Foundation Trust. DN assured members that any such agreement would have no impact on the number of beds or services in the Vale of York.

With regard to concerns about "the clinical voice" PM noted the opportunity at the subsequent private Governing Body meeting in the context of the CCG's commissioning intentions.

The Governing Body:

Received the update provided in accordance with the Internal Audit Report 'Quality Assurance: Compliance with National Guidance for Mental Health and Learning Disabilities'.

11. NHS Vale of York and NHS Scarborough and Ryedale CCGs: Infection Prevention Strategy

MC highlighted that this was the first strategy identifying the CCG's responsibilities and strategic approach to the prevention of healthcare acquired infections. The strategy aimed to establish ownership of infection prevention and control at all levels in organisations commissioned by the CCG and included the national and local contexts, strategic objectives, strategy delivery and the CCG's approach.

In noting the absence of Vale of York GP representation on the multi professional forum MC emphasised that efforts were being made to address this historical gap. AB offered Local Medical Committee support in this regard.

Members commended the strategy noting that it had been supported at the December meeting of the Quality and Patient Experience Committee.

The Governing Body:

Approved the NHS Vale of York and NHS Scarborough and Ryedale CCGs Infection Prevention Strategy.

12. Designated Professionals Safeguarding Adults Annual Report 2017/18

MC referred to the first stand- alone Safeguarding Adults team Annual Report which described the work undertaken by the Safeguarding Adults team on behalf of the four North Yorkshire and York CCGs. It also described the national context for safeguarding adults; the local arrangements in place and how the CCG discharges its duties in relation to them; key achievements in 2017/18 and key priorities and challenges for 2018/19; and introduced the new Safeguarding Adult Strategy against which future reporting would be measured.

MC clarified that Safeguarding Adults Boards were run by Local Authorities but with CCGs and the Police forming triple partnership arrangements. She noted that Tim Madgwick had recently been appointed as Chair of the City of York Safeguarding Adults to replace Kevin McAleese who had stepped down.

MC confirmed that safeguarding training would be a standing topic on the protected learning time events.

The Governing Body:

Received the Designated Professionals Safeguarding Adults Annual Report 2017-18.

RECEIVED ITEMS

The Governing Body noted the following items as received:

13. Audit Committee chair's report and minutes of 29 November 2018.

14. Executive Committee chair's report and minutes of 17 October, 7 and 21 November 2018.

15. Finance and Performance Committee chair's report and minutes of 25 October and 22 November 2018

16. Primary Care Commissioning Committee chair's report and minutes of 22 November 2018.

17. Quality and Patient Experience Committee chair's report and minutes of 13 December 2018.

18. Medicines Commissioning Committee recommendations of 10 October and 14 November 2018.

Close of Meeting and Exclusion of Press and Public

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it was considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted as it contains commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.

A glossary of commonly used terms is available at:

http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/governing-body-glossary.pdf

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 3 JANUARY 2019

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
3 January 2019	Accountable Officer Report	• Communication to be sent to Practices advising that medication should not be stockpiled • Potential for a bid to the Voluntary, Community and Social Enterprise Health and Wellbeing Fund 2019/20 on Children and Young People's Mental Health to be explored	PM DN	
3 January 2019	Risk Update Report	• Brexit to be added to the Executive Committee Risk Register • Request to Practices for their resilience and emergency plans	AC PM / NW	

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Accountable Officer's Report

Purpose of Report
To Receive

Reason for Report
To provide an update on a number of projects, initiatives and meetings that have taken place since the last Governing Body meeting along with an overview of relevant national issues.

Strategic Priority Links

☒Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital- single acute contract
☐Transformed MH-LD- Complex Care
☒System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts- Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

The Governing Body is asked to note the report.

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	Sharron Hegarty Head of Communications and Media Relations

GOVERNING BODY MEETING: 7 MARCH 2019

Accountable Officer's Report

1. Turnaround, local financial position and system recovery

1.1 The CCG's financial position in January remains in line with the previously reported forecast deficit for the end of the year of £18.6million. QIPP forecasts and additional financial recovery actions remain on track and although there are challenges to delivering these the CCG is anticipating that there will be no further deterioration.

1.2 The key pressures remain around the aligned incentive contract the completion of the Continuing Healthcare reconciliation position by NHS Scarborough and Ryedale CCG as previously reported.

1.3 Therefore, the CCG anticipates it will be able to report another year of stabilisation of the financial position and deliver a modest improvement on the 2017-18 deficit of £20.1m (excluding Commissioner Sustainability Funding).

1.4 As previously reported, ensuring the CCG delivers no worse a position than the forecast 2018-19 deficit is essential to underpinning a realistic longer-term plan. This position formed the start of the proposed approach and principles for improvement and recovery over a multi-year period as part of a York-Scarborough System Plan agreed in principle between commissioners and York Teaching Hospital NHS Foundation Trust by respective Governing Bodies and Boards. These principles formed the basis of the first joint / aligned activity plan submitted to regulators on the 14 January 2019 and was further supported by 15 January 2019 system meeting with CCGs, NHS Trusts, NHS regulators, LMC, Councils.

1.5 Following the release of the planning guidance, allocations and respective control totals across the system commissioners and providers submitted draft financial plans on the 2 February 2019. The CCG submitted on the basis of the above with an initial £4.3m gap to control total deficit of £14m. However, York Teaching Hospital NHS Foundation Trust submitted a control total compliant draft based on a rebased PbR activity plan, plus growth, albeit acknowledging it is unaffordable to CCGs. The CCG has therefore sought joint regulator and System Transformation Partnership mediation to close the £20.6m contract alignment gap this creates by the required deadline and this is taking place on the 7 March 2019.

1.6 The CCG will make every effort to continue to work with system partners on the principles previously agreed to resolve the gap but will also be clear what an alternative and robust contract offer would look like to inform these mediation discussions.

2. Acute service transformation

2.1 The CCG continues to work with NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust to identify, develop and deliver the joint programmes of work that support delivery of sustainable acute services in line with the agreed financial strategy for 2019-20. The focus continues to be on bringing primary and secondary care clinicians together to drive and shape these programmes of work, and to focus on shared care pathways from referral to discharge which can better manage the pressures on our services where activity is highest.

2.2 The CCG is also working with the Humber, Coast and Vale (HCV) Health and Care Partnership and the new joint NHS England and NHS Improvement team to align and agree activity, performance and financial plans locally and as part of the aggregated HCV plan. This will support confirming the contractual form for acute services which will best support the delivery of the system multi-year financial recovery alongside the proposed investments the CCG will make from the confirmed allocation to primary care and mental health services.

2.3 Our work with the HCV is also supporting us in confirming the priorities for collaborative working at scale with our fellow providers and commissioners, and identifying where we national funding would support transformation work in areas such as cancer and digital enablement.

3. Operational Planning

3.1 The CCG is continuing to work with all partners to respond to the emerging 2019-20 operational planning requirements from our joint regulators and to identify and align our priorities for 2019-20. All our planning is framed by the priorities captured in our commissioning intentions and our focus on improving population health.

3.2 The NHS Long Term Plan provides a vision and level of ambition which is helpful for prioritising the work we will do with partners in 2019-20. The new GP Contract and development of Primary Care Networks also provide opportunities for our clinicians to shape the development of integrated out of hospital services moving forward.

4. Primary care - creating opportunities for professional learning and development

4.1 Local GPs and primary care staff recently embarked on a two-year programme of peer-led development following some important investment into

primary care services. The first Protected Learning Time event took place on Thursday 31 January 2019.

4.2 The Vale of York area is fortunate to have high quality primary care services, but we are now experiencing challenges in the recruitment of new staff, the retention of experienced colleagues and an ever-increasing work load. That is why, in partnership Hull and York Medical School's Academy of Primary Care, the CCG is providing professional learning and development opportunities for primary care.

4.3 The CCG aim to put primary care at the centre of service delivery, ensuring that hospital based care focuses on the elements that can only be done in a hospital setting. The protected learning time that has been developed for our member practices will help towards providing a firm foundation for us to deliver care that meets the population's changing needs and allow for a renewed focus on improving health over treating disease.

4.4 York Teaching Hospital NHS Foundation Trust, the University of York, Tees, Esk and Wear Valleys NHS Foundation Trust, and local GPs all presented at the first event which focused on important topics such as dementia, safeguarding, end of life care, opiates and chronic plain, sepsis, diabetes, obesity and managing resilience and workforce issues.

4.5 The learning and development sessions will take place four times a year and to ensure that patients continue to receive the care they need from their local practice, local Out of Hours GP provider, Vocare will be supplying clinical cover from 12 midday to 6pm to the practices that choose to take up this learning and development opportunity. The next event takes place 11 April 2019.

5. Pickering Medical Practice in North Yorkshire has featured in a case study by NHS England in celebration of the practice's participation and successes as part of the national General Practice Improvement Leaders programme which is part of the support available through the General Practice Forward View.

5.1 Some of the practice's successes include:

- Average waiting time for a routine GP appointment reduction from 19 days to 10 days (47% improvement to date);
- Reduction in the demand for urgent care appointments (48% to 37%)
- A 12% increase in telephone appointments = reduction of GP face to face appointments (8%).
- Appointment of a new clinical pharmacist, releasing six hours of GP time per week across the practice, representing a 90% drop in medication tasks for a GP.
- Appointment of a new Nurse Practitioner

- Signposting and patient awareness has led to a 20% increase for nurse appointments

5.2 The full case study is available on the NHS England website at: https://www.england.nhs.uk/gp/case-studies/routine-gp-appointment-waiting-times-reduced-by-47-pickering-medical-practice-north/

6. EU Exit preparations

6.1 NHS England issued EU Exit Operational Readiness Guidance in December 2018 to providers and commissioners of health and care services across the country. The guidance lists the actions that organisations need to take if the UK leaves the EU without a ratified deal. The guidance aims to ensure that organisations are prepared and can manage the risks in such a scenario.

6.2 The guidance covers seven areas:-

- Supply of medicines and vaccines;
- Supply of medical devices and clinical consumables;
- Supply of non-clinical consumables, goods and services;
- Workforce;
- Reciprocal healthcare;
- Research and clinical trials;
- Data sharing, processing and access.

6.3 Organisations have also been asked to identify local risks which may arise with a 'No Deal' Exit. Nothing unique to the Vale of York has been identified at this stage. East Riding of Yorkshire Council has raised concerns about activity at the port of Hull.

6.4 The CCG was represented at NHS England's EU Exit workshop on the 12 February 2019 and the learning and scenarios from the event were shared and tested with the local A&E Delivery Board on the 21 February 2019.

6.5 City of York Council will be opening an Emergency Control Centre at West Offices during the week commencing 25 March 2019 and will be instigating daily Sit-Rep reporting on all of its services.

6.6 The CCG Director on-call rota around this period and up to June 2019 has been agreed. The CCG's Senior Responsible Officer for the EU Exit will be on-call on the planned exit day on the 29 March 2019.

7. Local System Review

7.1 The Care Quality Commission's (CQC) Lead Inspectors attended the York Health and Wellbeing Board workshop in January 2019 to present their

findings from the November 2018 progress review. The report was published on 16 January 2019. The CQC found that some good progress had been made in a number of areas, but reported that the pace of improvement had been slow.

7.2 The report highlighted several areas for future focus and York's Place Based Improvement Partnership, supported by a number of delivery groups for specific work streams is leading on the development of these. This work is aligned with Humber, Coast and Vale Health and Care Partnership priorities. To increase the pace of change a lead officer from the Place Based Improvement Partnership has been nominated for each of the Workforce, Digital, and Estates and Capital work streams.

8. Emergency, Preparedness, Resilience and Response Update

8.1 Our partners at North Yorkshire County Council are taking the lead on reviewing the Mass Treatment and Vaccination Plan for North Yorkshire and York. The CCG has been involved in the discussions and the plan will be tested at a workshop with other partner organisations on Thursday 9 May 2019.

8.2 The routes for this year's Tour de Yorkshire have now been announced. They are:

Day 1	Thursday 2 May 2019, Doncaster to Selby
Day 2	Friday 3 May 2019, Barnsley to Bedale
Day 3	Saturday 4 May 2019, Bridlington to Scarborough
Day 4	Sunday 5 May 2019, Leeds to Halifax

8.2.1 On Day 1 the race will finish in Selby at approx. 5.30 p.m. This will impact on access to the GP surgeries in the town due to road closures.

8.2.3 Access to Selby Hospital will be unaffected by the race, however, Thursday 2 May 2019 is also the date for Local Government Elections and there may be some additional activity at the Council Offices that are located on the same site as the hospital. Final details of the race timings and road closures will be shared with GP practices in due course.

9. Better Care Fund

9.1 The quarterly returns for the Better Care Fund (BCF) were submitted in line with requirements covering Quarter 3 of the 2017-19 plan on the 25 January 2019. Reporting on the Improved Better Care Fund (iBCF) was not required this quarter. The Quarter 4 return is due on the 18 April 2019, and as a result of the timing of the submission, the return will include forecast and provisional data.

9.2 The NHS has published final 2019-20 Operational Planning and Contracting Guidance for NHS organisations. It provides guidance following the

publication of the NHS long term plan and references DToCs in the guidance have been updated.

9.3 The Government's Better Care Fund Policy Framework and the detailed Planning Requirements will set out DToC expectations for 2019-20. To support planning in advance of these publications, CCGs and Health and Wellbeing Boards are expected to plan for the continued delivery of the current reductions in the DToC rate or plan to maintain performance where targets have been achieved.

10. Strategic and national issues

10.1 In March 2019 Public Health England will launch a new national campaign to help increase participation in the National Cervical Screening Programme. Cervical screening is estimated to save 5,000 lives a year and yet coverage is at a 20 year low.

10.2 Diabetes Prevention Week, which is taking place from 1 to 7 April 2019, is a joint campaign from NHS England, Public Health England and Diabetes UK. It aims to raise awareness of Type 2 diabetes, complications associated with the condition, at-risk groups and, importantly, how to prevent it.

10.3 NHS England recently announced that flash glucose monitors will be available on prescription for every patient who qualifies for them, in line with NHS clinical guidelines. This action will end the current variation some patients with Type 1 diabetes are facing. Currently, it is estimated that around 3-5% of patients with Type 1 diabetes in England have access to Flash Glucose Monitors but this new action means it will be funded for 20-25% of patients with Type 1 diabetes,

10.4 207 CCG data packs have been produced to support health and care systems design and deliver services that work to reduce health inequalities in access to services and health outcomes for their diverse local populations. The data packs consider measures of health inequality and aim to support CCGs and health systems to identify areas of improvement. Previously such analysis has not been available at CCG level.

10.5 The publication, Frailty: a framework of core capabilities, aims to improve the effectiveness and capability of services for people living with frailty through developing the workforce to ensure high quality, holistic, compassionate care and support. The framework was developed by NHS England working with Health Education England, Skills for Health and partners from across health and care. It is targeted at commissioners and service providers, as well as education and training providers and practitioners. It provides a consistent and comprehensive framework to support service improvement, review and develop staff at all levels by setting out core, transferable behaviours,

knowledge and skills, and support collaborative approaches to commissioning.

10.6 A letter published by NHS England on 23 January 2019, provides further information on recommended seasonal flu vaccines for 2019-20. It confirms which vaccines, that providers of the seasonal flu vaccination programme, should order for their eligible populations groups and will also be eligible for reimbursement.

10.7 Most women (97.6%) were asked how they are feeling emotionally by a midwife or health visitor at home after giving birth, says the latest Care Quality Commission survey of more than 17,500 women. The survey reports experiences of women, who gave birth last February, across 129 NHS trusts. Findings are available at national and trust level. 96.4% of women said their partner, or someone close to them, was able to be involved as much as they wanted during labour and 88.1% of women reported always being treated with respect and dignity. Postnatal care at home and feeding showed a decline across several questions since 2017.

10.8 The recently published NHS Long Term Plan says the time has come to give people the same choice and control, over their mental and physical health, that they have come to expect in every other part of their life. Universal Personalised Care sets out the plan to achieve this change. It establishes the comprehensive personalised care model, with six evidence-based programmes of work and details how the NHS can support people of all ages, and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.

10.9 The National Cardiovascular Disease (CVD) Prevention System Leadership Forum, led by Public Health England (PHE) and NHS England has set out the first ever national ambitions to tackle prevention, and reduce the health inequalities associated with CVD. The latest edition of PHE's Health Matters- 'Preventing cardiovascular disease – saving hearts and minds together' commits to improving the detection and treatment of Atrial Fibrillation, High Blood Pressure and High Cholesterol (A-B-C) – the major causes of CVD. The NHS Long Term Plan includes CVD as a new clinical priority, and sets out a major ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next ten years. The ambitions include recommendations for decision makers and frontline professionals on getting more people checked and best practice for identifying and treating those already at risk.

10.10 The Yorkshire and Humber Care Record is an innovative programme that has the potential to produce a transformational change in healthcare in the region. Currently, patient data is not shared between the NHS and other organisations that play a role in health and social care, such as care homes, social services, and private clinical care organisations. Furthermore, relatively

little patient data is shared within the NHS. For example, if an individual attends one hospital for a cardiac condition and another hospital for a neurological condition, information on their diagnosis, condition, test results and treatments for their cardiac condition is not accessible for staff involved in managing their neurological condition, and vice versa. This situation is inconvenient for patients and clinicians, leads to additional costs and delays with care, and is also potentially dangerous. The Yorkshire and Humber Care Record is being developed to address the problem of data sharing. It is a digital care record which enables clinical and care staff to access real-time health and care information across health and social care providers and between different systems. It brings together a core of information about patients who have used services provided by their GP, local hospitals, community healthcare, social services or mental health teams. This information is stored on a secure computer system and so can be accessed by different care providers regardless of the computer system they use. More details about the launch date and project launch will follow in the next report.

11. Recommendation

11.1 The Governing Body is asked to note the report.

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Item Number: 6

Name of Presenter : Phil Mettam

Meeting of the Governing Body

Date of meeting : 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Risk Update Report

Purpose of Report
To Receive

Reason for Report
To provide assurance that risks are strategically managed, monitored and mitigated.

This report provides present details of current events and risks escalated to Governing Body by the sub-committees of the Governing Body for consideration regarding effectiveness of risk management approach.

All events have been reviewed by the relevant lead since the last Governing Body.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☒Fully Integrated OOH Care
☒Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☒Legal
☒Primary Care
☒Equalities

Covalent Risk Reference and Covalent Description
All corporate risks escalated to the Governing Body.

Emerging Risks (not yet on Covalent)

No new risks or events have been identified.

Recommendations

The Governing Body is requested to:

- review risks arising and to consider risk appetite for events and high scoring risks.

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	Rachael Simmons Corporate Services Manager

GOVERNING BODY: 7 MARCH 2019

Risk Update Report

All events have been reviewed since the last Governing Body.

The following event rating has decreased :

Reference	Description
PC.02	Primary Care; capacity over winter. Improving Access is giving some pressure to OOH GPs which will need monitoring. Other trials are due to commence in April 2019, and the new Parkinson's Disease Specialist Nurse interviews will take place in March 2019. Was likelihood 4; impact 3 – RAG 12 Now likelihood 3; impact 3 – RAG 9

The ratings for the following events have remained the same:

Reference	RAG	Key Points
ES.17 Failure to deliver 1% surplus in-year	Likelihood 4; impact 4 RAG 16	The CCG and YTHFT respective Boards and Governing Bodies have now agreed the principles of a multi- year financial recovery plan, however the specifics of this (in particular 2019/20 contract value) are still to be agreed.
ES.20 There is a potential risk of failure to maintain expenditure within allocation	Likelihood 4; impact 4 RAG 16	The CCG and YTHFT respective Boards and Governing Bodies have now agreed the principles of a multi- year financial recovery plan, however the specifics of this (in particular 2019/20 contract value) are still to be agreed.
JC.26a CAMHS long waiting lists	Likelihood 4; impact 4 RAG 16	No change to report.
JC.26b Children autism assessments	Likelihood 4; Impact 3 RAG 12	No change to report.
JC.26c Children and young people's eating disorders	Likelihood 4; impact 4 RAG 16	Meeting with primary care leads arranged for 17.01.2019 to discuss approach to managing physical health checks.
JC.30 Dementia - failure to achieve 67% coding target in general practice	Likelihood 3; impact 4 RAG 12	A proposal to fund two research psychology assistants for six months to reconcile coding and case find in care homes has been submitted to NHS England.

QN.02 Potential risk to quality of care and patient safety at Unity Practice	Likelihood 4; impact 4 RAG 16	The practice was re inspected on 08.01.2019. Formal outcome awaited.

CORPORATE ON-GOING EVENTS MANAGED BY GOVERNING BODY

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review
ES.17 There is a potential risk that the CCG will fail to deliver a 1% surplus in-year.	The scale of the financial challenge for the organisation is such that the CCG will not deliver a 1% surplus in-year or cumulatively in the short term and will likely require a number of years to reach this point.	Failure to retain a surplus of 1% will not have an overall impact on patient care.	AIC including joint cost reduction programme. Joint System Transformation Board.	The CCG has submitted a 2018/19 plan that delivers the required in-year control total deficit of £14m against which it will be measured and for which it would then be able to access Commissioner Sustainability Funding of £14m, a technical adjustment that would mean an in-year break-even position. The CCG will, therefore, not deliver a 1% surplus in-year This is confirmed in the Month 10 financial position as the CCG is reporting a forecast deficit of £18.6m after £1.4m of Commissioner Sustainability Funding and £6m away from plan. The CCG and YTHFT respective Boards and Governing Bodies have now agreed the principles of a multi- year financial recovery plan, however the specifics of this (in particular 2019/20 contract value) are still to be agreed.	Michael Ash-McMahon	Chief Finance Officer	4	4	16		15 February 2019
ES.20 There is a potential risk of failure to maintain expenditure within allocation	The scale of the financial challenge for the organisation is such that the CCG will not maintain expenditure within the in-year allocation.		Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	This is confirmed in the Month 10 financial position as the CCG is reporting a forecast deficit of £18.6m after £1.4m of Commissioner Sustainability Funding and £6m away from plan. The CCG and YTHFT respective Boards and Governing Bodies have now agreed the principles of a multi- year financial recovery plan, however the specifics of this (in particular 2019/20 contract value) are still to be agreed.	Michael Ash-McMahon	Chief Finance Officer	**4**	**4**	16		15 February 2019
JC.26a CAMHS: long waiting lists for assessment and treatment that significantly extend beyond national	Continued sustained demand since 2015/16 has generated long waiting lists to be assessed and commence treatment. Long waiting lists may adversely affect response to treatment and	Delays in assessment and diagnosis leading to delays in treatment and support options. Poor patient experience.	Governing Body strategic commitment to mental health investment as a priority for the CCG. Service action plan in place.	Waiting lists remain long reflecting the high levels of referral into service despite the schools projects and the crisis team, all of which have reduced demand for support. The CCG is investing £120k recurrently into CAMHS	Susan De Val	Executive Director of Transformation, Complex Care and Mental Health	**4**	**4**	16		11 January 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review
constitutional standards	outcomes. CYP and families experience longer periods of stress and anxiety waiting for appointments and treatment. Poorer or reduced outcomes may have effects on longer term emotional and mental health. There is potential detriment to CCG reputation, and effects on partnerships, e.g., local authority.		Close monitoring at CMB / F&P / QPEC and Governing Body. Capacity and Demand Gap Analysis received at end of July 2018 and considered by CMB. It will inform future decisions around further reinvestment. Commitment to continue school well-being services in York and North Yorkshire funding (in the baseline) to support those with lower level needs. . Local Transformation Plan highlights need for early identification and intervention to prevent escalation of symptoms and conditions. This is across the CCG area and engages all agencies.	services from 2018/19; TEWV will use this for additional support to the emotional and eating disorders pathways. Staff have been appointed and are in post. The CVs for this investment have set out measures to show effect on waiting times and are under discussion with TEWV. The numbers waiting on the emotional pathway (depression anxiety, self-harm and other similar conditions) have reduced in December, largely due to the commencement of group therapy work for those at the lower end of the scale of need. There will be further reductions as the new staff become active in post. We expect reduction in risk rating to 12 by end of 2018/19.						
JC.26b Children's Autism Assessments: long waiting lists and non-compliance with NICE guidance for diagnostic process	For the 5-18 pathway there is a long waiting list. Waits increase the strain and anxiety for families who do not always receive support for other agencies pending diagnosis. Issue is becoming more prominent in media enquiries and MP correspondence.	Delays in assessment and diagnosis mean families wait longer for specialist support in school and other settings.	Action plan to address issues around waiting list and diagnostic process. Close monitoring at CMB / F&P / QPEC and Governing Body. The capacity and gap analysis has been received and considered at CMB and will inform future decisions on investment should funds be available. Changes in TEWV internal triage process in Autumn 2017 will work through into Autumn/Winter 2018 and improve ratio of assessments: conversion rate and the reduction in waiting times. The matter remains referenced at CMB to ensure focus is maintained.	TEWV is investing an additional £50k recurrently in the service from 2018/19. Staff have been appointed and coming into post in October/November 2018. The CCG has committed non-recurrent funding of £120k in 2018/19 to fund additional assessments (combination of slippage and additional in year funding). TEWV projects 67 additional assessments in the current year: 27 undertaken by the independent sector, and the remainder utilising bank staff and overtime payments. Numbers awaiting assessment continue to rise notwithstanding the additional assessments. We are planning to review in detail the conversion rate, which is low compared to other services in the YH region: around 50% of	Susan De Val	Executive Director of Transformation, Complex Care and Mental Health	**4**	**3**	**12**		11 January 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review
			TEWV is reviewing the pathway around integration of autism and ADHD referrals to improve overall response to patient need. Expect to see conversion rate start to improve by end of 2018/19 and waiting times to reduce by end Q4/Q1 2019/20	assessments result in a negative diagnosis, we are discussing with TEWV how best to review and provide assurance around the screening and assessment process. Workshops in November and December 2018 to map full pathway across agencies has provided greater transparency and begins to highlight how agencies can work together more effectively to support children with a view to reducing need for assessment in the long term.							
JC.26c Children and young people eating disorders. Non-compliance with national access and waiting time standards	Higher than anticipated referral rates into the NYY eating disorder service in York hampers TEWV in meeting access and waiting time standards. These patients are usually very ill and require intensive long term care and support. The high volume means patients may not receive early intensive treatment	Delays in assessment and diagnosis and potentially longer periods in treatment with potential for poorer outcomes. Doubtful will meet national waiting time standards by 2021. Currently unable to develop early intervention activity or training in schools and other community settings.	Action plan across NYY to set out how TEWV will deliver to national standards and examine improving issues around dosage and physical health checks. TEWV's performance improving against local trajectories: expect to meet in year targets for urgent and routine cases. . Close monitoring at CMB / F&P / QPEC and Governing Body.	Additional funding agreed for 0.6WTE (0.4 psychologist and 0.2 mental health nurse) as part of additional recurrent CCG investment. Performance against access and waiting times standards is improving at Q2 and will come close to meeting in year targets, and delays in assessment due to staff capacity have reduced significantly Meeting with primary care leads arranged for 17.01.2019 to discuss approach to managing physical health checks.	Susan De Val	Executive Director of Transformation, Complex Care and Mental Health	4	4	16		11 January 2019
JC.30 Dementia - Failure to achieve 67% coding target in general practice.	Non delivery of mandatory NHS England targets. Lack of sufficient providers in some areas resulting in delayed transfers of care or limited choice available to patients. Meeting new standards.	Further pressure from NHS England to rectify this. Service users may not be appropriately flagged and therefore on-going referrals from primary care will not have the relevant information to make reasonable adjustments for their carers support.	CCG leads have devised a comprehensive action plan. CCG to provide focussed support targeting the larger practices with the lowest coding rates. All practices will be encouraged to re-run the toolkit and review all records identified. Controls include: Programme meeting and TEWV CMB.	Diagnosis rate decreased in December from 60.1% to 59.6%. This was largely due to a number of patient deaths across three practices. Diagnosis rates have decreased further in January to 59.1% The number of registered patients fell by 25 against a static estimated prevalence rate. Work continues to try and improve the transfer of data between TEWV and Primary Care to ensure	Sheila Fletcher	Executive Director of Transformation, Complex Care and Mental Health	3	4	12		19 February 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review
				that all dementia diagnosis are accurately recorded on SystmOne and EMIS. A proposal to fund two research psychology assistants for six months to reconcile coding and case find in care homes has been submitted to NHS England.							
QN.02 Potential risk to quality of care and patient safety at Unity Practice	Unity Practice in NHS Vale of York CCG area has been assessed as 'Inadequate' by the CQC in all but one domain and placed in special measures. There is a risk the practice may not meet the required improvements when fully re-inspected in around six months' time leading to potential for the CQC to close the service.	Quality of patient care and patient safety may be compromised	Unity are continuing to fully engage with the CCG and are responsive to all offers of support and subsequent improvement. The support from C. Lythgoe will cease in November but there as a plan to recruit to Nurse Leadership posts in the future. Lou Johnson attending the Yorkshire and the Humber Leadership Academy Practice Managers Programme 2018/19. Actively involved in the self-assessment process and support provided by Lynn Lewendon and Sarah Goode. Support from a GP appraisal lead from NHS England medical team who is supporting Unity review their clinical leadership.	Following a comprehensive inspection by CQC on 23.05.2018 the practice was rated as inadequate overall. The practice have closed their patient list. CQC will review on 18/09/18. CQC re-inspected Unity Practice on 18 September and the CCG. Improvements were noted and the practice were allowed to reopen their list to new registrations from 26.09.2018. The practice will be re-inspected within three months where there is opportunity to impact on their rating which remains inadequate. The practice was re inspected on 08.01.2019. Formal outcome awaited.	Sarah Goode / Jenny Brandom	Executive Director of Quality and Nursing	4	4	16		25 January 2019
PC.02 - Primary Care; capacity over winter	There are increasing signs that workforce numbers in primary care (GPs, Nurses and other staff) are impacting on capacity. With the additional challenges of winter there is a risk that services will not be maintained with consequent risks to patient safety.	As capacity in general practice is limited by workforce, access to routine and urgent appointments may deteriorate resulting in patients not accessing care, or accessing care inappropriately (e.g., unnecessary use of A&E). Patients may also not receive regular reviews through routine care as limited capacity switches to manage urgent. This could lead to more patients with long term conditions	Practices are reviewing their provision to match demand to capacity. Access to locums is now limited and so other clinical staff are being asked to support tasks previously performed by GPs. Practices are beginning to work together to address long term capacity issues. On-going work to provide additional staffing progressing; both as an outcome of the January 2019 LTP which endorses and financially supports this approach, and as new	Tiger Team have taken their individual actions to make rapid and responsive changes to urgent and primary care projects. CoR have had two updates around the on-going resilience work, winter planning group meetings continue, and new lead for the Central locality has taken up post. Work to provide additional physio. support, and bids for funding to provide additional capacity are also on-going. Rollout of Improving Access has demonstrated some of the potential for working together in	Becky Case	Executive Director of Primary Care and Population Health	3	3	9		25 February 2019

Risk Ref & Title	Description	Impact on Care, Potential for Harm	Mitigating Actions	Latest Note	Operational Lead	Lead Director	L'hood	Impact	Current Risk Rating	Movement this Month	Last Review
		requiring hospitalisation.	schemes transferring staff from acute to community/primary care improve. Current examples include having a First Contact Physio in two practices, a session per week from a geriatrician working in the community and a new mental health team supporting low level problems. A new staff member has been appointed to support Central (York) GPs to evolve. Additional sessions for primary care to see unplanned patients were funded by the CCG in January 2019. Numbers being seen by the Improving Access work have increased and electronic consultations have commenced.	localities, and cooperative work is starting to grow. Improving Access is giving some pressure to OOH GPs which will need monitoring. Other trials are due to commence in April 2019, and the new Parkinson's Disease Specialist Nurse interviews will take place in March 2019.							

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Item Number: 7

Name of Presenter: Dr Lincoln Sargeant – Director of Public Health for North Yorkshire

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Director of Public Health Annual Report 2018 – Back to the Future

Purpose of Report *(Select from list)*
For Information

Reason for Report

There is a mandatory requirement for the Director of Public Health to produce an annual report setting out the health priorities for the local population. The 2018 Director of Public Health Annual Report for North Yorkshire is called "Back to the Future". Dr Sargeant has looked back to review progress made in improving population health in North Yorkshire since 2013, viewed data and engaged with partners to jointly develop priorities for population health until 2025.

Strategic Priority Links

☐Strengthening Primary Care
☒Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☐Financial Sustainability

Local Authority Area

☐CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☒North Yorkshire County Council

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

1. Reduce health inequalities

NHS Vale of York CCG should consider the role it can play to improve the health and wellbeing of people with the poorest health outcomes and take explicit actions to address the factors that they can influence to close the gap experienced by people and communities who have shorter and less healthy lives compared to the rest of the CCG population.

2. Improve public mental health

As signatories to the Prevention Concordat for Better Mental Health the North Yorkshire Health and Wellbeing Board have committed to implement its principles. Specifically, this commits partner organisations, including NHS Vale of York CCG, to work to strengthen individuals and communities to be resilient and to remove the structural barriers to good mental health including reducing poverty and discrimination, and improving access to education, employment, transport, housing and support for the most vulnerable people.

3. Embed a public health approach

NHS Vale of York CCG to consider how to embed a public health approach into their practice, including impact on sustainability, integration, prevention and reducing inequalities; and increasing skills around data, evidence and evaluation.

Responsible Executive Director and Title	**Report Author and Title**
Dr Kevin Smith Executive Director of Primary Care and Population Health	Dr Lincoln Sargeant Director of Public Health for North Yorkshire

Full report available at:

http://www.nypartnerships.org.uk/dphreport2018

Item Number: 8

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Commissioning Intentions 2019/20

Purpose of Report
For Approval

Reason for Report

Commissioning Intentions for 2019/20 identify how Vale of York CCG will;

- commission services that meet the core requirements of ensuring patient safety and achieving national/constitutional standards
- make improvements in specific priority areas in 2019/20
- move towards the achievement of longer term aims that reflect the ambitions of the NHS long term plan
- take partnership working at a Primary Care Network (PCN) level, and as an "integrated system" across North Yorkshire and York to the next level of development
- work with partners to achieve better value health care, so that long term strategic change can be supported across the health and care system.

Part II of the Governing Body received draft Commissioning Intentions for information at the January meeting. These have now been updated to include the most recent information on population health needs, to ensure that they are consistent with commissioning guidance published in January 2019 and in particular, to ensure that they reflect the ambitions of the NHS long-term plan published in January 2019.

As this is the final year of the 2017-19 planning timeframe they build upon delivery of existing strategies and the ambitions set out in last year's commissioning intentions, updated and reframed to take account of changes and developments that took place in 2018/19 and the emergence of new priorities.

The document provides an overview of our main priorities for investment and improvement; primary care and general practice, developing locally focused community services, mental health and wellbeing, services for people with the highest care needs and cancer services, going on describe how we will work with partners to achieve strategic change across the health and care system and concluding by reaffirming our strategy for system change, summarised as:

> *"Shifting the balance to prevention and early intervention by supporting people and communities to improve their own health and wellbeing and strengthening primary care at a population level, so that hospitals provide only the care and treatment that needs to be provided in a hospital setting."*

The main body of the document then describes the strategic context and the specific commissioning priorities for 2019/20.

The commissioning intentions describe ambitious but realistic ambitions for 2019/20. Subject to approval, the next step is to share these intentions with partner organisations as a means of signalling our intent regarding service improvement and wider system change.

The Governing Body is asked to support the proposal that the Governing Body Part II consider and approve the commissioning intentions for issuing week commencing 11th March 2019.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☒Fully Integrated OOH Care
☒Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☒Financial ☒Legal ☒Primary Care ☒Equalities	

Emerging Risks (not yet on Covalent)

Recommendations

The Governing Body is asked to support the proposal that the Governing Body Part II consider and approve the commissioning intentions for issuing week commencing 11th March 2019.

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Chief Officer	Lisa Marriott Head of Community Strategy

VALE OF YORK CCG COMMISSIONING INTENTIONS 2019/20

1. Introduction

This paper and seeks approval from the Governing Body for the Commissioning Intentions for 2019/20, which subject to approval would be issued week commencing 11th March 2019.

2. Purpose of Commissioning Intentions

The Commissioning Intentions for 2019/20 identify how Vale of York CCG will;

- commission services that meet the core requirements of ensuring patient safety and achieving national/constitutional standards
- make improvements in specific priority areas in 2019/20
- move towards the achievement of longer term aims that reflect the ambitions of the NHS 10-year plan
- take partnership working at a Primary Care Network level, at "place" and as an "integrated system" across North Yorkshire and York to the next level of development
- work with partners to "balance the NHS Budget", so that long term strategic change can be supported across the health and care system.

As this is the final year of the 2017-19 planning timeframe, they build upon delivery of existing strategies and the ambitions set out in last year's commissioning intentions, updated and reframed to take account of changes and developments that took place in 2018/19 and the emergence of new priorities.

3. Commissioning intentions 2019/20

The document is structured as follows;

Part 1 - provides an overview of priorities for 2019/20, the focus for investment and improvement, describes how we will work together with partners to achieve our ambitions and reaffirms our commitment to our strategy for system change, which can be summarised as;

> *"Shifting the balance to prevention and early intervention by supporting people and communities to improve their own health and wellbeing and strengthening primary care at a population level, so that hospitals provide only the care and treatment that needs to be provided in a hospital setting."*

Part 2- covers two areas;

A: Strategic context

This section covers the following;

1. National Context
2. Vale of York CCG Strategic Priorities

3. Effective Collaboration
4. Better Value Healthcare
5. Strategy for System Change

B: Commissioning Priorities for 2019/20

This covers specific priorities for 2019/20, in the following areas;

1. Primary Care and General Practice.
2. Joint Commissioning.
3. Services commissioned in the community.
4. Services for children and young people and maternity services.
5. Services for people with mental ill-health.
6. Services for people with a learning disability and/or autism or behavior that challenges.
7. Urgent and emergency care.
8. Acute hospital transformation.
9. Cancer Services.
10. Commissioning for Quality.

Part 3 - Conclusion and Next Steps

The commissioning intentions describe ambitious but realistic ambitions for 2019/20. The next step is to share these intentions with partner organisations as a means of signalling our intent regarding service improvement and wider system change.

4. Recommendations

The Governing Body is asked to support the proposal that the Governing Body Part II consider and approve the commissioning intentions for issuing week commencing 11th March 2019

Item Number: 9

Name of Presenter: Lisa Marriott

Meeting of the Governing Body

Date meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title - Services in the Community; Improving Health and Tackling Inequalities

Purpose of Report
For Approval

Reason for Report

We aim to reshape our approach to community services to one that is one focused on Primary Care Networks; that considers the needs of local populations, recognises the need to work with social care, to integrate physical and mental health care and to consider the needs of all age groups, in order to improve the health of our whole population and tackle long standing inequalities.

In line with the Long Term Plan, our ambition is to support the development of community services which reflect local needs, integrate at neighbourhood level, work seamlessly with social care, and which promote independence and self-care as the norm

The purpose of this paper is to set out the CCGs approach to achieving this ambition.

The paper;

- Sets out the national and local context;
  - the national strategic context set by the Long Term Plan and "Investment and evolution; a five-year framework for the GP contract, both of which were published in January 2019; the most significant aspect of which is the development of Primary Care Networks (PCN).
  - the local context, which focuses on meeting the needs of our population; specifically, addressing inequalities and meeting the needs of an ageing population, within the overall strategic aim of;

    "Shifting the balance to prevention and early intervention, by supporting people and communities to improve their own health and wellbeing and strengthening primary care at a population level, so that hospitals provide only the care and treatment that needs to be provided in a hospital setting."

- It proposes principles to guide the design and development of services.

- It describes a model for understanding the needs of the population, based on population segmentation and stratification, how this has been used to develop “health care aims” for discrete groups of people within populations and how this model can be used as the basis for service design.

- It describes the delivery role of Primary Care Networks (PCN) in providing strategic and clinical leadership for change across primary and community health services as the “natural unit for integration” and the approach for services that are best commissioned and provided for a larger population.

- It describes the progress that has been made to date working in localities

- It outlines the contractual implications of the new GP contract.

- It identifies the need to support the establishment and development of PCN, by building on the work that has already taken place in localities and concludes by outlining the next steps for implementation.

Strategic Priority Links

☒Strengthening Primary Care
☐Reducing Demand on System
☒Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☐Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☐Financial ☒Legal ☒Primary Care ☒Equalities	

Emerging Risks (not yet on Covalent)

Recommendations

The Governing Body is asked to approve the approach set out in this paper.	
Responsible Executive Director and Title Dr Kevin Smith Executive Director of Primary Care and Population Health	**Report Author and Title** Lisa Marriott Head of Community Strategy

Services in the Community; Improving Health and Tackling Inequalities

1. Introduction

As a CCG we recognise that services in the community offer the majority of clinical contacts for our patients. Visits to practices to see GPs, practice nurses and other professionals; district nursing visits and the other community nursing services; community mental health services and services delivered out of practices. These are the services that keep people well, keep them independent and keep them safe.

We also know that many of the things that help people to stay healthy and have a good quality of life, for example, work, education and being active members of their community, do not directly link to health services. We need to be able to work with partners in local councils, with the voluntary sector and with local communities to address these wider issues.

The challenge is to develop services that are integrated with social care, integrated across providers, integrated for physical and mental health and which encompass prevention, treatment and support.es

The term "Community services" is used in the context of this document to describe a broad range of services, including; preventative services, primary care, community nursing and therapy services and community mental health services, as well as some more specialist services (Appendix 1 describes the scope).

2. National Context

There is a strong focus on integration in both the NHS Long Term Plan (LTP)[1] and "Investment and evolution; a five-year framework for the GP contract [2]; both published in January 2019, with the ambition of "dissolving the historic divide between primary and community health services" and "creating genuinely integrated teams of GPs, community health and social care staff".

Central to this is the development of primary care networks (PCN) of GP practices and community teams covering populations of between 30,000-50,000 people, with PCNs identified as the "natural unit for integrating most NHS care".

PCN will be the vehicles for an expanded multi-disciplinary primary care team with additional posts in five primary care roles; clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics. These roles will be introduced in a phased way with the full range in place by 2021/22.

There is a requirement for functions such as district nursing to be configured on network footprints, and to reflect the commitment to integration between mental and physical health. There is an intention that a significant proportion of community mental health staff will become aligned with PCN; building on the co-location of IAPT workers.

[1] NHS Long Term Plan (2019) https://www.longtermplan.nhs.uk/
[2] Investment and evolution; a five-year framework for the GP services contract reform to implement the Long Term Plan (2019) https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

PCN's will also have a key role in population health management and in identifying and supporting people with complex needs. From 2020/21 PCN will assess their local population by risk of unwarranted health outcomes and will work with local community services to make support available to people where it is most needed; including improved services for recovery, reablement and support which "wrap around" core services, to support people with highest need.

The NHS long term plan sets out an ambition to deliver the "triple integration" of primary and specialist care, physical and mental health services and health with social care. PCN are central to achieving this.

3. Local Context

3.1 Meeting the needs of our Population

There are two main drivers that relate to the distinct needs of our population that direct our approach;

- **Addressing inequalities**; the population overall benefits from good health and good services, however, there are areas of relative deprivation and greater need (e.g. when looking at unplanned admissions, these are highest in our most deprived areas). If this is to be addressed, then this is best achieved by services working together in smaller geographies; with a community focus that identifies and supports the most vulnerable, and which builds in prevention and self-care to help people and communities stay healthy for longer; targeting investment at greatest need.

- **Meeting the needs of an aging population**; there are more people surviving into their 70s and more of these people are developing additional long-term conditions, therefore the focus needs to be on preventing ill health and supporting people to manage their own conditions. Key to this is a whole-person approach that recognises that, for example, many people are living with more than one long term condition and that poor mental health increases the likelihood of a person needing other health services. Primary care and community services therefore need to be person centred not disease specific, as an increasing number of people are living with more than one condition.

3.2 Strategic Aims

The CCGs strategy for system change, has been summarised as;

> *"Shifting the balance to prevention and early intervention, by supporting people and communities to improve their own health and wellbeing and strengthening primary care at a population level, so that hospitals provide only the care and treatment that needs to be provided in a hospital setting."*

To do this we need to be able to support people to maintain good health, detect health problems early, so that people get better outcomes and to prevent any existing condition getting worse.

We aim to reshape our approach to community services to one that is one focused on Primary Care Networks; that considers the needs of local populations, recognises the need to work with social care, to integrate physical and mental health care and to

consider the needs of all age groups, in order to improve the health of our whole population and tackle long standing inequalities.

In line with the Long Term Plan, our ambition is to support the development of community services which reflect local needs, integrate at neighbourhood level, work seamlessly with social care, and which promote independence and self-care as the norm.

4. Principles for designing and developing services

The elements of what good community services should look like are well understood. The Kings Fund in "Reimagining Community Services propose a number of design principles, based on good practice;[3]

- Organise and coordinate care around people's needs
- Understand and respond to peoples physical, mental health and social needs in the round
- Make the best use of all the community's assets to plan and deliver care to meet local needs
- Enable professionals to work together across boundaries
- Build in access to specialist advice and support
- Focus on improving population health
- Empower people to take control of their own health and care
- Design delivery models to support and strengthen the relational aspects of care
- Involve families, carers and communities in planning and delivering care
- Make community-based care the central focus of the system.

It is proposed that these principles be adopted to guide the design of community services, in addition, when considering local need, it will be important to;

- be flexible and able to adapt to the local situation, including population distribution, urban/rural, socio-economic characteristics. etc.
- take account of, but not be driven by, what services are currently available.

There is evidence from the New Care Models Programme that by focusing on population health needs, rather than current organisational arrangements it's possible to shift the balance of care from having a primarily reactive, service delivery focus towards a more proactive, preventative approach.[4]

[3] Taken from Reimagining Community Services; Kings Fund (2018)
https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_summary_0.pdf

[4] There is evidence from NCM evaluation that this approach has an impact on reducing hospitalisation rates and length of stay. This is referenced in the Long Term Plan.

5. Approach; starting with population health and care needs

So that we can understand the needs of local populations we have developed a model that considers people at different stages of their life and the range of care or support that they may need, from helping people to stay healthy, through to caring for people with the most complex needs. The model considers both physical and mental health and care needs (see below).

We have used population segmentation and stratification as a means of understanding population health and care needs.

- **Segmentation**; grouping the population by what kind of care they need, as well as how often they might need it.

- **Stratification** provides a means of understanding who within each segment, has the greatest risk of needing care. Stratification can also be used to inform likely future service demand for different risk cohorts (including geographic distribution) to design care pathways and to and target funds and interventions appropriately[5].

5.1 Methods of Population Segmentation used

City of York Council, North Yorkshire County Council and East Riding Council use a life course approach to the development of Joint Strategic Needs Assessment (JSNA), with broadly similar approaches to population segmentation.

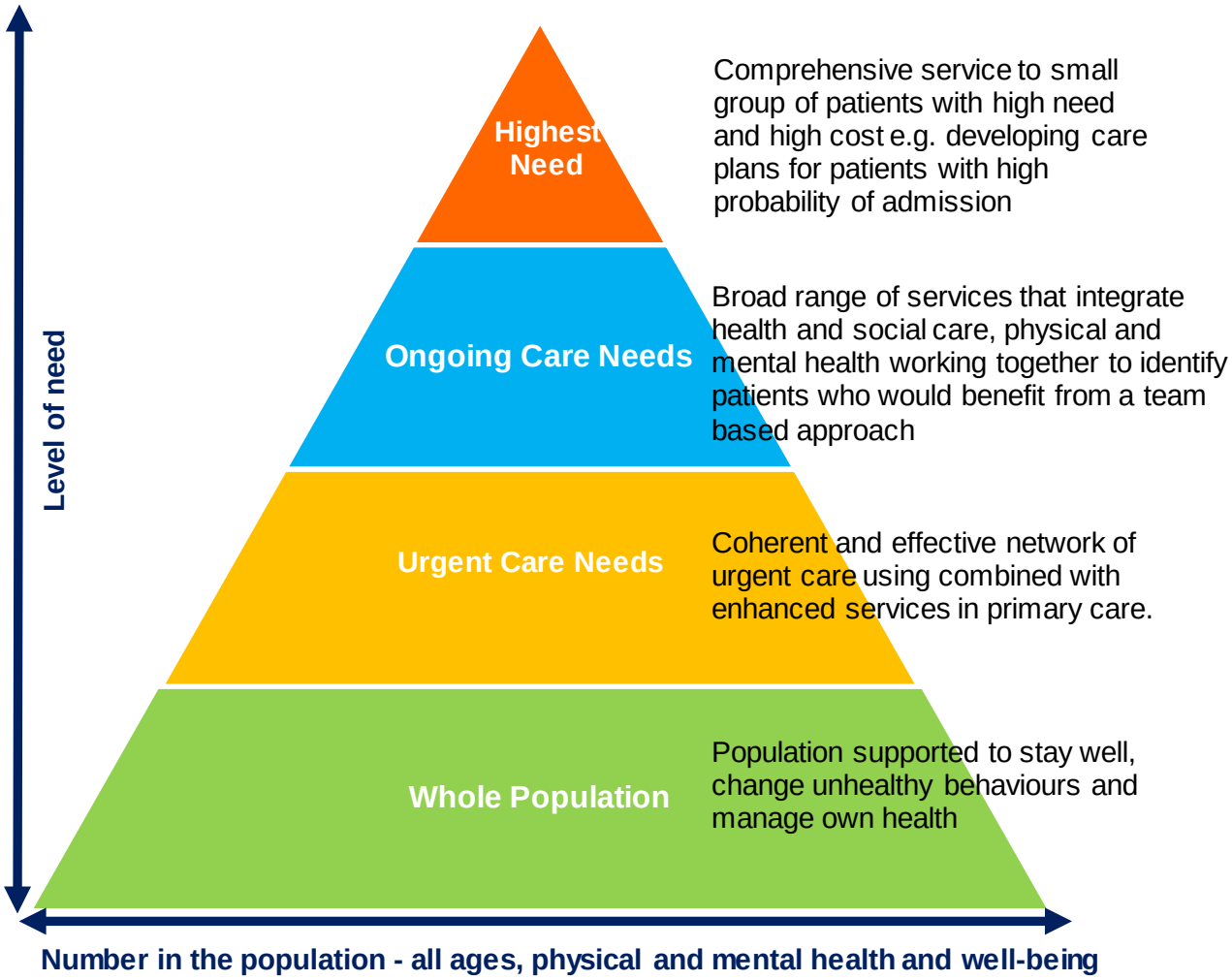
- North Yorkshire County Council; Start well, Live Well, Age Well
- City of York Council; Starting and growing well, Living and working well, Ageing well
- East Riding; Start well, Develop well, Live and work well, Age well and End of Life

5.2 Population Stratification

Population stratification can be used to facilitate the design of services around population need, as illustrated below (adapted from the New Care Models Multi Specialty Community Provider Framework)[6].

[5] **Risk Stratification; Learning and Impact Study** (2017) Operational research and Evaluation Unit NHS England https://www.necsu.nhs.uk/wp-content/uploads/2018/06/2017-07-ORE-RiskStratificationLearning-and-ImpactStudy.pdf

[6] **The multispecialty community provider (MCP) emerging care model and contract framework** (2016) NHS England https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf



5.3 Healthcare aims

This has been used to outline the profile of discrete groups for three age groups within the population, and to suggest what the healthcare aim would be (see Appendix 2).

The majority of services would be focused on populations of 30-50,000 people, but this model also supports the development of a "tiered" approach to the way that services are provided, reflecting the numbers of people with a defined need in a given population. This will range from tailored integration for small numbers of individuals with complex care needs, through to services focused on groups of people with similar needs provided across a larger population e.g. urgent out of hospital care or care for a specific long-term condition.

6. Delivery through Primary Care Networks

6.1 Primary Care Networks as the locus for integration

The NHS Long Term Plan and the five-year framework for the GP services contract, Investment and Evolution, see Primary Care Networks as the "natural unit for integration"

The establishment of PCN will result in a significant shift in focus both nationally and locally. The expectation is that;

- Networks will be instrumental in developing the vision for how services can best be provided to meet the needs of their population and in driving service redesign. The Network Clinical Directors role will be to "provide a strategic and clinical leadership to help support change across primary and community health services".

- delivery will be coordinated at network level through the Network agreement which in addition to determining how practices within the Network will work together, will describe how it will partner with other non-General Practice stakeholders and will be the formal basis for working with other community-based organisations.

6.2 Above and beyond PCN

With PCNs as the building blocks for integration at a local level, there will also be the need to consider how integration works most effectively for services that can best be provided to a larger population;

- Where working at scale is needed to ensure availability of expertise, ensure a sustainable workforce or realise economies of scale e.g. specialist nursing and therapy services.

- So that health can work effectively with Local Authorities, on issues such as prevention, early years and social care.

Working effectively with partners in Local Authorities will be especially important in achieving our ambition of achieving further progress in joint commissioning and integration of health and social care.

7. Locality development to date

Until recently, the CCG has worked in localities. A key factor in developing this approach was consideration of Local Authority boundaries, in order to facilitate integration with social care and prevention services as well as joint commissioning approaches for community services (as outlined above).

In summary;

- The Primary Care Home (PCH) model has developed within the City of York and work has been undertaken to align boundaries with council localities.

- Recent funding has been made available to develop a Primary Care Network in the North, building on the progress that has been made working as a locality.

- There has been a recent decision that there should be two PCN in the South Locality (reflecting the natural groupings of patients and populations which exist and function as communities largely independent from each other) but working together where it make sense to do so.

- Good progress has been made to develop an approach to the population of East Riding that is registered with the CCG, working GP Practices in and around Pocklington and with East Riding Council, with whom the practices have a good working relationship.

Initial work has been done to assess health need based on the current configuration of localities (see Appendix 3) and shared at locality meetings.

8. Contractual arrangements

PCN are being established as a DES, with Primary Care taking a leading role. As stated previously, a requirement of this is that each PCN must have a Clinical Director and a Network Agreement setting out the collaboration between its member practices. The Network Agreement will also set out how it will partner with non-GP stakeholders and will be the formal basis for working with other community-based organisations (collaboration arrangements with other local organisations, including community health providers will be a distinct part of every Network Agreement).

For the CCG the implications of this is that there is a benefit in stability; meaning that services would stay with current providers, at least in the medium term (2019/20 - 2021/22), so that there is time to develop effective working relationships, and for new primary care team roles to be introduced, however, as individual contracts come to an end there will be the opportunity to align and consolidate these.

In line with the Long Term Plan we would anticipate that integration will be achieved locally through collaborative agreements between providers. We anticipate that in the longer term this could lead to the development of prime/sub-contractor or alliance contracts.

9. Summary

For Vale of York CCG the model for population health and all services delivered in the community, will be focused on natural neighbourhoods built on the foundation of Primary Care Networks

Supporting the establishment and development of PCN, by building on the work that has already taken place in localities, will be central to achieving the strategic changes that we want to see and importantly the changes to the way that services are delivered on the ground which make a difference to people.

The framework that has been developed is consistent with the new service model described in the Long Term Plan and is designed so that the local requirements can be assessed in a consistent way for;

- Prevention and population health management
- Urgent community response and the requirement for a consistent offer for out of hospital urgent care.
- Coordination of care for people with long term conditions
- Targeted intervention for people with complex needs.

It is also consistent with the Universal Model of Personalised Care, published in January 2019[7]

[7] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf

10. Next Steps

- We will support the establishment and development of Primary Care Networks as the main vehicle for delivering integrated services to meet the needs of their population.

- We would expect providers to align to neighbourhoods, and work with PCN as they become established; we will work with providers to support this.

- We will co-produce a response to meeting the needs of the local population, that makes best use of local assets, uses collectives resource more effectively (workforce, estates and financial) and where necessary targets investment to address gaps. This will allow a local response to delivery, while meeting same outcome objectives and "health aims" for specific groups of people. Involving patients and local communities to shape this.

- We recognise the important role that Local Authorities play and want to work in partnership with them in the development of this approach.

- We will work with providers and other stakeholders at a neighbourhood/PCN level to clarify what services are best delivered locally, and which need to be delivered at scale, which will in turn inform future commissioning decisions.

- We will work with partners to commission services to achieve outcomes that meet the needs of the population irrespective of provider.

- We will consider how to align our own strategic programmes to support the delivery of this strategy.

Scope of Community Services

- **Preventative services;** public health funded services such as stop smoking or weight loss designed to improve population health.
- **Sexual health services**
- **Maternity Services**
- **Services for Children and Young People** (child health, health visiting, school nursing)
- **Primary care services;** care provided by surgery based teams of clinical and non-clinical staff providing general care and support to a registered list of patients. Excluding services provided as part of PMS.
- **Primary and community mental health services;** teams including medical, nursing and administrative staff who provide services to support people with mental health conditions.
- **Community pharmacy;** pharmacists and pharmacy technicians working in pharmacies and practices, who support the management of minor illness, prescribing and medicines management.
- **Community nursing services;** care provided by nursing teams including district nurses, registered nurses and healthcare assistants currently linked to practice groupings.
- **Urgent Care;** including minor injury and Urgent Care provision; Urgent Care Centres, paramedic care linked to Primary Care Out of Hours.
- **Community therapy services**; including; podiatry, speech and language therapy, physiotherapy and occupational therapy.
- **Reablement/intermediate care/integrated care teams;** teams that provide home based and inpatient support to prevent admission and facilitate earlier discharge.
- **End of life services;** a range of services to support people approaching the end of their lives including palliative care teams, hospice services (residential and home based), Macmillan and Marie Curie nursing and services.
- **Specialist services;** including specialist nursing services (such as heart failure, diabetes and Tissue Viability).
- **Adult social care including assessment functions;** teams of social workers, vocationally qualified social care co-ordinators, advice and information teams providing community based assessment of individuals' needs for care and support.
- **Community optometry and dental services**
- **Equipment services**
- **Learning disability services**
- **Independent sector long term care providers**
- **Voluntary and community services that support health and wellbeing**

Healthcare Aim

Healthcare Aim for Children and Young People

Children and Young People	Typical Profile	What they need from the Health and Care System[a]
Whole (general) population	Mostly healthy, minor health or social care issues. Predictable contact for health maintenance and promotion. Unpredicted contact with health and care system e.g. accident, sudden illness	Advice prevention, e.g. immunisation, mental and physical health promotion, e.g. healthy eating, exercise, dental health.
Children in the population at risk	Children who have identified risk factors of developing of developing physical and/or psychological ill health. e.g. Adverse Childhood Experiences (ACE) on long term health.	Prevention and mitigation of the impact
Urgent care need	Acute or moderately unwell with time limited condition, ranging from moderately unwell to acute e.g. infectious disease, acute/time limited mental health problem, (e.g. self-harm or eating disorder psychosis), trauma.	Rapid access to advice and treatment when required that reflects the health/clinical need. Health care provided by staff who are trained and experienced in caring for children and young people.
Ongoing care need	Single long term mental of physical health condition or learning disability e.g. ADHD, ASD e.g. epilepsy, diabetes.	Health care provided by staff who are trained and experienced in caring for children and young people. Recognition of the wider impact of a LTC on the psycho-social wellbeing of the individual and the dynamics of the family. Support in active management of the condition to optimise life chances
Highest care need	Complex mental or physical health needs; e.g. severe autism, psychosis, emotional trauma ramifications e.g. severe neuro-disability, child on long term ventilation,	Health care provided by staff who are trained and experienced in caring for children and young people. Rapid support close to home in a crisis. Someone to monitor/coordinate care from multiple providers. No need to repeat story/assessment. Minimise; duplication, visiting, paperwork. Technology part of the menu of options in place for C&YP to effectively self-manage their long-term condition

Healthcare aim for the adult population

Adults	Typical Profile	What they need from the Health and Care System[b]
Whole (general) population	Relatively healthy. Minor health or social care issues. Unpredictable crisis related contact with the system (e.g. fracture, accident). Unfamiliar with the system. May or may not be aware of the need to manage health proactively.	Access to primary care for seamless rapid access to emergency services if required. Health prevention and promotion. Signposting to relevant community activities/support) exercise classes, smoking cessation, etc)
Urgent care need	Acute or moderately unwell with time limited condition, ranging from moderately unwell to acute e.g. infectious disease, acute/time limited mental health problem, trauma.	Rapid access to advice and treatment when required that reflects the health/clinical need.
Ongoing care need	Single long term mental or physical health condition or learning disability e.g. anxiety, depression, psychosis e.g. diabetes, hypertension/CVD	Proactive integrated care plan to prevent deterioration. Navigation/signposting between services in the system. Effective referral between services. Social care support where needed. No need to repeat story/assessment. Voluntary sector support where needed. Someone to monitor/coordinate care from multiple providers. No need to repeat story/assessment. Minimise; duplication, visiting, paperwork. The use of technology is part of the menu of options in place for people to effectively self-manage their long-term condition.
Highest care need	Complex mental or physical health needs; including C&YP transitioning to adult services e.g. complex neuro disability e.g. acute psychosis	Intensive care in home/community. Rapid support close to home in a crisis. Someone to monitor/coordinate care from multiple providers. No need to repeat story/assessment. Minimise; duplication, visiting, paperwork.

Healthcare aim for the older adult population

Older Adults	Typical Profile	What they need from the Health and Care System[c]
Whole (general) population	Relatively healthy but increased likelihood of one or more health condition. Opportunity to maintain and improve health and maintain social inclusion and engagement.	Promotion of healthy lifestyle and the prevention and management of illness and disability associated with ageing (including vaccination). Promoting mental and physical health and wellbeing including social inclusion[d] rapid access to primary care for conditions which may limit independence. Support to maintain healthy lifestyle; regular exercise, not smoking, reducing alcohol consumption, healthy eating and preventing obesity/malnutrition
Urgent care need	Acute or moderately unwell with time limited condition, ranging from moderately unwell to acute e.g. infectious disease, acute/time limited mental or physical health problem, e.g. delirium e.g. acute infection, trauma	Rapid access to advice and treatment when required that reflects the health/clinical need. Care provided by staff trained and experienced in care of older people. Any hospital stay minimised to prevent decompensation.
Ongoing care need	Mental or physical health care need stemming from pre-existing condition or as a result of the ageing process[8] e.g. dementia e.g. CHD	Treatment and management of long-term conditions in older people is optimised with no discrimination on the basis of age alone. Personalised care planning and shared decision-making. The use of technology is part of the menu of options in place for patients to effectively self-manage their long-term condition.
Highest care need	Complex mental or physical health needs linked to ageing, multi-morbidity or frailty.	Rapid support close to home in a crisis including access to ambulatory clinics available for the provision of specialist advice from the multi-disciplinary team specialist mental health assessments if appropriate. Someone to monitor/coordinate care from multiple providers. No need to repeat story/assessment. Minimise; duplication, visiting, paperwork. Avoiding unnecessary transfer of care.

[8] Most long-term conditions are more prevalent among the older age groups; c16% of people aged 65 have difficulty with activities of daily living, this increases to c50% of those aged 85[8])

[a] Based on **Whole population integrated child health - segmentation model; Connecting Care for Children; Impe**
https://www.cc4c.imperial.nhs.uk/our-experience/segmentation-model
[b] Based on information in the **How to' Guide: The BCF Technical Toolkit** (2014) https://www.england.nhs.uk/wp-conte

[c] Based on information in
Safe Compassionate Care for Frail Older People Using an Integrated Care Pathway (2014) NHS England
https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf **Healthy Ageing Evidence Review** (201
https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_april11_evidence_review_healthy_ageing.pdf

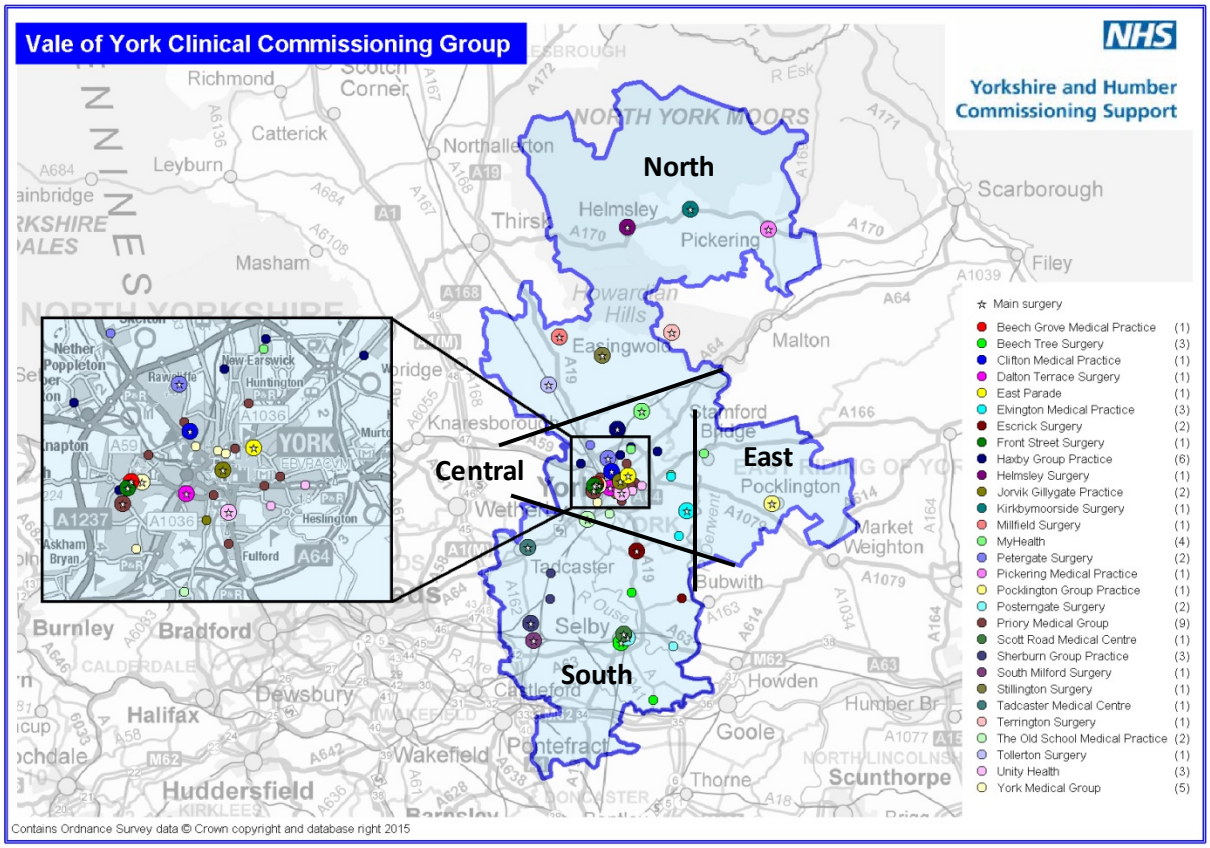
Appendix 3

Localities mapping

The Vale of York CCG area has been divided into 9 'local footprint' areas as follows:

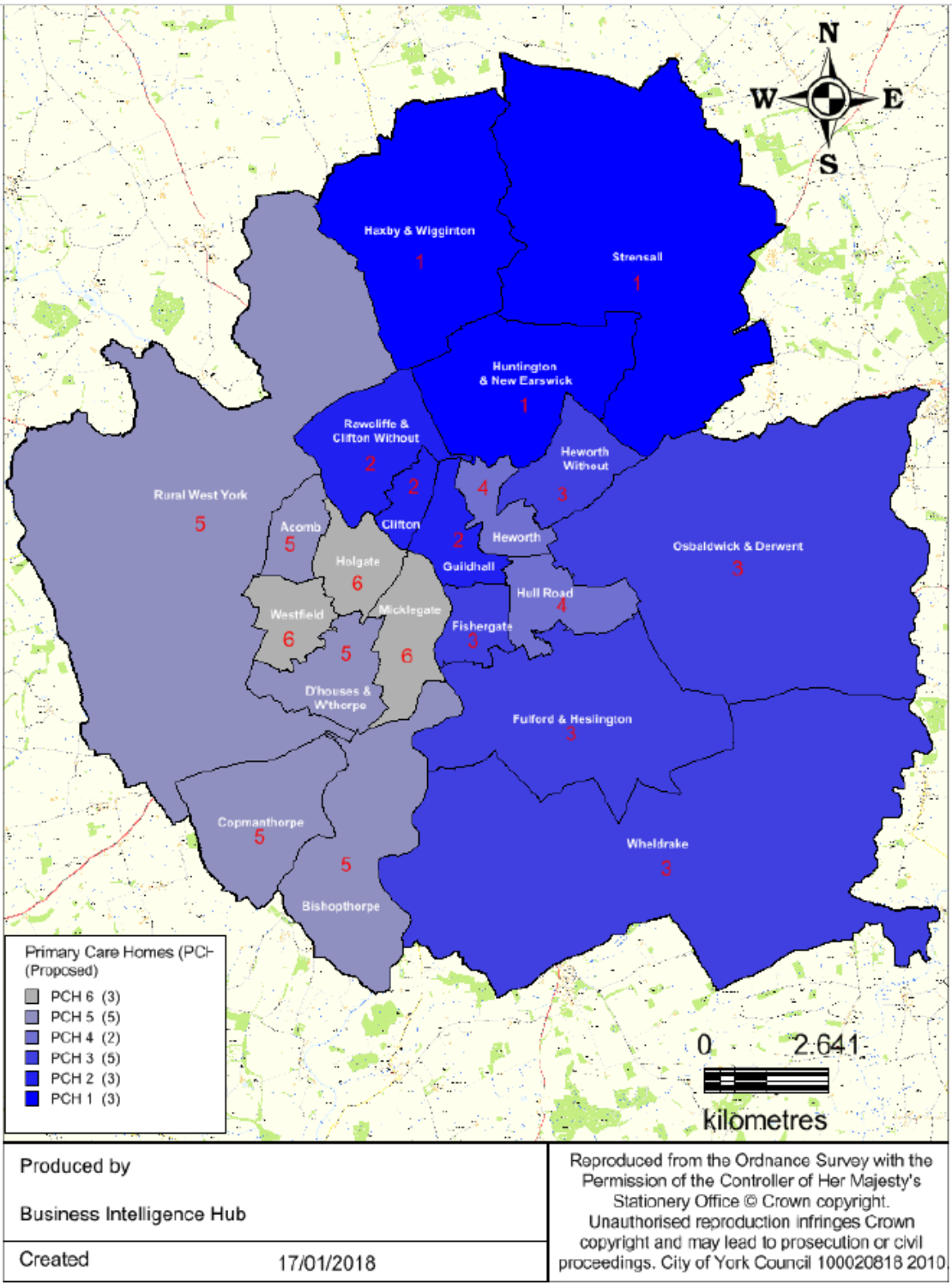
- Central locality
  - PCH 1: Haxby & Wigginton, Huntington & New Earswick, Strensall
  - PCH2: Clifton, Guildhall, Rawcliffe & Clifton Without
  - PCH3: Fishergate, Fulford & Heslington, Heworth Without, Osbaldwick & Derwent, Wheldrake
  - PCH4: Heworth and Hull Road
  - PCH 5: Acomb, Bishopthorpe, Copmanthorpe, Dringhouses & Woodthorpe, Rural West York
  - PCH 6: Holgate, Micklegate and Westfield
- North locality
- South locality[9]
- East locality

The North, Central/East and South localities are mapped roughly as below:



The PCH (primary care home) areas in the central locality can be mapped as follows:

[9] There is the possibility that South could be split into two (Selby and rural), giving two populations of c.30,000 each in line with the other areas



General overviews of each population are set out below, including information on population demographics, health concerns and wider determinants of health.

PCH1: Haxby & Wigginton, Huntington & New Earswick, Strensall

General population: There are 33,061 people living in the PCH1 area. PCH1 has a roughly average proportion of 0-17 year olds, a below average working age population and an above average proportion of people aged 65+. The average deprivation level is fairly low (in the least deprived 20% of areas nationally); however, H&NE has a higher level of deprivation than Strensall and H&W. The population is predominantly (>95%) White British. There is a relatively low population density.

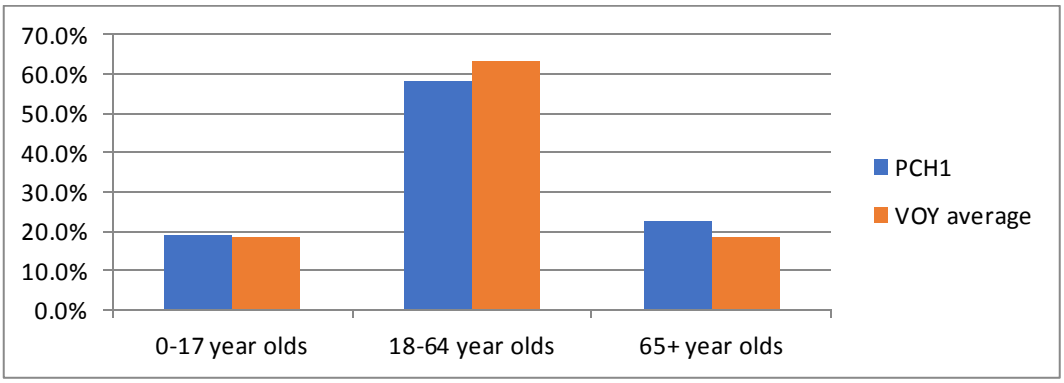


Figure 1: Graph of PCH1 population breakdown by age category (%)

Children and young people: Strensall has more young people and fewer over-65s than the other two wards. Child poverty is low in H&W and Strensall, but slightly above local average in H&NE. Particular health concerns include emergency admissions in under-5s, and admissions for injuries in 15-24 year olds.

Working age population: The majority of residents are home owners, with a small proportion renting and very few council houses (none in Strensall or H&W). H&W and H&NE have above average proportions of people living with a limiting long term illness or disability (H&NE highest in York), with a significant proportion of people providing 1 hour or more unpaid care per week. There is above average homecare usage in H&NE across all age groups (most noticeably 0-64yrs), particularly for learning disability and physical disability. Other issues include adult obesity (Strensall, H&NE) and low levels of healthy eating (H&NE).

Older age population: There is a high burden of homecare support in H&W and H&NE, with H&NE containing an above average proportion of households of 65+yr olds. Particular health concerns include elective hospital admissions, particularly for hip replacements (all wards) and CHD (H&W); emergency hospital admissions, particularly for falls in H&W; and cancer incidence (breast and prostate in H&W, colorectal in H&NE). Strensall has above average premature mortality from CHD, and high mortality from stroke.

PCH2: Clifton, Guildhall, Rawcliffe & Clifton Without

General population: There are 38,265 people living in the PCH2 area. A high proportion of the PCH2 population are working age, with a slightly below average proportion of 0-17 year olds and a low proportion of 65+ year olds. The average deprivation level is similar to the national average; however, Clifton and Guildhall have much higher levels of deprivation (in the worst 40-50% of areas nationally) than R&CW, which is in the lowest 20% of areas nationally. The population is mostly white, but Clifton and Guildhall have more substantial black and minority ethnic communities (7.8% in Clifton, 10.2% in Guildhall), particularly of Asian residents. There are a large number of students in Guildhall (2260 households considered learners & earners/student scene), with some also in Clifton (600 households). There are also small gypsy traveller communities in Guildhall and R&CW. There is a relatively high population density.

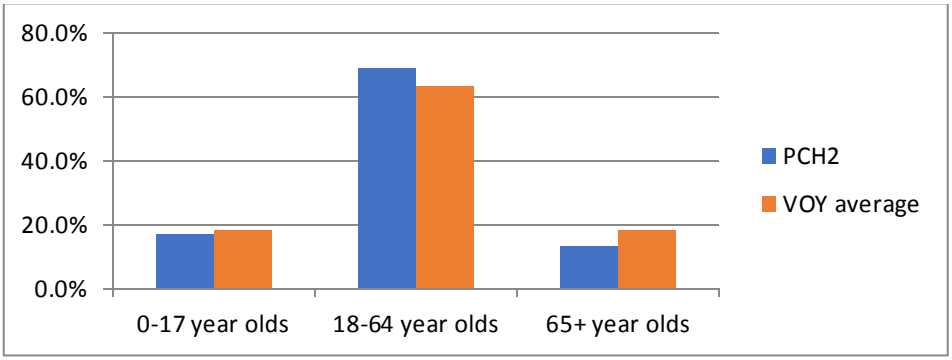


Figure 2: Graph of PCH2 population breakdown by age category (%)

Children and young people: Clifton has a high proportion of children receiving free school meals, with below average educational attainment and above local average child poverty. Particular health concerns include childhood obesity, emergency hospital admissions for under-5s, A+E attendance in 0-4 year olds (Clifton) and teenage conception (Guildhall).

Working age population: As noted above, PCH2 has a large proportion of working age people, particularly in Guildhall, which has a correspondingly smaller 0-17 population. Compared to the local (York) average, Clifton and Guildhall have high levels of Universal Credit claimants. Clifton and Guildhall have higher than average proportions of rented accommodation, whereas R&CW has a higher proportion than average of home owners. There are a large number of single person (<65yrs) households in Clifton and Guildhall. Guildhall has the highest proportion in York of binge drinking adults, and Clifton has a low proportion of healthy eating adults. Particular health concerns include hospital stays for self-harm and alcohol-related self-harm, and deaths from all causes in under-65s.

Older age population: Clifton and Guildhall have above (local) average fuel poverty, and significantly more pensioners living alone than the national average. Particular health concerns include emergency hospital admissions (Clifton and Guildhall; particularly falls in over-65s, CHD, MI, COPD and hip fractures in Guildhall, and falls in over-65s, intentional self-harm, and COPD in Clifton), premature mortality (Clifton – all causes; Guildhall – circulatory disease, CHD), mortality from strokes (particularly R&CW), lung cancer incidence (Clifton and Guildhall), and deaths from cancer (under 75s).

PCH3: Fishergate, Fulford & Heslington, Heworth Without, Osbaldwick & Derwent, Wheldrake

General population: There are 30,010 people living in the PCH3 area. A high proportion of the PCH3 population are working age, with below average proportions of 0-17 year olds and of 65+ year olds. The deprivation level is generally low (in the least deprived 20% of areas nationally, although Fishergate has a higher deprivation level than the other wards. Fishergate and F&H have large BME communities (14.1% in Fishergate, 13.2% in F&H), particularly Asian residents, likely due to their proximity to the University of York. There are a large number of students in Fishergate (1965 households learners & earners/student scene). The overall population density is low, although there are areas of higher density within that (Fishergate).

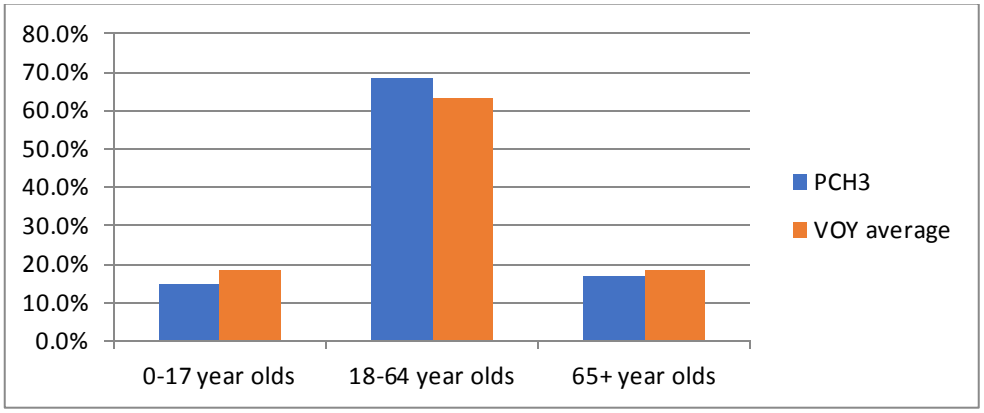


Figure 3: Graph of PCH3 population breakdown by age category (%)

Children and young people: Wheldrake has a higher proportion of 0-17 year olds (23.8%) than the other wards. Children's health is generally good, although Fishergate has an above average level of teenage conception.

Working age population: The Fishergate population is particularly skewed towards the student age band (37.5% 20-29 year olds). The main health concern for the working age population is the high proportion of adults binge drinking. The Unity Health practice population also has a low proportion of women aged 25-64 attending cervical screening and a high proportion of people reporting a long term mental health problem.

Older age population: Fishergate has a higher level of fuel poverty (13.3% households). Fishergate also has a high proportion of privately rented houses, whereas other wards have a majority of homeowners (with predominant Experian groups including village retirees and bungalow haven). Particular health concerns include hospital admissions for intentional self-harm (Fishergate and HW), hip replacements (Wheldrake and O&D) and knee replacements (HW); cancer incidence; mortality from cardiovascular disease; and emergency hospital admissions for CHD, COPD, and hip fractures (Fishergate), MI (HW) and falls in over-65s (F&H).

PCH4: Heworth and Hull Road

General population: There are 29,677 people living in the PCH4 area. A high proportion of the PCH4 population are working age, with a low proportion of 65+ year olds and a roughly average number of 0-17 year olds. Deprivation is above average for York, but similar to the middle 20% of areas nationally. The population is mostly White British, but has an above average BME (particularly Asian) population. PCH4 contains a large number of students (1872 learners & earners/student scene in Hull Road, 986 in Heworth). There is a high population density, with overcrowding levels worse than the national average.

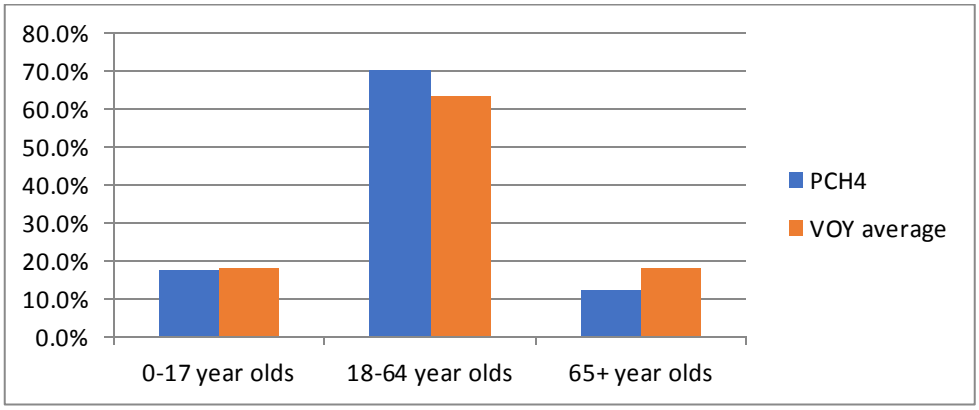


Figure 4: Graph of PCH4 population breakdown by age category (%)

Children and young people: Both wards have high levels of child poverty (20.4% Hull Road, 15.6% Heworth), with an above average proportion receiving free school meals. The main health concern is childhood obesity, with other issues including A+E attendances and emergency hospital admissions for under-5s and deliveries to teenage mothers.

Working age population: In Hull Road 60% are aged 15-29, influenced by its proximity to the University (1384 households learners and earners, 1280 households student scene). Around 50% own their own home, but there are a high proportion of both private and social renters. A high proportion of households are in fuel poverty (16.9% Hull Road, 12.2% Heworth). Particular health concerns include mental health and a high proportion of binge drinking adults.

Older age population: Particular health concerns include premature mortality (all causes) and mortality from CHD. Whilst Heworth has above average hospital admissions (knee replacement, intentional self-harm and emergency admissions for MI, COPD, CHD) Hull Road has below average admissions, with physical health generally better than the population average.

PCH5: Acomb, Bishopthorpe, Copmanthorpe, Dringhouses & Woodthorpe, Rural West York

General population: There are 37,446 people living in the PCH5 area. PCH5 has an above average proportion of 0-17 year olds and 65+ year olds, and a below average working age population. The average deprivation level is relatively low (in the least deprived 20% of areas nationally), although it is higher in Acomb and D&W than the other three wards. There is a high proportion of over-65s (particularly in Bishopthorpe) and a fairly high proportion of children and young people, with a correspondingly smaller working age population. The population is predominantly (>95%) white British. PCH5 has a relatively low population density.

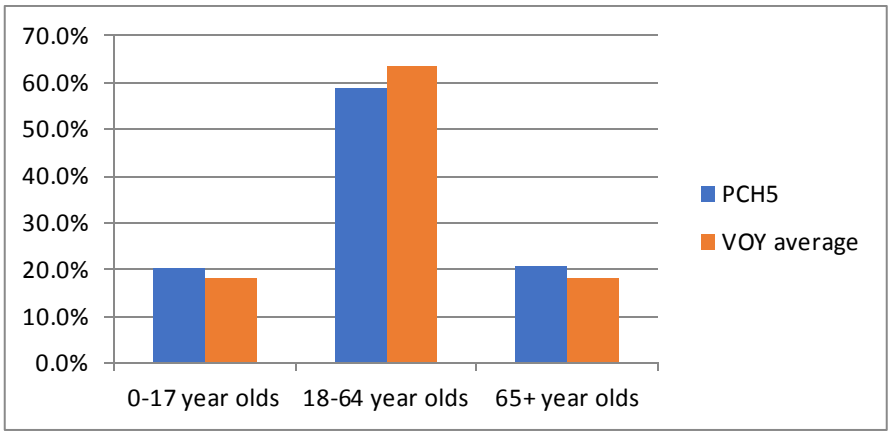


Figure 5: Graph of PCH5 population breakdown by age category (%)

Children and young people: Acomb has above (local) average levels of child poverty (12.7%) and proportion of children on free school meals. Particular health concerns include childhood obesity and emergency hospital admissions for under-5s.

Working age population: Acomb has an above (local) average proportion of adults claiming benefits. There are high levels of home ownership in all wards, with some pockets of social housing in Acomb and D&W. Particular health concerns include binge drinking adults, and adult obesity in Acomb and D&W.

Older age population: There is an above average proportion of people providing one or more hour of unpaid care per week. Although generally health is better than average, there are some issues including elective hospital admissions for hip replacements, breast and prostate cancer incidence, and premature mortality from CHD (Bishopthorpe). Acomb also has above average hospital admissions (especially for hip fractures and CHD), higher mortality (stroke, respiratory diseases), and increased incidence of colorectal cancer.

PCH6: Holgate, Micklegate and Westfield

General population: There are 39,908 people living in the PCH6 area. PCH6 has an average proportion of 0-17 year olds (19%; VoY average 18.4%), an above average working age population (67.2%, av. 63.3%) and a low proportion of 65+ year olds (13.7%; av. 18.4%). The deprivation level is relatively high compared to York average; additionally deprivation is higher in Westfield (in the most deprived 40% of areas nationally) than Holgate and Micklegate (middle 20% of areas nationally). The population is mostly white, but Micklegate in particular has a larger BME population (7.1%) than other areas. PCH6 has a relatively high population density.

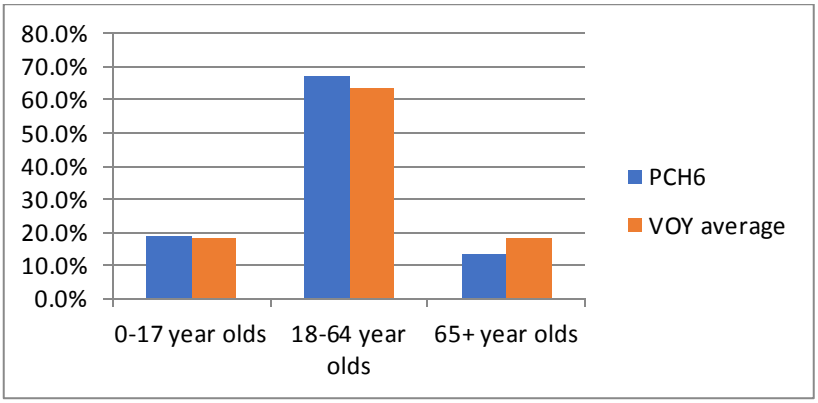


Figure 6: Graph of PCH6 population breakdown by age category (%)

Children and young people: Westfield in particular has a high proportion of young children (under-10s). Westfield has many issues associated with deprivation, including an above average proportion of children receiving free school meals, below average educational attainment, and high levels of child poverty, teenage conceptions, birth rate, childhood obesity, A+E attendances and emergency admissions in under-5s. Childhood obesity is also an issue in Holgate, and emergency admissions in under-5s are higher than national average across the PCH6 patch.

Working age population: Westfield has a large proportion of social housing (32%), with 22% of York's council houses, above average benefits claimants and a high proportion of lone parent households with dependent children. Micklegate has more privately rented housing, above average fuel poverty and a larger working age population than the other wards, with health generally better than average. Health issues include hospital stays for self-harm and alcohol related self-harm, binge drinking adults (except Westfield), obese adults (Westfield), and poor diet (Holgate and Westfield).

Older age population: PCH6 has a high proportion of pensioners living alone. Health concerns include emergency hospital admissions for all causes (especially COPD and CHD), elective admissions for hip replacements, mortality in under-75s and from respiratory diseases, lung cancer incidence (Westfield and Micklegate). Westfield in particular has poor health outcomes, being in the bottom 5 wards in York for most health indicators. Additional health issues in Westfield include all-cause premature mortality (with reduced life expectancy), mortality from intentional self-harm and alcohol attributable conditions, and a high proportion of the population with a limiting long term illness or disability.

North locality

General population: There are 34,515 people living in the North locality. A high proportion of the population are aged 65+, with a below average proportion of 0-17 year olds and a small working age population. The level of deprivation varies across the locality, with some areas (North and rural Easingwold, Kirkbymoorside, Pickering) in the least deprived 20% of areas nationally whilst other areas (particularly in the north) are in the middle 20% of areas nationally. The population is predominantly white (>98.5%); the most diverse area is in Ampleforth ward but even this is minimal. The locality is mainly rural, with a very low overall population density and challenging geographical access to services, particularly in the northernmost areas.

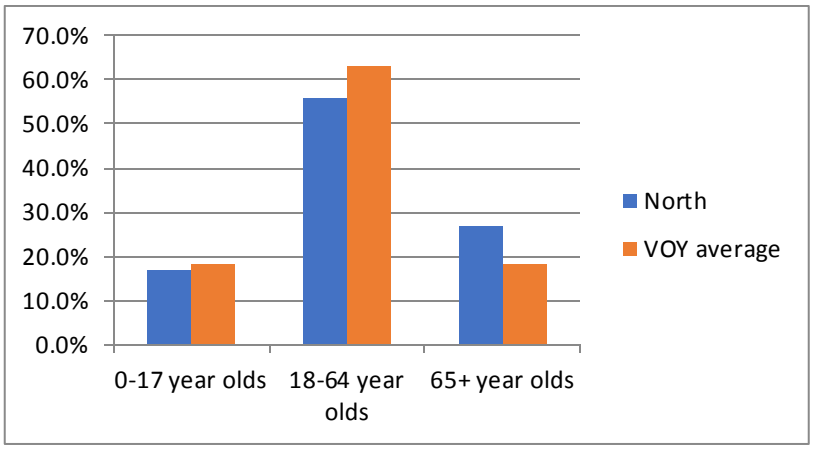


Figure 7: Graph of North locality population breakdown by age category (%)

Children and young people: Child health is generally good, although there are some health concerns including the proportion of pregnant women smoking at time of delivery (Ryedale), unintentional injuries in 0-4 and 0-14 year olds (Hambleton) and the proportion of 12yr olds free from dental decay.

Working age population: Adult health is generally good, although there are some health concerns including smoking prevalence in adults in routine and manual occupations (Hambleton), chlamydia screening and detection rates, and the proportion of people killed and seriously injured (KSI) on the roads.

Older age population: Ryedale has a high proportion of lone pensioner households. There is above average fuel poverty, particularly in the north (Dales and Sinnington wards). Particular health concerns include cardiovascular disease, back pain, the proportion of people require palliative/supportive care (Kirkbymoorside and Helmsley practice populations), osteoporosis (Kirkbymoorside, Pickering). The number of people who have been formally diagnosed with dementia or diabetes are below the estimated number of people living with dementia or diabetes. Additionally, Helmsley and Easingwold areas have historically had higher non-elective hospital admissions than the rest of the locality.

South Locality

General population: There are 76,149 people living in the South locality. The locality has an above average proportion of 0-17 year olds, with a slightly below average working age population and an average proportion of people aged 65+. The level of deprivation varies across the locality, with most of the rural areas in the least deprived 40% of areas nationally but with some areas of higher deprivation, particularly around Selby and Brotherton. Two areas of Selby (NW and SE) are in the most deprived 20% of areas nationally; around 3450 people live in these areas. The population is predominantly white (98.4%), although the north-west corner of Selby has a slightly larger BME community (3.9%). The locality is mostly rural, with Selby the main urban centre. The overall population density is low, although the north-west Selby corner is in the most densely populated 20% of areas in the country.

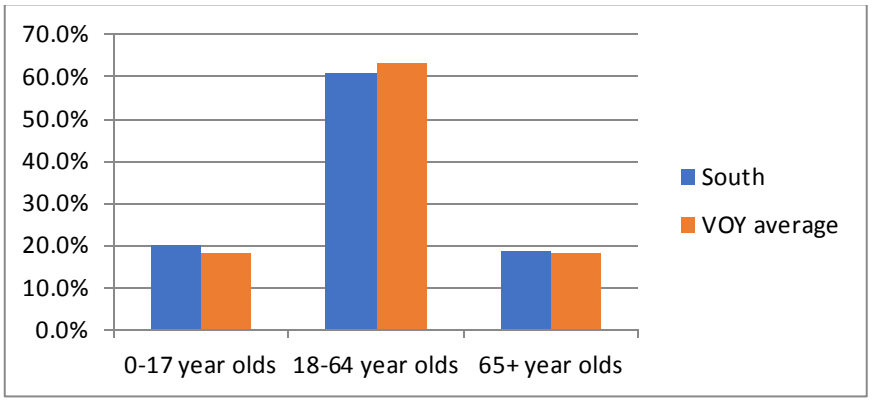


Figure 8: Graph of South locality population breakdown by age category (%)

Children and young people: Children in Selby have below average educational attainment and a higher level of child poverty. Health concerns include childhood obesity, and teenage pregnancies in Selby North/South wards. Some areas have more hospital admissions in under-5s (Selby, Sherburn-in Elmet, South Milford, Tadcaster) and in 15-24 year olds (Whiteley, Eggborough, Sherburn-in-Elmet) than the national average.

Working age population: Around 75% of households own their own home. Health concerns include adult obesity, alcohol-related traffic accidents and the proportion of people killed or seriously injured on the road. GP practices in Selby have additional issues, including prevalence of depression (Scott Road), COPD (Beech Tree), learning difficulties (Beech Tree) and estimated prevalence of smoking (Scott Road).

Older age population: There is an increased proportion of pensioners living alone in Selby and Tadcaster. Particular health concerns include low uptake of bowel cancer screening, more than expected excess winter deaths, and diabetes. Selby, Sherburn in Elmet/South Milford, and Tadcaster (south) have higher non-elective hospital admissions than the rest of the locality.

South Locality data: split by GP population

The above looks at the south locality as a single Primary Care Network unit. However, as this is larger than the standard PCN size of 30-50,000 people a request was made for further information with the locality split into two sub-populations: Selby practices & Escrick; and Tadcaster, Sherburn and South Milford.[10]

Sub-population A: Selby practices (Scott Road, Posterngate, Beech Tree) and Escrick
Registered population size: 49,090[11]
Age profile: Similar proportion of under-18s to national average. All practices have above average proportion of over-65s except Scott Road, which has a significantly lower proportion of over-65s.
Socioeconomic: All in least deprived 50% of GP practice populations but with significant variation – Escrick in least deprived 10%, with Beech Tree, Posterngate and Scott Road in 3rd, 4th and 5th least deprived deciles nationally. Geographically, pockets of very high deprivation in NW and SE of Selby town.
Ethnicity: 1.5-2% non-White ethnicity, 4.8% of the population of Selby town are from white non-British ethnic groups.
Health issues:
Areas in which these practices perform worse than the national average include adult obesity (Scott Road and Posterngate), CHD prevalence (QOF), cancer prevalence (QOF – except Scott Road), stroke (QOF – Beech Tree and Posterngate).
Scott Road has the highest unemployment rate in the CCG, high estimated smoking prevalence, above average prevalence of depression (QOF).
Beech Tree has above average QOF prevalence of hypertension and COPD.

Sub-population B: Tadcaster, Sherburn and South Milford
Registered population size: 27,256[2]
Age profile: Similar number of under-18s to national average, above national average 65+
Socioeconomic: Least deprived 20% of GP populations nationally
Ethnicity: 1.5-1.9% non-White ethnicity
Health issues:
Areas in which these practices perform worse than national average include adult obesity (all practices), stroke, hypertension and CHD prevalence (Tadcaster and South Milford), AF and asthma (QOF – Tacaster, Sherburn),
Tadcaster and South Milford have high rates of diabetes compared to the local average.
Tadcaster has a high prevalence of COPD compared to the local average.

Additional data on A+E attendances[12]
All practices in the south locality have standardised A+E attendance rates below the CCG average. Tadcaster has the highest rate of attendances and Escrick the lowest. Also of note – South Milford has had a significant fall in attendances over the last 3 years.

[10] Data from PHE General Practice Profiles https://fingertips.phe.org.uk/profile/general-practice/data#page/0/gid/3000007/pat/152/par/E38000188/ati/7/are/B82105
[11] N.B. the overall locality population is based on the geographical population, whereas this reflects practice populations
[12] CCG data

East locality

General population: There are around 24,000 people living in the East locality area, which includes Pocklington Provincial ward and part of Wolds Weighton ward (both part of the East Riding of Yorkshire).[13] The locality has a slightly above average proportion of 0-17 year olds. Pocklington Provincial has an above average proportion of people aged 65+ and below average working age population, with Wolds Weighton similar to the local average. Deprivation varies across the locality, with the west part being generally less deprived (in the least deprived 20% of areas nationally) than the east of the locality (middle 20% of deprivation scores nationally). The population is predominantly white (98%). The locality is mainly rural, with a low overall population density; all areas except Pocklington town and Stamford Bridge (east) are in the least densely populated 20% of areas nationally.

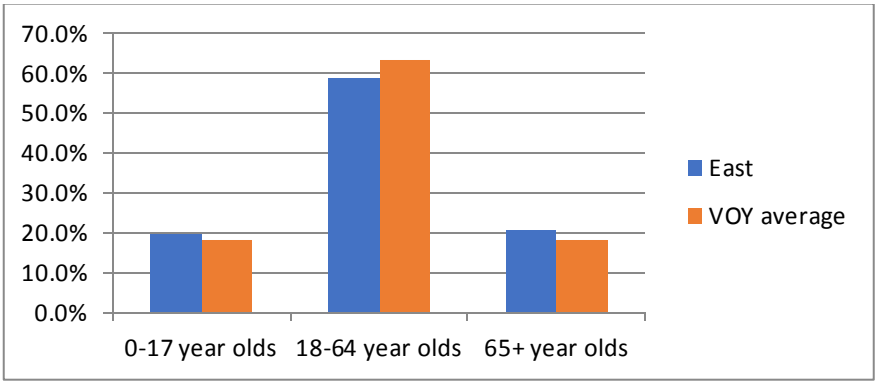


Figure 9: Graph of East locality population breakdown by age category (%)

Children and young people: Child health is generally good compared to local (East Riding) and national averages.

Working age population: The most common household types (Mosaic) are wealthy professionals, comfortable rural middle aged, and rural community. Adult health is generally good compared to local (East Riding) and national averages.

Older age population: Wolds Weighton has a high level of fuel poverty (20% households). Although people in this locality age fairly healthily, areas of greater concern include prevalence of cancer, stroke/TIA and atrial fibrillation. There are also more elective hip and knee replacements carried out than the national average.

[13] Pocklington Provincial and Wolds Weighton both have around 16,600 residents. However, only around 50% of WW is in the Vale of York area geographically. There are 23,658 residents of the East Riding who are registered with a Vale of York CCG GP practice. However, not all of these live in PP/WW.

Information sources:

SHAPE tool (https://shapeatlas.net/)

NOMIS (https://www.nomisweb.co.uk/census/2011/ks102ew)

City of York Council

- York Ward Profiles (https://data.yorkopendata.org/dataset/york-ward-profiles-2018-19-q1)
- Business Intelligence Hub Discussion Paper: Primary Care Homes – Draft Boundaries (v.2)
- York JSNA (www.healthyork.org)

North Yorkshire County Council

- Locality Profiles (http://hub.datanorthyorkshire.org/dataset/locality-profiles)

East Riding of Yorkshire Council

- Data observatory – Pocklington Provincial and Wolds Weighton wards (http://dataobs.eastriding.gov.uk/profiles/profile?profileId=1&geoTypeId)
- Pocklington Provincial JSNA

Public Health England

- PHE Fingertips (https://fingertips.phe.org.uk/)
- Local health profiles (http://www.localhealth.org.uk)

Vale of York CCG

- Locality Mapping: Summary of Service Provision (Powerpoint presentation, 2015)

Dr Victoria Turner, Public Health Registrar
15th November 2018

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Item Number: 10

Name of Presenter: Michael Ash-McMahon

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Report Month 10

Purpose of Report
For Information

Reason for Report

To brief members on the financial performance of the CCG and achievement of key financial duties for 2018/19 as at the end of January 2019.

To provide details and assurance around the actions being taken.

Strategic Priority Links

☐Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

F17.1- ORG Failure to deliver 1% surplus
F17.2 – ORG Failure to deliver planned financial position
F17.3 – ORG Failure to maintain expenditure within allocation

Emerging Risks (not yet on Covalent)
Recommendations The Committee is asked to note the financial performance to date and the associated actions.

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Caroline Goldsmith, Deputy Head of Finance Natalie Fletcher, Head of Finance

Finance and Contracting Performance Report – Executive Summary

April 2018 to January 2019

Month 10 2018/19

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

IMPROVEMENTS IN PERFORMANCE

Issue	Improvement	Action Required
Other Mental Health	It has been confirmed that a TCP patient previously accounted for outside the risk share arrangement between the North Yorkshire CCGs should be included within the risk share. This has led to a further reduction in the forecast expenditure.	Continue to monitor information regarding TCP costs. Build in full year effect and on-going impact into financial planning.
Funded Nursing Care	There has been an improvement of £207k on the forecast outturn as a result of improved analysis relating to prior year costs, and the resulting adjustment to forecast outturn.	
Continuing Care	A financial audit of continuing care packages has identified circa £300k on underspent packages which was not previously reflected in the FOT. This is offset by new Fast Track cases and backdated cases to give an overall improvement of £93k.	

Financial Performance Headlines

DETERIORATION IN PERFORMANCE

Issue	Deterioration	Action Required
Prescribing	No Cheaper Stock Obtainable (NCSO) continued to increase prices during November and the forecast spend includes £833k in relation to this. This has been separately identified within the forecast calculations to ensure that the cost pressure is forecast as accurately as possible.	Continue work to deliver additional savings through Prescribing Indicative Budgets in Q4. Monitor the national situation regarding NCSO and continue to forecast taking account of all available information relating to this cost pressure.
Acute Services (excluding York Teaching Hospital NHS Foundation Trust)	Acute Services have deteriorated by £438k in comparison to the Month 9 forecast outturn. This largely relates to Leeds, Hull and Ramsay contracts.	Start to negotiate year end agreements with providers to reduce the risk of any further increases in activity and cost. Continue to investigate increases in activity to establish if there are any areas of concern.

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. Financial recovery actions – The financial recovery actions agreed by Executive Committee are shown in Section 8 of the financial performance report. Delivery of these actions will be reported on each month for the remainder of the financial year.

2. Multi-year financial recovery plan – The CCG has now submitted it's draft financial plan for 2019/20, as approved by governing body. However, there is a significant risk in the financial plan due to different assumptions between the CCG and YTHFT on contract value. This gap results in an additional £14.5m pressure in the Vale of York health system. Discussions have taken place with regulators on how the CCG and YTHFT could resolve this gap and options are being drawn up and considered by the two organisations and the regulators. The impact of any solution for 2019/20 will need to be considered in the context of the multi-year financial recovery plan and the impact on the trajectory of both organisations returning to financial balance.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation					7.6	7.0	0.6	G →
In-year total expenditure does not exceed total allocation (Programme and Running costs)					467.9	486.5	(18.6)	R →
Better Payment Practice Code (Value)	95.00%	99.30%	4.30%	G	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	96.46%	1.46%	G	95.00%	>95%	0.00%	G
CCG cash drawdown does not exceed maximum cash drawdown					486.5	486.5	0.0	G →

- 'In-year total expenditure does not exceed total allocation' – outturn expenditure is forecast to be £18.6m higher than the CCG's in-year allocation. This represents a £6.0m deterioration from plan.

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
Running costs spend within plan	5.7	5.8	(0.1)	A	6.8	7.0	(0.2)	G
Programme spend within plan	395.1	403.1	(8.0)	R	473.7	479.5	(5.9)	R
Actual position is within plan (in-year)	(10.3)	(18.4)	(8.1)	R	(12.6)	(18.6)	(6.0)	R
Actual position is within plan (cumulative)					(56.4)	(62.5)	(6.0)	R
Risk adjusted deficit					(18.6)	(18.6)	0.0	G
Cash balance at month end is within 1.25% of monthly drawdown (£k)	464	253	211	G				
QIPP delivery	11.3	5.7	(5.6)	R	14.5	7.7	(6.9)	R

QIPP Summary

QIPP Summary	£m
QIPP Target	14.5
Delivered at Month 10	5.7
QIPP Remaining	8.8

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Detailed Narrative

Report produced: February 2019

Financial Period: April 2018 to January 2019 (Month 10)

1. Overall reported financial position

The Year to Date (YTD) reported deficit at Month 10 is £18.4m, and the forecast deficit for 2018/19 remains at £18.6m. The forecast position represents a £6.0m adverse variance against the CCG's financial plan and includes the anticipated effect of the additional financial recovery actions which have been agreed by Executive Committee and detailed in Section 8. The delivery of these actions will continue to be monitored in this report and via the Financial Recovery Board.

Excluding the receipt of Quarter 1 Commissioner Sustainability Funding (CSF), the CCG is forecasting an in-year deficit of £20.0m against a planned deficit of £14.0m. This continues to represent a further year of stabilisation of the CCG's financial position when compared to the 2017/18 deficit of £20.1m.

For clarity, the table below shows the CCG's financial plan (YTD and forecast outturn) adjusted for CSF.

	Year to Date	Forecast Outturn	
CCG planned surplus / (deficit)	(£10.5m)	(£14.0m)	As per submitted financial plan
CSF received	£1.4m	£1.4m	Q1 payment received, 10% of total value as per national quarterly profile
Planned surplus / (deficit) net of receipt of CSF	(£10.3m)	(£12.6m)	
Reported surplus / (deficit)	**(£18.4m)**	**(£18.6m)**	
Variance to financial plan	(£8.1m)	(£6.0m)	

2. Year to Date Supporting Narrative

The reported YTD deficit is £18.4m against a plan of £10.3m. Within this position are several variances from plan which are explained in further detail in the table below.

QIPP delivery of £5.7m has been achieved against a plan of £11.3m. This largely relates to schemes outside of the Aligned Incentive Contract (AIC) with York Teaching Hospital NHS Foundation Trust (YTHFT), and these are shown in detail in Section 7.

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust (YTHFT)	(£10.38m)	The AIC contract with YTHFT is reported with the risk share fully invoked within the contract position. The YTD position also includes the impact of the over trade on high cost drugs and devices and an estimated cost relating to the increase in unplanned activity.
Continuing Care	(£2.59m)	The reported year to date position is based on information from the QA system. The YTD position includes the £1.0m pressure resulting from the reconciliation work completed by Scarborough and Ryedale CCG. The CHC plan includes £1.88m of YTD QIPP; actual savings of £1.28m have been delivered within the YTD position.
Contingency	£2.32m	The 0.5% contingency provided for in plan has been fully released in the YTD position.
Mental Health Out of Contract Placements	(£1.44m)	The overspend in this area has been reviewed and found to be due to a combination of corrections of coding of packages between budget lines by the PCU, the full year effect of placements agreed in 2017/18 and minimal placements ending in year.
Other Primary Care	£1.32m	The primary care £3 per head provided in plan was £897k for April to January. Schemes funded by £3 per head have slipped and so spend in this period has been minimal. The plan also includes £156k year to date expenditure for the RightCare Circulation QIPP; however no expenditure has been incurred against this scheme.
Primary Care Prescribing	(£1.14m)	There has been a significant overspend against budget on prescribing due to No Cheaper Stock Obtainable (NCSO) adjustments. The year to date impact of this is £681k.
Ramsay	£1.13m	The trading position with Ramsay remains below plan, but has seen a slight increase over the last month.
QIPP adjustment	£0.86m	The CCG identified QIPP schemes totalling £859k more than required to deliver the financial plan. Identified schemes were applied to the relevant expenditure lines in full, which therefore created an additional QIPP 'contingency' of £859k. This has been fully released in the YTD position.
Other Prescribing	(£0.76m)	Other prescribing includes a YTD overspend on prescribing indicative budgets which is being managed within the forecast outturn by partly deferring the payment into next year.
CHC Clinical Team	£0.64m	The YTD position reflects the lower level of spend compared to the budget set to fund the former Partnership Commissioning Unit.
Non-Contracted Activity	(£0.59m)	Spend on non-contracted activity has continued to increase in month 10 and is being reviewed to understand if it relates to particular providers or

		specialities.
Prior Year Balances	£0.57m	This includes the financial impact of resolving expenditure relating to the 2017/18 financial year, where estimates had been made at year end.
Other Mental Health	£0.51m	Costs in relation to Transforming Care Partnerships (TCP) have been re-profiled in line with expected discharge timescales.
Other variances	£1.57m	
Total impact on YTD position	**(£8.11m)**	

3. Forecast Outturn Supporting Narrative

The forecast outturn is £18.6m which represents a £6.0m deterioration against the plan. The main variances within this forecast are detailed in the following table.

The CCG is not reporting any further risks to the forecast financial position, and all identified mitigations are now reflected in the reported forecast outturn.

Forecast in-year financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust (YTHFT)	(£12.32m)	The AIC contract with YTHFT is forecast with the risk share fully invoked. The forecast also includes the impact of the over trade on high cost drugs and devices, and an estimated cost relating to the increase in unplanned activity. The AIC position is reported in more detail in Section 9.
Continuing Care	(£2.39m)	The reported forecast position is based on information from the QA system. The forecast includes delivery of £1.90m of QIPP against a QIPP target of £2.50m. The YTD and forecast positions include the £1.00m cost pressure relating to the reconciliation work carried out by Scarborough and Ryedale CCG.
Contingency	£2.32m	The full value of the 0.5% contingency has been released in to the forecast outturn position.
Reserves	£2.11m	This forecast includes additional system recovery actions of £829k. This has been forecast through reserves as it is currently not known exactly where the cost reduction will be realised, although plans are being developed with system partners.
Mental Health Out of Contract Placements	(£1.66m)	The overspend in this area has been reviewed and found to be due to a combination of corrections of coding of packages between budget lines by the PCU, the full year effect of placements agreed in 2017/18 and minimal placements ending in year.
Ramsay	£1.34m	The forecast trading position with Ramsay remains below plan, but has seen an increase of £281k over the last month.
Other Primary Care	£1.25m	This includes financial recovery actions relating to £3 per head practice transformation funding and

		Improving Access – the value of these is £872k.
Prescribing	(£1.15m)	Adjustments in respect of No Cheaper Stock Obtainable (NCSO) continue to be an issue in November. The forecast impact of this is £833k.
QIPP adjustment	£0.86m	The CCG identified QIPP schemes totalling £859k more than required to deliver the financial plan. Identified schemes were applied to the relevant expenditure lines in full, which therefore created an additional QIPP 'contingency' of £859k. This has been fully released in the forecast position
CHC Clinical Team	£0.75m	The forecast position reflects the lower level of spend compared to the budget set to fund the former Partnership Commissioning Unit.
Non-Contracted Activity	(£0.71m)	Spend on non-contracted activity has continued to increase and is being investigated to understand if it relates to particular providers or specialties, and if a similar pattern is being seen in other CCGs.
Tees, Esk and Wear Valleys NHS Foundation Trust	£0.68m	The forecast position includes a proposed £750k reduction to the contract value in 2018/19.
Other Mental Heath	£0.64m	The forecast has been updated to reflect the expected financial impact of Transforming Care Partnerships, which is lower than plan.
Other Services	£0.63m	This includes financial recovery action of £400k relating to NHS Property Services.
York Teaching Hospital NHS Foundation Trust – Community Services	(£0.63m)	The AIC included a planned £700k QIPP relating to community services, this variance represents the risk share element of non-delivery of this scheme.
Prior Year Balances	£0.57m	This includes the financial impact of resolving expenditure relating to the 2017/18 financial year, where estimates had been made at year end.
Other Community	£0.54m	The CCG's QIPP plan included reinvestment in community services, provided that savings relating to unplanned admissions were realised. This saving is not expected to be delivered, so funding for reinvestment will not become available. This underspend against plan is offset by non-delivery of QIPP on the YTHFT acute line.
Other variances	£1.13m	
Total impact on forecast position	**(£6.04m)**	

4. Allocations

Allocation adjustments have been received in Month 10, as follows:

Description	Recurrent / Non-recurrent	Category	Value
Total allocation at Month 9			£423.87m
Resource Allocation Transfer - TCP - patient packages of care	Non-recurrent	Core	£0.11m
DWP Employment Advisors in IAPT	Non-recurrent	Core	£0.05m
Transformation - Cancer	Non-recurrent	Core	£0.04m
Total allocation at Month 10			**£424.06m**

5. Underlying position

Following development of the CCG's draft plan model, the underlying position below now takes account of full year effects and reflects the opening position for 2019/20.

Description	Value
Planned in-year deficit	**(£12.60m)**
Adjust for non-recurrent items in plan -	
Commissioner Sustainability Funding Q1	(£1.40m)
Primary Care £3 per head	£1.08m
Repayment of system support	£0.33m
Other non-recurrent items in plan	£0.04m
Forecast outturn variance from financial plan	(£6.05m)
Adjust for non-recurrent variances in forecast outturn	
CHC legacy reconciliation	£1.00m
Non recurrent financial recovery actions	(£4.05m)
Other non-recurrent variances	£0.66m
Full year effect of QIPP schemes	£1.19m
Other full year effects	(£0.40m)
Underlying financial position	**(£20.20m)**

6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31st January 2019. The CCG's Maximum Cash Drawdown as determined by NHS England was updated in November for the expected value of depreciation and is now showing as being met in year.

The CCG achieved the Better Payment Practice Code in terms of both the volume and value of invoices being paid above the 95% target in Month 10.

7. QIPP programme

			Year to Date			Forecast Outturn		
Area	**Ref**	**Scheme**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Planned Care	2018/01	Trauma and Orthopaedics	1,688	0	(1,688)	2,250	0	(2,250)
	2018/02	Optimising Health Thresholds	833	1,961	1,127	1,000	2,336	1,336
	2018/03	General Surgery / Gastroenterology	778	0	(778)	1,000	0	(1,000)
	2018/04	Biosimilar high cost drugs gain share	527	212	(315)	632	437	(195)
	2018/05	Microsuction (ENT)	167	0	(167)	250	0	(250)
	2018/06	Cardiology	311	0	(311)	400	0	(400)
	2018/07	Ophthalmology	263	0	(263)	338	0	(338)
	2018/08	Back Pain PLCV	263	0	(263)	338	0	(338)
	2018/09	Neurology	233	0	(233)	300	0	(300)
	2018/10	PLCVs	219	0	(219)	282	0	(282)
	2018/11	General Medicine	117	0	(117)	156	0	(156)
Out of Hospital	2018/17	Reduce ED Attendances	126	0	(126)	151	0	(151)
	2018/20	Non Elective Admissions Management	974	0	(974)	1,169	0	(1,169)
	2018/21	Delayed Transfers of Care (DToC) Reduction	512	0	(512)	614	0	(614)
	2018/22	Community Beds Productivity Programme	467	0	(467)	700	0	(700)
	2018/23	Patient Transport project - reprocurement	120	217	97	150	277	127
	2018/24	Community Podiatry	22	37	15	26	37	11
Prescribing	2018/40	Minor Ailments Prescribing	63	0	(63)	75	0	(75)
	2018/41	Prescribing Schemes	1,250	1,175	(75)	1,500	1,628	128
	2018/42	Continence and Stoma Care	42	0	(42)	53	0	(53)
Primary Care	2018/31	GPIT - NYNET	94	94	(0)	113	113	(0)
	2018/32	Other Primary Care Indicative Budgets	97	0	(97)	125	0	(125)
Complex Care	2018/50	Complex Care - CHC and FNC benchmarking	1,875	1,275	(600)	2,500	1,900	(600)
	2018/51	Recommission MH out of contract expenditure	375	231	(144)	500	331	(169)
Running Costs	2018/60	Commissioning support (eMBED) contract savings	194	194	0	233	233	0
	2018/61	Vacancy Control	439	317	(122)	527	376	(151)
		Optimising elective capacity	0	0	0	0	0	0
		Adjustment for identified schemes above in-year QIPP requirement	(716)	0	716	(859)	0	859
			11,332	**5,713**	**(5,619)**	**14,524**	**7,668**	**(6,856)**

8. Financial Recovery Actions

The CCG's Executive Committee agreed financial recovery actions with a total value of £3.83m on 27 September 2018, which are detailed below. These recovery actions are included within the CCG's forecast outturn, alongside additional unidentified recovery actions of £829k.

Action	Value agreed by Executive Committee (£m)	Value included in FOT (£m)	Comments
Additional unplanned activity at YTHFT	1.00	1.00	The forecast outturn for the AIC with YTHFT includes an estimate of cost for additional unplanned activity, which is currently based on 20% of tariff value. The CCG is disputing this basis and is challenging the need for additional Winter Planning costs over and above this.
Contract negotiations	1.37	1.37	The CCG has approached a number of providers to discuss non-recurrent in-year system support around contract values.
Primary Care underspends	1.10	1.47	Various actions to maintain the currently anticipated underspends within primary care over the remainder of the year.
City of York Council Better Care Fund uncommitted funds	0.05	0.05	The CYC BCF fund currently has £50k of CCG contribution uncommitted.
Vascular activity	0.30	0.00	The CCG has reviewed coding of vascular activity and concluded that charges are in line with guidance. This recovery action has now been removed from the CCG's forecast outturn.
Total identified recovery actions	**3.83**	**3.89**	
Additional unidentified financial recovery actions	0.00	0.83	This forecast includes additional system recovery actions of £829k. This has been forecast through reserves as further cost reduction opportunities are still being explored.
Total recovery actions	**3.83**	**4.72**	

9. Aligned Incentive Contract with York Teaching Hospital NHS Foundation Trust

The detail of the reported position for the AIC is shown in the table below.

	YTD £m	FOT £m	Comments
Contract value	183.05	219.32	This represents the value of the agreed contract.
Application of risk share above contract value	2.91	3.70	The reported position assumes that the risk share related to non-delivery of QIPP schemes has been invoked in full.
Excluded drugs and devices	0.83	1.00	High cost drugs and devices are included in the AIC as a risk / gain share, with the CCG and YTHFT sharing additional costs and benefits on a 50/50 basis. YTD spend is higher than the contract value for this element, and it is assumed that this will continue for the remainder of the financial year.
Increased cost of additional unplanned activity	1.49	1.79	The AIC allows for quantified and agreed exceptional incremental costs of delivering unplanned care activity where this is over and above the baseline included in the contract value. The YTD and forecast figures reported have been aligned with YTHFT's assessment of additional cost.
Funding of winter schemes	0.67	1.00	The CCG has not committed to fund the £1.0m of winter schemes proposed by YTHFT over and above the additional unplanned activity costs.
Financial recovery action – additional unplanned activity at YTHFT	(0.67)	(1.00)	See Section 8 above.
Cardiac Resynchronisation Therapy Pacemakers	0.00	0.47	This service was not included in the original contract value due to uncertainty whether commissioning responsibility was CCG or NHS England Specialised Commissioning. The CCG are expecting to pay YTHFT for this service, but are seeking to confirm whether any funding should transfer from NHS England.
Excluded drugs QIPP schemes	(0.21)	(0.44)	Forecast savings on biosimilar high cost drugs
Total reported contract position	**188.07**	**225.83**	

Appendix 1 – Finance dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioned Services																		
Acute Services																		
York Teaching Hospital NHS FT	160,136	170,518	(10,382)	144,343	153,474	(9,131)	15,794	17,044	(1,250)	191,650	203,974	(12,324)	191,613	203,937	(12,324)	37	37	0
Yorkshire Ambulance Service NHS Trust	10,925	10,850	76	9,833	9,833	0	1,093	1,017	76	13,110	13,035	76	13,110	13,110	0	0	(76)	76
Leeds Teaching Hospitals NHS Trust	7,187	6,942	245	6,439	6,153	286	748	789	(41)	8,604	8,300	304	8,604	8,208	396	0	92	(92)
Hull and East Yorkshire Hospitals NHS Trust	2,672	2,545	126	2,423	2,249	173	249	296	(47)	3,173	3,043	130	3,173	2,946	227	0	97	(97)
Harrogate and District NHS FT	1,905	2,013	(108)	1,705	1,821	(116)	201	192	8	2,283	2,412	(129)	2,283	2,439	(156)	0	(27)	27
Mid Yorkshire Hospitals NHS Trust	1,983	1,700	284	1,783	1,549	234	201	151	50	2,365	2,026	339	2,365	2,056	310	0	(29)	29
South Tees NHS FT	1,132	1,156	(24)	1,019	1,036	(17)	113	120	(7)	1,358	1,378	(20)	1,358	1,380	(22)	0	(2)	2
North Lincolnshire & Goole Hospitals NHS Trust	380	319	61	342	299	43	38	20	18	456	366	90	456	375	81	0	(9)	9
Sheffield Teaching Hospitals NHS FT	168	348	(179)	151	318	(167)	17	30	(13)	202	381	(179)	202	369	(167)	0	13	(13)
Non-Contracted Activity	3,594	4,188	(594)	3,235	3,726	(491)	359	463	(103)	4,313	5,018	(705)	4,313	4,950	(638)	0	67	(67)
Other Acute Commissioning	881	900	(19)	793	816	(23)	88	84	4	1,057	1,085	(28)	1,057	1,090	(32)	0	(4)	4
Ramsay	4,908	3,780	1,127	4,354	3,272	1,082	554	508	45	5,939	4,603	1,336	5,939	4,323	1,617	0	281	(281)
Nuffield Health	2,647	2,980	(333)	2,372	2,593	(220)	275	388	(113)	3,159	3,507	(348)	3,159	3,430	(272)	0	76	(76)
Other Private Providers	1,037	1,117	(80)	934	1,037	(104)	104	80	24	1,245	1,341	(96)	1,245	1,383	(138)	0	(42)	42
Sub Total	**199,556**	**209,357**	**(9,800)**	**179,724**	**188,176**	**(8,452)**	**19,832**	**21,181**	**(1,349)**	**238,916**	**250,471**	**(11,556)**	**238,879**	**249,996**	**(11,118)**	**37**	**475**	**(438)**
Mental Health Services																		
Tees, Esk and Wear Valleys NHS FT	34,265	34,189	77	30,817	30,671	146	3,448	3,518	(70)	41,130	40,454	675	41,083	40,424	659	47	30	17
Out of Contract Placements	4,603	6,042	(1,440)	4,167	5,388	(1,221)	435	654	(219)	5,473	7,136	(1,663)	5,473	7,045	(1,571)	0	92	(92)
SRBI	1,408	969	438	1,267	882	386	141	88	53	1,689	1,189	500	1,689	1,204	486	0	(15)	15
Non-Contracted Activity - MH	343	498	(155)	309	454	(145)	34	44	(10)	412	547	(136)	412	541	(129)	0	6	(6)
Other Mental Health	861	350	511	1,041	310	731	(180)	40	(220)	1,034	396	638	1,388	459	929	(355)	(63)	(291)
Sub Total	**41,480**	**42,049**	**(569)**	**37,602**	**37,705**	**(104)**	**3,878**	**4,344**	**(465)**	**49,738**	**49,723**	**15**	**50,045**	**49,672**	**373**	**(308)**	**50**	**(358)**
Community Services																		
York Teaching Hospital NHS FT - Community	15,143	15,563	(420)	13,699	14,014	(315)	1,444	1,549	(105)	18,031	18,661	(630)	18,031	18,661	(630)	0	0	0
York Teaching Hospital NHS FT - MSK	1,957	1,915	41	1,757	1,721	36	200	194	6	2,356	2,303	53	2,356	2,303	53	0	0	0
Harrogate and District NHS FT - Community	2,143	2,290	(148)	1,929	2,069	(140)	214	222	(7)	2,571	2,741	(169)	2,571	2,764	(193)	0	(24)	24
Humber NHS FT - Community	1,659	1,659	0	1,483	1,483	0	175	175	0	2,009	2,009	0	2,009	2,009	0	0	0	0
Hospices	1,060	1,060	(0)	954	954	(0)	106	106	(0)	1,271	1,272	(1)	1,271	1,272	(1)	0	0	0
Longer Term Conditions	351	235	116	316	219	98	35	17	18	422	283	139	422	291	130	0	(9)	9
Other Community	2,361	1,903	458	2,124	1,672	453	236	231	5	2,833	2,297	536	2,833	2,268	565	0	29	(29)
Sub total	**24,672**	**24,625**	**47**	**22,262**	**22,132**	**130**	**2,410**	**2,493**	**(83)**	**29,493**	**29,565**	**(72)**	**29,493**	**29,568**	**(75)**	**0**	**(3)**	**3**

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			FOT Previous Month			FOT Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Other Services																		
Continuing Care	21,597	24,183	(2,586)	19,562	22,202	(2,640)	2,035	1,981	54	25,667	28,058	(2,392)	25,667	28,151	(2,485)	0	(93)	93
CHC Clinical Team	1,560	925	636	1,404	861	543	156	64	92	1,873	1,125	748	1,873	1,213	659	0	(88)	88
Funded Nursing Care	3,612	3,313	299	3,251	3,088	163	361	225	136	4,334	3,885	450	4,334	4,092	242	0	(207)	207
Patient Transport - Yorkshire	1,679	1,690	(11)	1,511	1,524	(13)	168	166	2	2,015	2,024	(8)	2,015	2,024	(9)	0	(1)	1
Voluntary Sector / Section 256	419	420	(0)	377	378	(0)	42	42	(0)	503	504	(0)	503	504	(0)	0	0	0
Non-NHS Treatment	485	488	(3)	437	440	(3)	49	49	(0)	582	587	(4)	582	587	(5)	0	(0)	0
NHS 111	745	745	0	671	671	0	75	75	0	894	894	0	894	894	0	0	0	0
Better Care Fund	9,381	9,224	157	8,449	8,306	142	932	918	14	11,245	10,877	368	11,245	10,877	368	0	0	(0)
Other Services	1,379	1,186	193	1,249	1,072	177	131	114	16	1,641	1,009	632	1,641	1,007	634	0	2	(2)
Sub total	**40,858**	**42,174**	**(1,316)**	**36,910**	**38,541**	**(1,631)**	**3,948**	**3,633**	**315**	**48,754**	**48,962**	**(208)**	**48,754**	**49,350**	**(595)**	**0**	**(387)**	**387**
Primary Care																		
Primary Care Prescribing	39,668	40,804	(1,135)	35,660	36,616	(956)	4,008	4,187	(179)	47,272	48,417	(1,145)	47,272	48,101	(829)	0	316	(316)
Other Prescribing	1,351	2,107	(756)	1,216	1,923	(707)	135	184	(49)	2,026	2,306	(281)	2,026	2,331	(306)	0	(25)	25
Local Enhanced Services	1,677	1,714	(37)	1,510	1,569	(60)	168	145	23	2,013	2,060	(47)	2,013	2,095	(82)	0	(35)	35
Oxygen	265	310	(46)	238	278	(39)	26	33	(6)	318	372	(55)	318	370	(53)	0	2	(2)
Primary Care IT	786	737	50	701	648	53	85	88	(3)	957	881	76	957	887	70	0	(6)	6
Out of Hours	2,661	2,680	(20)	2,394	2,426	(31)	266	255	11	3,193	3,243	(50)	3,193	3,257	(65)	0	(14)	14
Other Primary Care	2,284	968	1,317	1,908	718	1,191	376	250	126	3,118	1,868	1,250	3,070	1,820	1,250	48	48	(0)
Sub Total	**48,692**	**49,319**	**(627)**	**43,628**	**44,178**	**(550)**	**5,064**	**5,141**	**(77)**	**58,896**	**59,148**	**(251)**	**58,848**	**58,862**	**(14)**	**48**	**285**	**(237)**
Primary Care Commissioning	**36,452**	**36,097**	**355**	**32,816**	**32,470**	**346**	**3,636**	**3,627**	**8**	**43,718**	**43,396**	**321**	**43,718**	**43,389**	**329**	**0**	**7**	**(7)**
Trading Position	**391,711**	**403,621**	**(11,911)**	**352,941**	**363,202**	**(10,261)**	**38,769**	**40,419**	**(1,650)**	**469,514**	**481,265**	**(11,751)**	**469,737**	**480,838**	**(11,101)**	**(223)**	**428**	**(650)**
Prior Year Balances	0	(567)	567	0	(555)	555	0	(12)	12	0	(567)	567	0	(555)	555	0	(12)	12
Reserves	179	0	179	226	0	226	(46)	0	(46)	958	(1,150)	2,108	546	(947)	1,493	412	(203)	615
Contingency	2,318	0	2,318	2,318	0	2,318	0	0	0	2,318	0	2,318	2,318	0	2,318	0	0	0
Unallocated QIPP	859	0	859	859	0	859	0	0	0	859	0	859	859	0	859	0	0	0
Reserves	**3,357**	**(567)**	**3,924**	**3,403**	**(555)**	**3,958**	**(46)**	**(12)**	**(34)**	**4,136**	**(1,718)**	**5,853**	**3,724**	**(1,502)**	**5,226**	**412**	**(216)**	**627**
Programme Financial Position	**395,067**	**403,054**	**(7,987)**	**356,345**	**362,647**	**(6,303)**	**38,723**	**40,407**	**(1,684)**	**473,650**	**479,548**	**(5,898)**	**473,461**	**479,336**	**(5,875)**	**189**	**212**	**(23)**
In Year Surplus / (Deficit)	(10,267)	0	(10,267)	(9,100)	0	(9,100)	(1,167)	0	(1,167)	(12,600)	0	(12,600)	(12,600)	0	(12,600)	0	0	0
In Year Programme Financial Position	**384,801**	**403,054**	**(18,253)**	**347,245**	**362,647**	**(15,403)**	**37,556**	**40,407**	**(2,851)**	**461,050**	**479,548**	**(18,498)**	**460,861**	**479,336**	**(18,475)**	**189**	**212**	**(23)**
Running Costs	**5,701**	**5,824**	**(122)**	**5,131**	**5,268**	**(137)**	**570**	**555**	**15**	**6,843**	**6,994**	**(151)**	**6,843**	**7,017**	**(174)**	**0**	**(23)**	**23**
Total In Year Financial Position	**390,502**	**408,878**	**(18,375)**	**352,376**	**367,916**	**(15,540)**	**38,126**	**40,962**	**(2,836)**	**467,893**	**486,542**	**(18,649)**	**467,704**	**486,353**	**(18,649)**	**189**	**189**	**0**
Brought Forward (Deficit)	(36,526)	0	(36,526)	(32,873)	0	(32,873)	(3,653)	0	(3,653)	(43,831)	0	(43,831)	(43,831)	0	(43,831)	0	0	0
Cumulative Financial Position	**353,976**	**408,878**	**(54,901)**	**319,503**	**367,916**	**(48,413)**	**34,474**	**40,962**	**(6,488)**	**424,062**	**486,542**	**(62,480)**	**423,873**	**486,353**	**(62,480)**	**189**	**189**	**0**

Appendix 2 – Running costs dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
Directorate	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Chief Executive / Board Office	489	997	(508)	440	897	(457)	342	666	(324)	587	1,167	(580)	587	1,169	(582)	0	(2)	2
Primary Care	508	441	67	457	403	54	356	271	85	610	514	96	610	511	99	0	3	(3)
System Resource & Planning	944	914	30	850	823	27	661	663	(2)	1,133	1,093	40	1,133	1,086	47	0	7	(7)
Planning and Governance	899	813	86	809	736	73	617	565	53	1,079	974	105	1,079	974	104	0	(0)	0
Joint Commissioning	178	154	24	160	146	14	124	120	4	213	177	36	213	190	23	0	(13)	13
Medical Directorate	101	50	51	91	53	38	70	34	36	121	69	51	121	81	39	0	(12)	12
Finance	1,089	1,097	(8)	980	1,002	(22)	774	804	(30)	1,307	1,333	(26)	1,307	1,342	(35)	0	(8)	8
Quality & Nursing	608	483	126	548	423	124	426	336	89	730	623	107	730	620	110	0	3	(3)
Planned Care	883	851	32	795	764	31	618	597	21	1,060	1,014	46	1,060	1,014	46	0	(0)	0
Risk	3	24	(21)	3	22	(19)	2	17	(15)	3	29	(26)	3	29	(26)	0	(0)	0
Overall Position	**5,701**	**5,824**	**(122)**	**5,131**	**5,268**	**(137)**	**570**	**555**	**15**	**6,843**	**6,994**	**(151)**	**6,843**	**7,017**	**(174)**	**0**	**(23)**	**23**

Item Number: 11

Name of Presenter: Michael Ash-McMahon

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Quarter 3 Financial control, planning and governance assessment

Purpose of Report
For Information

Reason for Report

On the 30 May 2018 NHS England wrote to all CCGs to request an update to the previously reported Financial Control Environment Assessment template that CCGs were first asked to populate in 2015. The purpose of the new Financial Control, Planning and Governance assessment template is to provide 'early warning signs' of CCGs in financial distress and to provide assurance that there are adequately-designed and effective financial controls and governance processes in place to manage risk.

The self-assessment is designed to consider the overall control environment and covers financial control, planning and governance. The questionnaire has been completed based on the Month 9 financial position and revised forecast and has been signed off by the CCG Chief Finance Officer as required by NHS England. However, the assessment also needs to feature as part of the next available Governing Board meeting and so it is presented here in full as an Appendix with a summary and key updates as follows:

Domain	Q1	Q2	Q3	Q4	Annual
Detailed Financial Planning	100%	0%	0%	0%	82%
In year Financial Performance	100%	70%	70%	0%	100%
Contracts	67%	67%	67%	0%	N/A
System-wide Performance	100%	100%	100%	0%	N/A
Financial Control	71%	71%	71%	0%	100%
Risk Management	100%	80%	80%	0%	N/A
Audit	100%	100%	100%	0%	83%
Finance & Investment Committee	100%	100%	100%	0%	80%
Governing Body (GB)	100%	100%	100%	0%	100%
Capability and Capacity	75%	100%	100%	0%	100%
PMO Function (QIPP)	67%	83%	83%	0%	100%
CSU Support	100%	100%	100%	0%	N/A

There were no changes made that impacted the individual domain scores although some progress has been made in the following areas and it is expected that there will be improvement in one or two domains in Q4.
Strategic Priority Links ☐Strengthening Primary Care ☐Reducing Demand on System ☐Fully Integrated OOH Care ☐Sustainable acute hospital/ single acute contract ☐Transformed MH/LD/ Complex Care ☐System transformations ☒Financial Sustainability
Local Authority Area ☒CCG Footprint ☐City of York Council ☐East Riding of Yorkshire Council ☐North Yorkshire County Council

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☒Financial ☐Legal ☐Primary Care ☐Equalities	F17.1- ORG Failure to deliver 1% surplus F17.2 – ORG Failure to deliver planned financial position F17.3 – ORG Failure to maintain expenditure within allocation

Emerging Risks (not yet on Covalent)
Recommendations The Governing Body is asked to receive and note the CCG's self-assessed 03Q Q3 CCG Financial Control Planning and Governance Self-Assessment_18-19_v4 in full, with specific awareness of the exceptional items noted above.

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Michael Ash-McMahon, Deputy Chief Finance Officer

Period	Q3	<<*Select Period*

Completion Overview

Assessments	52
Completed	52
Incomplete	0
Error	N

Dashboard Summary	**% Score**
Detailed Financial Planning	0%
In year Financial Performance	70%
Contracts	67%
System-wide Performance	100%
Financial Control	71%
Risk Management	80%
Audit	100%
Finance & Investment Committee	100%
Governing Body (GB)	100%
Capability and Capacity	100%
PMO Function (QIPP)	83%
CSU Support	100%

Sign off details

	Name	Email	Contact Number
Completed by	Michael Ash-Mcl	m.ash-mcmahon@nhs.	01904 551831
Signed off by	Simon Bell	simonbell@nhs.net	01904 555923

Signature

CCG Financial Control, Planning and Governance Self-Assessment

Table below demonstrates % of answers equating to a Yes

Domain	Q1	Q2	Q3	Q4	Annual
Detailed Financial Planning	100%	0%	0%	0%	82%
In year Financial Performance	100%	70%	70%	0%	100%
Contracts	67%	67%	67%	0%	N/A
System-wide Performance	100%	100%	100%	0%	N/A
Financial Control	71%	71%	71%	0%	100%
Risk Management	100%	80%	80%	0%	N/A
Audit	100%	100%	100%	0%	83%
Finance & Investment Committee	100%	100%	100%	0%	80%
Governing Body (GB)	100%	100%	100%	0%	100%
Capability and Capacity	75%	100%	100%	0%	100%
PMO Function (QIPP)	67%	83%	83%	0%	100%
CSU Support	100%	100%	100%	0%	N/A

Checklist for completion	Q1	Q2	Q3	Q4	Annual
Assessments	52	52	52	52	33
Completed	52	52	52	0	33
Status					
Yes	45	43	43	0	29
No	2	6	6	0	1
Partial	4	3	3	0	3
Not Applicable	1	0	0	0	0
Incomplete	0	0	0	52	0

CCG Financial Control, Planning and Governance Self-Assessment

Domain	#	Assessment Criteria	Frequency	Q1	Q2	Q3	Q4	Annual
Detailed Financial Planning and Budget Setting	1	Is the CCG planning to meet all business rules in 2018 - 19 as set by NHS England? *(In-year control total compliant, achieving 1% cumulative surplus, contingency set aside for unforseen events, Admin spending contained within technical limits, Mental Health Investment Standard compliant)*	Annual					Partial
	2	Is the CCG planning compliance with all additional expectations in 2018 - 19 as defined by NHS England? *(Meeting Mental Health Investment expectations accross all metrics (e.g. C&YP Year on Year growth), Compliant with requirement to invest £3per head in primary care over 2 years (2017-19), Meeting requirement to reinvest Non-Elective Marginal rate benefit, reinvesting readmissions penalties (where levied)).*	Annual					Yes
	3	Is the CCG plan meeting good practice expectations in preparation of 2018 - 19 financial plans? *(underlying position maintained (balanced or in surplus - e.g. by deploying some expenditure on a non-recurrent basis), Plan is realistically profiled, QIPP target is ambitious but not unrealistic (i.e. >2% and <4% of CCGs total allocation and in line with historic delivery), QIPP plan is not unduely profiled towards the last quarter of the year (i.e. <65% of QIPP is due to be delivered in months 7-12), plan templates analysed and completed in required level of granularity (new requirement for 18/19 Acute PODs & MH).*	Annual					Partial
	4	Has the CCG utilised and modelled year on year assumptions as per NHS England Planning Guidance? including activity growth broadly in line with National trend assumptions, tariff efficiency and inflation etc. If not, please clearly specify rationale and impact of alternative assumptions.	Annual					Yes
	5	Is the CCG unidentified QIPP less than 15%? if no, state value, % of allocation and process/timescales to close this gap	Annual					Yes
	6	CCG can confirm key risks are identified and quantified with clear and credible mitigations in place?	Annual					Yes
	7	Can the CCG confirm it has reasonable contingencies or reserves set aside to respond to **unforeseen** events and they are phased appropriately?	Annual					Yes
	8	CCG can confirm they have a high confidence that the plan is achievable and the CCG has the capacity and capability to deliver it?	Quarterly	Yes	No	No		
	9	Budgets are prepared with involvement of trained budget holders with guidance on assumptions (e.g. growth, efficiencies and inflation provided by CCG CFO); budgets are formally agreed / signed off including any budget adjustments/virements	Annual					Yes
	10	All areas of expenditure are budgeted at a sufficiently detailed level to facilitate understanding of actual performance and enable robust financial control?	Annual					Yes
	11	Is the finance function actively involved in service developments, procurements and wider commissioning agenda?	Annual					Yes
	12	Is the CCG within 5% above/below target funding?	Annual					Yes
In year Financial Performance	13	Is the CCG reporting FOT equal to or better than plan?	Quarterly	Yes	No	No		
	14	Is the CCG's underlying position equal to or better than plan, i.e. no emerging deficit or deterioration in-year?	Quarterly	Yes	No	No		
	15	CCG to confirm that all identified risks have been fully quantified within the reported position? If no, please specify	Quarterly	Yes	Yes	Yes		
	16	Is the CCG reporting **nil** net risks? i.e. gross risks identified and quantified with fully identified mitigating actions that are clear and developed and fully off-set identified risks, .	Quarterly	Yes	Yes	Yes		
	17	The CCG to positively confirm that it is not relying on any unconfirmed outstanding allocations as in-year mitigation to deliver forecast? If unable to confirm, please specify type of allocation, amount and anticipated funding source?	Quarterly	Yes	Yes	Yes		
	18	Is the CCG unidentified QIPP less than 15%? if no, state value and actions being taken	Quarterly	Yes	Yes	Yes		
	19	Is year to date QIPP delivery in line with planned profile?	Quarterly	Not Applicable	No	No		
	20	The CCG has robust process in place to provide timely realistic forecasts?	Annual					Yes
	21	Can the CCG confirm that there is consistency in financial reporting and that this is signed off by the CFO? (including but not limited to; internally and externally reported, across ledger system and related financial reporting such as agreement of balances and finance reports).	Quarterly	Yes	Yes	Yes		
	22	If the CCG is subject to a Financial Recovery Plan (FRP), the CCG can confirm that this is 'owned' by the whole CCG and not just finance? (potential evidence - as a minimum is an update provided to the Governing Body on a monthly basis, named leads)	Quarterly	Yes	Yes	Yes		
	23	Does the expenditure run rate triangulate with the cash run rate allowing for reasonable reconciling items? If no, state material causes	Quarterly	Yes	Yes	Yes		
Contracts	24	The CCG can confirm, all contracts signed for 2018-19 including; any MOUs, secondment agreements, BCF, pool agreements etc and any contract variations required for 2018-19	Quarterly	Partial	Partial	Partial		
	25	The CCG can confirm they have no identified / outstanding contractual disputes (formal or informal)?	Quarterly	Yes	Yes	Yes		
	26	The CCG can confirm that there are currently no Novel or contentious contract procurements planned (1-3 year pipeline)?	Quarterly	Yes	Yes	Yes		
System-wide Performance	27	The CCG can confirm that it has a positive working relationship with its key stakeholders? including main NHS providers, GPs and local authority/ies? If no, please specify	Quarterly	Yes	Yes	Yes		
	28	The CCG has strong engagement with it's main provider Trusts, including where the CCG is not the lead commissioner?	Quarterly	Yes	Yes	Yes		
	29	The CCG can confirm that it is operating within a system where the main providers have accepted their in-year control totals and are forecasting to deliver control total compliant plans? i.e. no providers are reported as 'off plan' or in special measures/financial recovery? If no, please specify?	Quarterly	Yes	Yes	Yes		
	30	The CCG is reasonably confident in the delivery of the reported financial position of its providers or partners including main NHS providers, independent sector, other partner organisations etc.? If no, please specify.	Quarterly	Yes	Yes	Yes		
Financial Control & Process	31	The CCG can confirm Prime Financial Policies and the underpinning detailed financial policies and procedures are regularly reviewed and updated.	Annual					Yes
	32	All staff including committee staff are trained on financial governance and training record is fully documented?	Annual					Yes
	33	Delegated authorities (as set out in the CCG scheme of delegation) are built into ISFE and are regularly reviewed and updated?	Annual					Yes
	34	The CCG has clear guidance documents in place for key processes of financial control such as procurement and recruitment?	Annual					Yes
	35	All Journals are fully documented and approved by appropriate level supervisor?	Annual					Yes
	36	CCG undertakes and can provide evidence of a process of internal financial management? this should include (but may not be limited to) detailed monthly financial reporting to budget managers / owners and review, evidence of challenge with the 'owner', and a process to seek Recover Action actual performance is adverse to plan.	Quarterly	Yes	Yes	Yes		
	37	The CCG can evidence that the balance sheet is reviewed every month with full reconciliations and sign off of all control accounts?	Quarterly	Yes	Yes	Yes		
	38	The CCG to confirm that robust processes are in place to support the completion of Agreement of balance returns and that they are completed on time and differences with NHS bodies are actively resolved?	Quarterly	Yes	Yes	Yes		
	39	Accounts payable and receivable are both regularly reviewed, proactively managed and regularly reported to the Governing Body?	Quarterly	Yes	Yes	Yes		
	40	The CCG can confirm that any debtor or creditor balances (Non-NHS) over 120 days have all been fully provided for?	Quarterly	No	No	No		
	41	All cash forecast and drawdown requirements are agreed and signed off with appropriate governance e.g. CCG CFO	Quarterly	Yes	Yes	Yes		
	42	The CCG manages cash balances effectively and has not required any supplementary cash drawdowns in the last 12 months? If no, confirm how many instances and actions being taken to avoid reoccurrence?	Quarterly	No	No	No		
	43	CCG can confirm it received a 'No material issues' opinion in the last Internal Audit report rating for "Financial Control"?	Annual					Yes
Risk Management	44	CCG can confirm there are effective risk management processes in place? Including; the identification, quantification and mitigation of risk	Quarterly	Yes	Yes	Yes		
	45	Where applicable, the CCG can confirm that risk sharing arrangements with other CCGs and trusts or other partners are fully documented and collectively agreed and the associated financial risks are evaluated monthly to inform CCG Forecasts.	Quarterly	Yes	Partial	Partial		
	46	Where applicable, the CCG can confirm that financial controls are in place to ensure the CCG is not placed at undue financial risk as a result of CCG hosting/lead arrangements? e.g. where the CCG receives income for the provision of services commissioned by other organisations	Quarterly	Yes	Yes	Yes		
	47	The CCG undertakes a Pro-active horizon scanning process with risks assessed in terms of likelihood and financial impact?	Quarterly	Yes	Yes	Yes		
	48	The CCG Governing Body financially assesses all risks on risk register on a periodic and timely basis, a process which is supported by a robust risk tracking and reporting system regularly reporting to the appropriate committee.	Quarterly	Yes	Yes	Yes		
Audit	49	The CCG Audit Committee Chair is a qualified accountant or is supported by an appropriately qualified Lay member?	Annual					Yes
	50	Audit Committee receives and follows up all internal audit reports and approves internal audit plan?	Annual					Yes
	51	Audit chair regularly meets with internal and external auditors without management present?	Annual					Yes
	52	Audit chair can confirm that lay members training needs are regularly reviewed and appropriately addressed?	Annual					Yes
	53	Where applicable, Audit Committee can confirm that service auditor reports are received from outsourced service providers and assurance is sought that the overall control environment of the CCG is not negatively impacted through the arrangement?	Annual					Yes
	54	Audit committee ensures responsibilities for implementing recommendations are appropriately assigned with timescales agreed and major items delivered on time.	Quarterly	Yes	Yes	Yes		
	55	Audit Committee obtains direct evidence in key areas of concern where appropriate to reduce reliance on representations from senior management	Quarterly	Yes	Yes	Yes		
	56	CCG can confirm it has no outstanding internal audit category 1 findings and recommendations and all lower level recommendations implemented on time and in full?	Quarterly	Yes	Yes	Yes		
	57	CCG can confirm it has no adverse external audit findings and recommendations in the last 12 months?	Annual					No

Domain	#	Assessment Criteria	Frequency	Q1	Q2	Q3	Q4	Annual
Finance & Investment Committee	61	Is there a robust process for investment decisions and monitoring of investment implementation and delivery?	Annual					Yes
	62	Does the investment process include a Post Implementation review stage that allows lessons learnt to be factored in to future investment proposals?	Annual					Partial
	63	The CCG can evidence that; the Finance & Investment Committee has met regularly as stipulated in terms of reference with agendas and minutes recording decisions, and robust monitoring and follow up of actions?	Quarterly	Yes	Yes	Yes		
	64	The Finance & Investment Committee chair/s report to the governing body following each meeting and have an annual review of the committee's performance?	Annual					Yes
	65	The Committee report clearly articulates: in year and forecast position, underlying run rate, key risks and mitigations, QIPP progress, clear actions and progress, key financial and related operational performance, procurement plan, committee work plan etc	Quarterly	Yes	Yes	Yes		
Governing Body (GB)	66	The GB Finance report clearly articulates key financial performance information including; in year and forecast position, the budget is reconciled to the allocation, underlying run rate, key risks and mitigations, QIPP progress, clear actions and progress, and key financial and related operational performance is evident?	Quarterly	Yes	Yes	Yes		
	67	The CCG GB fulfil a role of constructive, focussed and relevant challenges with timely and robust monitoring and follow up of actions? This will include (but is not limited to) the reporting of the financial position of the CCG is a standing agenda item, there is sufficient time given to discuss finance, there is effective challenge, the whole of the GB takes collective responsibility for the finances and receive appropriate training	Quarterly	Yes	Yes	Yes		
	68	CCG to confirm there is sufficient finance skills within the GB including lay members?	Annual					Yes
Capability and Capacity	69	CCG to confirm finance roles are all filled by substantive appointments? If no, state % wte vacancy and proportion covered by interim staffing arangements	Quarterly	Partial	Yes	Yes		
	70	Are the Executive Team all substantive appointments with no vacancies? If no, state which roles are currently vacant	Quarterly	Yes	Yes	Yes		
	71	Do all staff have clear roles and responsibilities that are supported by an process of performance development? i.e. including having had PDPs within the last 12 months, a clear training and development plan with CPD up to date for all applicable staff members?	Annual					Yes
	72	The CCG staff turnover % based on the previous 12 months is 5% or less? If no, state the turn over % and whether the CCG considers this acceptable stating the rationale	Quarterly	Yes	Yes	Yes		
	73	CCG can confirm where relevant, shared management team recognises the organisational boundaries and allows sufficient time to focus on the separate issues of each constituent CCG?	Quarterly	Yes	Yes	Yes		
PMO Function (QIPP)	74	CCG can confirm there is a robust PMO function in place for QIPP delivery?	Quarterly	Yes	Yes	Yes		
	75	CCG can confirm there is sufficient resource in place to ensure the delivery of the QIPP schemes?	Quarterly	Yes	Yes	Yes		
	76	Where QIPP Schemes require consultation, the CCG confirms consultation guidance has been followed?	Annual					Yes
	77	Has the CCG agreed QIPP plans with its main providers as part of its agreed contract with clearly defined risk management?	Annual					Yes
	78	Can the CCG evidence clear clinical leadership and engagement in the development and delivery of QIPP plans?	Quarterly	Yes	Yes	Yes		
	79	Can the CCG confirm and evidence that they have extensively reviewed the "Financial Resilience Support Site" and "Difficult Decision" paper taking necessary steps to fully implement identified opportunities?	Quarterly	Yes	Yes	Yes		
	80	Can the CCG confirm that all QIPP schemes have associated, risk assessed business cases with key milestones identified for delivery?	Quarterly	Partial	Partial	Partial		
	81	CCG can confirm that QIPP performance is monitored at least monthly at individual initiative level with QIPP performance figures reconciling to reported I&E performance?	Quarterly	Partial	Yes	Yes		
CSU Support	82	CCG can confirm it has robust contracting arrangements in place with commissioning support service provider? This includes; a signed contract detailing all services to be delivered and related standards of performance, regular meeting to review performance against the contract, CCG acts as an intelligent customer with clear specifications, division of duties and responsibilities with effective escalation and dispute procedures.	Quarterly	Yes	Yes	Yes		
	83	The CCG is confident that the CSU provider is resillient and provides value add? i.e. Service provider delivers economies of scale and regularly demonstrates value for money. Service provider able to draw on support from a wider pool of commissioning support staff across a wider geography and not over-reliant on one or two key staff. Niche expertise available as required to address specific issues, rigorous approach.	Quarterly	Yes	Yes	Yes		
	84	CCG can confirm it has an excellent working partnership with the service provider? i.e. roles and working arrangements clearly defined, shared purpose, mutual trust, customer service is routinely monitored, open communications with constructive challenge and joint organisational development	Quarterly	Yes	Yes	Yes		
	85	Commissioning support provider has the required Business Intelligence capability and capacity? i.e. capacity and expertise to handle and process large volumes of data and provide accurate, clean, relevant and timely information and intelligence. All data is stored and handled in accordance with required governance with full audit and tracking. Appropriate data and information held to support commissioning decisions	Quarterly	Yes	Yes	Yes		

CCG Financial Control, Planning and Governance Self-Assessment

Domain	#	Assessment Criteria	Frequency	Y/N/P/NA	Please explain key reasons where not met	Actions to address issues identified
Detailed Financial Planning and Budget Setting	8	CCG can confirm they have a high confidence that the plan is achievable and the CCG has the capacity and capability to deliver it?	Quarterly	No	As at Month 9 reporting the CCG continues to forecast the revised financial deficit of £18.6m after receiving Q1 CSF. Although this will represent another year of stabilisation of the financial postion compared to 17/18, it is £6m worse than planned. This is largely a result of the move to an Aligned Incentive Contract and a cost based approach to QIPP that has signficantly reduced the level of saving, the failure to deliver the requried repatriation of work from outside of core NHS capacity and the application of the terms of the contract with regards to the payment for unplanned care elements of activity. There have also been trading issues within Mental Health Out of Contract and the £1m pressure resulting from the reconciliation work completed by Scarborough and Ryedale CCG with regards to CHC.	The CCG has already taken the following actions: - Development of additional Financial Recovery Plan actions to mitigate some of the in-year deterioration. - Commissioned and received an independent peer review of the terms of the Aligned Incentive Contract to ensure lessons learned for future agreements. - Development of multi-year financial plan with the main acute provider that creates certainty in the system and delivers joint assessment of financial recovery timescales. - Review of all third party services in terms of assurances provided and given for hosting / risk share arrangements. - Implementation of a new iQA+ system for managing CHC, FNC, PHBs, Mental Health Aftercare and Neurological Rehab. The roll-out of further applications within this system is due throughout Q4.
In year Financial Performance	13	Is the CCG reporting FOT equal to or better than plan?	Quarterly	No	See response to Question 8	See response to Question 8
	14	Is the CCG's underlying position equal to or better than plan, i.e. no emerging deficit or deterioration in-year?	Quarterly	No	See response to Question 8	See response to Question 8
	15	CCG to confirm that all identified risks have been fully quantified within the reported position? If no, please specify	Quarterly	Yes		
	16	Is the CCG reporting **nil** net risks? i.e. gross risks identified and quantified with fully identified mitigating actions that are clear and developed and fully off-set identified risks, .	Quarterly	Yes		
	17	The CCG to positively confirm that it is not relying on any unconfirmed outstanding allocations as in-year mitigation to deliver forecast? If unable to confirm, please specify type of allocation, amount and anticipated funding source?	Quarterly	Yes		
	18	Is the CCG unidentified QIPP less than 15%? if no, state value and actions being taken	Quarterly	Yes		
	19	Is year to date QIPP delivery in line with planned profile?	Quarterly	No	See response to Question 8	See response to Question 8
	21	Can the CCG confirm that there is consistency in financial reporting and that this is signed off by the CFO? (including but not limited to; internally and externally reported, across ledger system and related financial reporting such as agreement of balances and finance reports).	Quarterly	Yes		
	22	If the CCG is subject to a Financial Recovery Plan (FRP), the CCG can confirm that this is 'owned' by the whole CCG and not just finance? (potential evidence - as a minimum is an update provided to the Governing Body on a monthly basis, named leads)	Quarterly	Yes		
	23	Does the expenditure run rate triangulate with the cash run rate allowing for reasonable reconciling items? If no, state material causes	Quarterly	Yes		
Contracts	24	The CCG can confirm, all contracts signed for 2018-19 including; any MOUs, secondment agreements, BCF, pool agreements etc and any contract variations required for 2018-19	Quarterly	Partial	The East Riding BCF and the associated S75 agreement has now been agreed and signed. The contract with Medequip for community equipment is not signed.	The Medequip contract will be signed in the early part of Q4 as the CCG has finalised negotiations on behalf of all the contract associates.
	25	The CCG can confirm they have no identified / outstanding contractual disputes (formal or informal)?	Quarterly	Yes	The CCG has not agreed the application of the unplanned care element of the AIC contract from YTHFT.	An unplanned care element has been built into the CCG's overall financial position which incorporates winter funding and clearly and transparently assessed extra costs to deliver additional unplanned demand as part of the AIC Management Group and System Transformation Board.
	26	The CCG can confirm that there are currently no Novel or contentious contract procurements planned (1-3 year pipeline)?	Quarterly	Yes		
System-wide Perform	27	The CCG can confirm that it has a positive working relationship with its key stakeholders? including main NHS providers, GPs and local authority/ies? If no, please specify	Quarterly	Yes		
	28	The CCG has strong engagement with it's main provider Trusts, including where the CCG is not the lead commissioner?	Quarterly	Yes		
	29	The CCG can confirm that it is operating within a system where the main providers have accepted their in-year control totals and are forecasting to deliver control total compliant plans? i.e. no providers are reported as 'off plan' or in special measures/financial recovery? If no, please specify?	Quarterly	Yes	YTHFT continues to meet the financial elements of its control total plan, although there is some adverse impact with regards to the ED performance element.	
	30	The CCG is reasonably confident in the delivery of the reported financial position of its providers or partners including main NHS providers, independent sector, other partner organisations etc.? If no, please specify.	Quarterly	Yes		
Financial Control & Process	36	CCG undertakes and can provide evidence of a process of internal financial management? this should include (but may not be limited to) detailed monthly financial reporting to budget managers / owners and review, evidence of challenge with the 'owner', and a process to seek Recover Action actual performance is adverse to plan.	Quarterly	Yes		The CCG is reviewing the on-going financial management arrangements to ensure appropriate challenge and recovery actions can be put in place of all budgets, potentially through an enhanced Financial Recovery Board.
	37	The CCG can evidence that the balance sheet is reviewed every month with full reconciliations and sign off of all control accounts?	Quarterly	Yes		
	38	The CCG to confirm that robust processes are in place to support the completion of Agreement of balance returns and that they are completed on time and differences with NHS bodies are actively resolved?	Quarterly	Yes		
	39	Accounts payable and receivable are both regularly reviewed, proactively managed and regularly reported to the Governing Body?	Quarterly	Yes		
	40	The CCG can confirm that any debtor or creditor balances (Non-NHS) over 120 days have all been fully provided for?	Quarterly	No	The CCG has two key outstanding creditors, which have not been provided for as they are in formal dispute. These largely relate to Harrogate Foundation Trust and NHS Property Services.	Harrogate CCG are taking forward the historic invoices with Harrogate Foundation Trust. As part of the 2017/18 year-end process the CCG agreed a full and final settlement figure with NHS Property Services for 2015/16 and 2016/17 debts. This exercise continues with senior engagement for the 2017/18 onwards bills. The CG has made an offer to NHS PS in an attempt to close down the issue, but this has not been accepted by NHS PS who have failed to provide any further response.
	41	All cash forecast and drawdown requirements are agreed and signed off with appropriate governance e.g. CCG CFO	Quarterly	Yes		
	42	The CCG manages cash balances effectively and has not required any supplementary cash drawdowns in the last 12 months? If no, confirm how many instances and actions being taken to avoid reoccurrence?	Quarterly	No	The CCG has made two supplementary cash draw downs in the last 12 months. The first at the 2017/18 year-end in line with additional allocation received and for Month 3 of 2018/19 as a result of increased CHC invoicing.	The first draw down was a business as usual adjustment. The second is a result of the recent in-housing of this service and it is anticipated this will improve throughout the year as the CCG gets to more accurately understand manage the associated expenditure flows.

Domain	#	Assessment Criteria	Frequency	Y/N/P/NA	Please explain key reasons where not met	Actions to address issues identified
Risk Management	44	CCG can confirm there are effective risk management processes in place? Including; the identification, quantification and mitigation of risk	Quarterly	Yes		
	45	Where applicable, the CCG can confirm that risk sharing arrangements with other CCGs and trusts or other partners are fully documented and collectively agreed and the associated financial risks are evaluated monthly to inform CCG Forecasts.	Quarterly	Partial	As part of TCP guidance nationally, all CCGs are required to have risk share arrangements in place. The risk share arrangement across NY&Y have been agreed and the documentation is being finalised for signature.	Harrogate CCG are the lead for the TCP and have provided confirmation that the documentation will be finalised and signed of in Q4.
	46	Where applicable, the CCG can confirm that financial controls are in place to ensure the CCG is not placed at undue financial risk as a result of CCG hosting/lead arrangements? e.g. where the CCG receives income for the provision of services commissioned by other organisations	Quarterly	Yes		
	47	The CCG undertakes a Pro-active horizon scanning process with risks assessed in terms of likelihood and financial impact?	Quarterly	Yes		
	48	The CCG Governing Body financially assesses all risks on risk register on a periodic and timely basis, a process which is supported by a robust risk tracking and reporting system regularly reporting to the appropriate committee.	Quarterly	Yes		
Audit	54	Audit committee ensures responsibilities for implementing recommendations are appropriately assigned with timescales agreed and major items delivered on time.	Quarterly	Yes		
	55	Audit Committee obtains direct evidence in key areas of concern where appropriate to reduce reliance on representations from senior management	Quarterly	Yes		
	56	CCG can confirm it has no outstanding internal audit category 1 findings and recommendations and all lower level recommendations implemented on time and in full?	Quarterly	Yes		
Finance & Investment Committee	60	CCG can evidence through reporting that there is a clear audit trail of reporting activity performance and the financial implications?	Quarterly	Yes		
	63	The CCG can evidence that; the Finance & Investment Committee has met regularly as stipulated in terms of reference with agendas and minutes recording decisions, and robust monitoring and follow up of actions?	Quarterly	Yes		
	65	The Committee report clearly articulates: in year and forecast position, underlying run rate, key risks and mitigations, QIPP progress, clear actions and progress, key financial and related operational performance, procurement plan, committee work plan etc	Quarterly	Yes		
Governing Body (GB)	66	The GB Finance report clearly articulates key financial performance information including; in year and forecast position, the budget is reconciled to the allocation, underlying run rate, key risks and mitigations, QIPP progress, clear actions and progress, and key financial and related operational performance is evident?	Quarterly	Yes		
	67	The CCG GB fulfil a role of constructive, focussed and relevant challenges with timely and robust monitoring and follow up of actions? This will include (but is not limited to) the reporting of the financial position of the CCG is a standing agenda item, there is sufficient time given to discuss finance, there is effective challenge, the whole of the GB takes collective responsibility for the finances and receive appropriate training	Quarterly	Yes		
Capability and Capacity	69	CCG to confirm finance roles are all filled by substantive appointments? If no, state % wte vacancy and proportion covered by interim staffing arangements	Quarterly	Yes		
	70	Are the Executive Team all substantive appointments with no vacancies? If no, state which roles are currently vacant	Quarterly	Yes	The Director and Transformation and Delivery is permanently employed by NHS Bassetlaw CCG on a two year secondment arrangement and the Director of Primary Care and Population Health is permanently employed by Public Health England, on a one year secondment arrangement.	The CCG has successfully appointed a permanent Director of Primary Care and Population Health and this is now progressing through the usual recruitment processes.
	72	The CCG staff turnover % based on the previous 12 months is 5% or less? If no, state the turn over % and whether the CCG considers this acceptable stating the rationale	Quarterly	Yes		
	73	CCG can confirm where relevant, shared management team recognises the organisational boundaries and allows sufficient time to focus on the separate issues of each constituent CCG?	Quarterly	Yes		
PMO Function (QIPP)	74	CCG can confirm there is a robust PMO function in place for QIPP delivery?	Quarterly	Yes		
	75	CCG can confirm there is sufficient resource in place to ensure the delivery of the QIPP schemes?	Quarterly	Yes		
	78	Can the CCG evidence clear clinical leadership and engagement in the development and delivery of QIPP plans?	Quarterly	Yes		
	79	Can the CCG confirm and evidence that they have extensively reviewed the "Financial Resilience Support Site" and "Difficult Decision" paper taking necessary steps to fully implement identified opportunities?	Quarterly	Yes		
	80	Can the CCG confirm that all QIPP schemes have associated, risk assessed business cases with key milestones identified for delivery?	Quarterly	Partial	Where relevant, schemes have business cases in place, however all schemes have a 'plan on a page' document with a project plan and key milestones.	
	81	CCG can confirm that QIPP performance is monitored at least monthly at individual initiative level with QIPP performance figures reconciling to reported I&E performance?	Quarterly	Yes		
CSU Support	82	CCG can confirm it has robust contracting arrangements in place with commissioning support service provider? This includes; a signed contract detailing all services to be delivered and related standards of performance, regular meeting to review performance against the contract, CCG acts as an intelligent customer with clear specifications, division of duties and responsibilities with effective escalation and dispute procedures.	Quarterly	Yes		
	83	The CCG is confident that the CSU provider is resillient and provides value add? i.e. Service provider delivers economies of scale and regularly demonstrates value for money. Service provider able to draw on support from a wider pool of commissioning support staff across a wider geography and not over-reliant on one or two key staff. Niche expertise available as required to address specific issues, rigorous approach, share and continuously implement best practice.	Quarterly	Yes		
	84	CCG can confirm it has an excellent working partnership with the service provider? i.e. roles and working arrangements clearly defined, shared purpose, mutual trust, customer service is routinely monitored, open communications with constructive challenge and joint organisational development	Quarterly	Yes		
	85	Commissioning support provider has the required Business Intelligence capability and capacity? i.e. capacity and expertise to handle and process large volumes of data and provide accurate, clean, relevant and timely information and intelligence. All data is stored and handled in accordance with required governance with full audit and tracking. Appropriate data and information held to support commissioning decisions	Quarterly	Yes		

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Item Number: 13

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Quality and Patient Experience Report

Purpose of Report *(Select from list)*
For Information

Reason for Report
To update Governing Body following the Quality and Patient Experience Committee

Key Messages

- The Committee welcomed the progress with NHS continuing healthcare but noted that considerable work was still required.
- The Committee noted the senior level staff turnover at York Teaching Hospital NHS Foundation Trust but recognised that appointment processes were taking place.
- The Committee noted the work pertaining to issues relating to opiates and the work to reduce their use.
- The Committee expressed concern at the two Never Events at York Teaching Hospital NHS Foundation Trust.

Strategic Priority Links

☒Strengthening Primary Care
☒Reducing Demand on System
☒Fully Integrated OOH Care
☒Sustainable acute hospital/ single acute contract
☒Transformed MH/LD/ Complex Care
☒System transformations
☒Financial Sustainability

Local Authority Area

☒CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☐Financial
☐Legal
☒Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington (Chief Nurse)	Quality and Nursing Team

NHS Vale of York Clinical Commissioning Group
Quality and Patient Experience Report
– February 2019

Contents

Purpose of the Report

The purpose of this report is to provide an overview of the Vale of York Clinical Commissioning Group in relation to the quality of services across our main provider services. In addition, it provides an update about the Vale of York CCG's Quality team's important work relating to quality improvements that affect the wider health and care economy.

Key pieces of improvement work that the team is involved in include

- Special School Nursing Review as part of review of the 0 – 19 pathway
- Care Home Strategy development
- Maternity services transformation
- Workforce transformation

Patient Story

The CCG's Senior Pharmacist presented a patient story at February's Quality and Patient Experience Committee (QPEC) that described the experiences of those affected by excessive opiate prescribing. The Campaign to Reduce Opioid Prescribing (CROP) has been introduced to highlight the increase in prescribing of opioids for non-cancer pain management. There has been a significant increase in the prescribing of opioids since 2005 which is not explained by increasing population Opioids provide useful and effective analgesia in the short term for acute pain following trauma (including surgery) and cancer pain, however, the safety and efficacy of opioids for chronic non-cancer pain is uncertain. There is a lack of clinical evidence for use of doses >120mg per day of morphine (or equivalent). They can cause problems of tolerance, dependence and addiction. Opioids can be put in to two main categories in accordance with the BNF:

- Weak- e.g. codeine, dihydrocodeine
- Strong- e.g. morphine, fentanyl, tramadol, buprenorphine, diamorphine, oxycodone

The CCG has teamed up with West Yorkshire Research and Development (WYRD) to offer support to our GP Practices that aims to reduce opiate prescribing. The process involves WYRD extracting anonymised data from your practice, bi-monthly for a period of 12 months. The data searches are designed to understand the numbers of strong and weak opioid prescriptions issued in the past two months for chronic and non-cancer pain. From the data, a report will be generated and include references to the latest guidance, sample action plans, practice audit frameworks along with answers to questions relating to better pain management. The report would help the practice to identify areas where they can improve on their prescribing for opioids and essentially reduce their prescribing. The benefits of being in the Campaign to Reduce Opioid Prescribing include:

- Fewer patients on opioids
- Better management of patients with chronic pain
- Savings made on prescribing budget

- Greater understanding of pain management for health care professionals

Update on progress

The CCG's Medicines Management Team have been seeking permission from practices to access their computer systems for the data extraction. The plan is to start the data extraction once the MMT have access to all of the practices in York. Unfortunately, due to resource pressures, we are not able to start the campaign with individual practices at different times hence we have to wait until all of the practices that want to take part have completed the relevant governance documents.

The CCG has also commissioned a PrescQIPP e-learning course for all health care professionals within the Vale of York, to enable them to become "opiate aware". The e-learning course will help equip healthcare professionals to tackle the growth in opiate use and to improve care for patients with chronic pain. The course also includes contributions from Ruth Bastable, a GP with experience of working in health care of patients who are homeless and at risk of homelessness and health care of patients in secure environments. She has an interest in substance misuse, and an interest in prescription drug misuse.

The MMT delivered a 90 minute opiate training event on the 31st of January at the Vale of York CCG protected learning time event. The platform was used to educate health care professionals on the risks of prescribing opiates, managing chronic pain, increasing awareness of CROP and the PrescQIPP e-learning course. Great feedback was received from the participants and there was certainly a greater level of awareness and engagement of the campaigns the CCG are working on.

Continuing Health care

The CCG's Director of Transformation (Complex Care and Mental Health) attended the February QPEC to provide an update on the development of the Continuing Healthcare Programme and its outputs across the Vale of York CCG. The paper was well received and it was agreed that a further update should come to the October 2019 meeting.

Quality in Primary Care

CQC Ready Programme

The CQC Ready project started in September 2018 and an update was shared with QPEC in December 2018. The final report will be presented at the next QPEC in April 2019. The programme has been very well received by all practices with 24/26 practices having returned their Self-Assessments to date.

Findings include strong engagement across the CCG with 24 practices requesting table top reviews. This has negated the need for the 20% verification audit and has given far greater insight to compliance with the core essential CQC standards across the practices in our area. As a result of the programme the following changes have been noted. Practices are now:

- Systematically reviewing their approach to investigating unexpected deaths as part of their significant event audit (SEA) programme.
- Using standardised pain tools and a nationally recognised adapted pain assessment tool for patients with communication difficulties.
- Using their local Joint Strategic Needs Assessment and CCG Priority Areas more effectively to understand their population needs.
- Promoting collaboration to support whistle-blowers or staff who wish to raise concerns through a buddy system that allows staff to approach an identified alternative practice manager if they do not feel comfortable raising the issue within their own practice.
- Reviewing and enhancing their processes for identifying carers.
- Proactively reassessing governance structures and accountability for sharing of responsibilities within the practice to have more effective continuity plans in the absence of leaders.
- Proactively identifying vulnerable patients who fail to collect medication by liaising with their local pharmacy to identify a list of 'top ten' medications they would want to be notified of by the pharmacist if these were not collected.
- More aware of and requesting support to implement the APEX Insight tool (capacity and workforce planning tool).
- Revising their palliative care registers and including non-cancer diagnosis patients.
- Proactively identifying vulnerable and frail patients through use of the electronic Frailty Index (eFI) leading to better recognition of patients in the last 12 months of their life to ensure parity of service provision for all patients and not only cancer patients.

The implementation of the programme has built on relationships between the CCG and practices and the CCG is gaining assurance that practices within the Vale of York are compliant with the requirements for registration with the CQC. In turn this has identified areas for further improvement that the CCG can support as well as recognising existing good work across all GP practices.

Further work will include publishing the findings through the GP Practice Communications bulletin with each practice being given a unique identifier code to enable them to identify how they benchmark against their peers for each domain and/or criterion. In addition priority areas in response to the findings will be agreed. Crucially this will inform a CCG plan to support practices to continue to improve the quality of service provision in primary care.

CQC Inspections
4 practices have had CQC inspections since the programme started – all of these have had positive outcomes.

Priory Medical Group CQC report was published on 2 November 2018 with an overall rating of good. Improvements had been made with respect to safety following the last inspection on 1 May 2018.

Front Street Surgery CQC report was published on 5 December 2018 with an overall rating of good.

Haxby Group volunteered to test the new CQC methodology for providers at scale. Inspection was carried out on 22 and 23 November 2018 and the publication of the report is anticipated.

Unity Practice, which was in special measures as a result of an inadequate CQC rating, awaits publication of their comprehensive inspection undertaken on 8 January 2019 (currently with the national panel for verification).

Protected learning time

To improve learning and networking opportunities protected learning time (PLT) brings together expertise in primary care research, education, clinical practice and scholarship delivered in partnership with the Academy of Primary Care, part of Hull and York Medical School.

The Practice Nurse & Allied Health Professional Forum has now been disbanded and incorporated into the PLT programme. The first PLT was held on 31 January with an attendance of approximately 187 GPs, 9 AHPs, 85 GPNs, 37 HCAs and 51 others including 25 medical students. The four hour PLT events will take place quarterly. PLT events have been arranged with Yorkshire Doctors Urgent Care providing cover for all practices.

Infection Prevention & Control (IPC)

Norovirus and flu are now circulating with prevalence as expected for this time of the year. This has had a significant impact on bed capacity and patient flow within York Teaching Hospital Foundation Trist (YTHFT). The IPC teams are supporting ward staff and their communications team are working on re-iteration of the messages to the public to stay away from the hospitals if unwell.

Norovirus

Yorkshire and Humber overview

Within Yorkshire and Humber the number of GP consultations for viral gastroenteritis is below the expected average currently.

The table below shows the number of outbreaks in high risk settings compared with last year and demonstrates a significantly lower number.

Table 1. Weekly trends in suspected and confirmed Viral Gastroenteritis incidents in key settings; hospitals, care homes and schools/nurseries in Yorkshire and the Humber 2017/18 to 2018/19-Source: HP Zone

		Social care	Health Care	Education	Other	Week 3 Total All Incidents (confirmed in brackets)	Season to Date All from Week 27 2018 (confirmed in brackets)	All Last Season - Week 27 2017 to Week 27 2018 (confirmed in brackets)
North Yorkshire and the Humber	Craven District	0	0	0	0	**0** (0)	**4** (0)	**4** (1)
	East Riding of Yorkshire	1	0	0	0	**1** (0)	**21** (1)	**52** (13)
	Hambleton District	0	0	0	0	**0** (0)	**4** (0)	**7** (2)
	Harrogate District	1	0	0	0	**1** (0)	**25** (1)	**23** (1)
	Hull	0	0	0	0	**0** (0)	**31** (13)	**29** (12)
	North East Lincolnshire	0	0	0	0	**0** (0)	**14** (2)	**42** (9)
	North Lincolnshire	0	0	0	0	**0** (0)	**11** (1)	**26** (6)
	Richmondshire District	0	0	0	0	**0** (0)	**7** (0)	**9** (1)
	Ryedale District	2	0	0	0	**2** (0)	**3** (0)	**3** (1)
	Scarborough District	0	0	0	0	**0** (0)	**11** (3)	**16** (2)
	Selby District	0	0	0	0	**0** (0)	**1** (0)	**9** (0)
	York	0	1	0	0	**1** (1)	**15** (3)	**31** (7)

GP in-hours consultation rates in Yorkshire and Humber for vomiting and diarrhoea remain below expected levels for the time of year.

Local norovirus overview

Norovirus continues to have a significant impact on York hospital which affects patient flow and bed capacity. Nursing and residential homes are also being affected with a number of homes within the Vale of York closing as the virus spreads. There has also been an issue with care homes declining to take patients who are medically fit for discharge back from wards where norovirus is present. The community Infection prevention team have been educating and supporting staff in conjunction with the City of York Council and the CCG have re-circulated the approved multi-agency guidance to support staff- Viral Gastroenteritis Systems Partners Guidance.

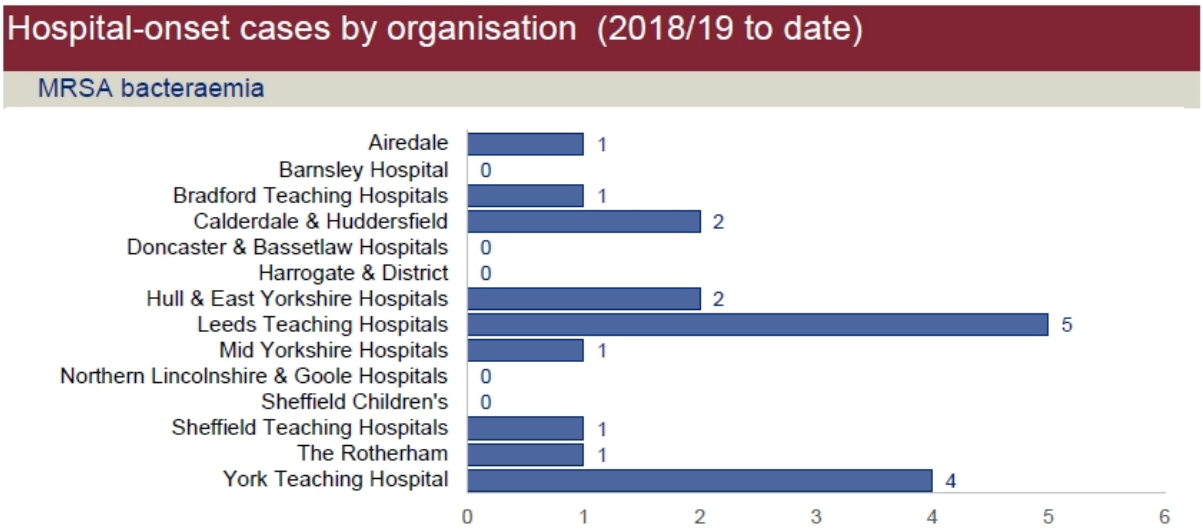
The number of staff infected in an outbreak in a Care Home is also reported on. This is monitored as a measure of the standards of compliance with universal precautions and general infection prevention standards. The community infection prevention team provide support to affected homes on the management of the outbreak every other day, confirm and check all infection prevention measures are in place plus provide an outbreak management pack. In instances where a large number of care home staff are affected, the CCG request assurance that the community IPC team have scheduled additional infection prevention training.

Multi Resistant Staph Aureus (MRSA)

MRSA remains a zero tolerance measure in 2019/20. Cases of MRSA are assigned by time of infection onset as opposed to time of patient admission. York Teaching Hospital NHS Trust have had three MRSA cases in January 2019 (not reflected in chart below which covers period to December 2018). Of the three cases, two are still awaiting review. The completed post infection review concluded that the case is attributable to the Trust as there was a delay in identification of the infected wound, a delay in isolation and de-colonisation. The difficulties isolating patients with a limited number of side rooms and the pressures on these due to norovirus and flu is a significant pressure and a review of all additional rooms on wards used for other purposes has taken place on both sites to ascertain any available for conversion to single room facilities.

Another issue identified from this and other post infection reviews has been microbiology staff being unable to obtain an answer from ward staff when ringing results through out of office hours when ward clerks are not on duty. This is due to the extreme pressures on nursing staff, and the option of using the bed managers for MRSA cases is currently being explored as they would be responsible for trying to find a side room for a patient requiring isolation. The inability of staff to answer telephones is to be raised at the Quality and Safety group.

Graph: Yorkshire and Humber overview of hospital onset MRSA cases in acute providers up to December 2018



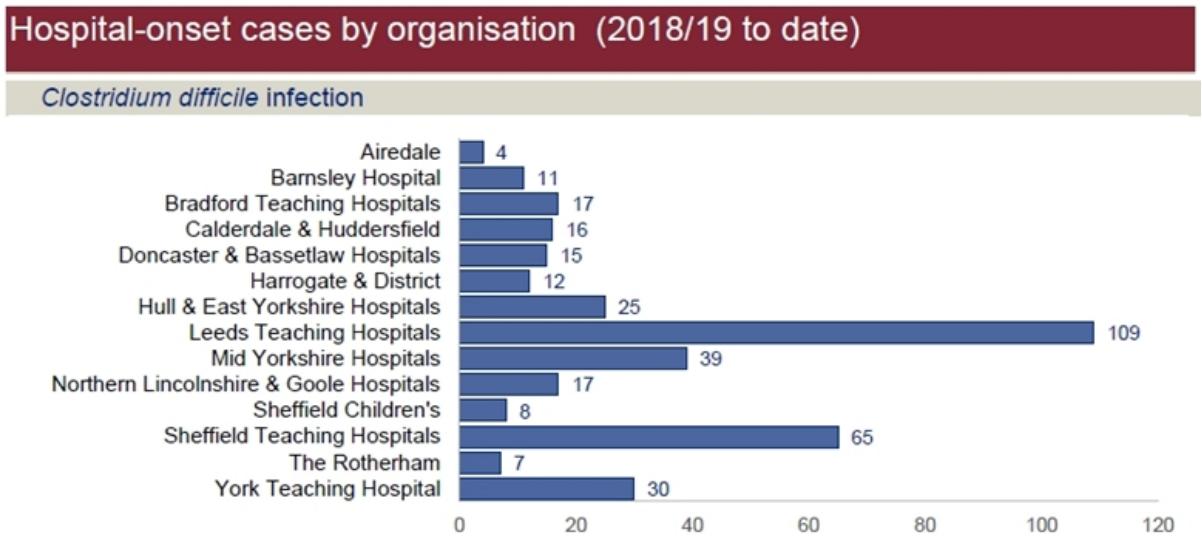
Clostridium Difficile Infection (CDI)

Following the amended guidance, a process for reviewing community and secondary care cases of clostridium difficile has commenced and is chaired by a Public Health Nurse Consultant. The first meeting has occurred and it is felt that improvements in the efficiency of the meeting and resultant outcomes will occur. Primary care involvement is still required, and an interest was expressed by the LMC however a response confirming this is awaited. Work to achieve more consistent medicines management attendance is underway.

The yearly threshold for clostridium difficile for 2018/19 stands at 47 for YTHFT (actual YTD to November = 28), and 77 for Vale of York CCG (actual YTD to November = 58); the thresholds for 2019/20 are awaited. Overall in summary, there has been a decrease in the number of C.diff cases in Quarter 3. This may not be reflected in Quarter 4 due to the number of Norovirus outbreaks which increases the number of samples sent for testing and can result in identifying an increased number of C.diff cases.

2018-19															
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Position 18-19	Objective 18-19	Position 17-18
Clostridium Difficile Infection															
Vale of York CCG Attributable Cases (All)	8	9	8	9	6	7	7	4	9				67		93
Objective	4	5	8	8	9	5	7	5	8	8	4	6		77	
Vale of York CCG Number of Lapses in Care (All)	2 lapses	3 lapses	1 lapses 1 awaiting review	3 lapses	1 lapses 1 awaiting review	1 awaiting	1 lapses 2 awaiting review	1 lapses 1 awaiting review	8 awaiting review				12		
Scarborough Ryedale CCG Attributable Cases (All)	1	3	1	0	2	1	1	4	3				16		34
Objective	2	1	2	1	1	4	4	4	4	1	4	2		30	
Scarborough Ryedale CCG Number of Lapses in Care (All)	0	1 lapse	0	0	1 awaiting review	0	1 awaiting review	3 awaiting review	awaiting review				1		
YFT Attributable Cases (All)	4	7	6	3	4	1	0	3	2				30		45
Objective	4	4	4	3	4	4	4	4	4	4	4	4		47	
YFT Lapse in Care (All)	2 lapses	3 lapses	1 lapse	1 lapse	2 lapses	0	0	1 lapse	1 awaiting review				10		

Graph: Yorkshire and Humber overview of hospital onset c-difficile cases in acute providers up to December 2018



The post infection reviews do show improvements in practices and adherence to guidance within YTHFT. Concerns about the environment continue and the scheduled de-cant and deep clean has started, including some minor refurbishments.

A recurrent issue has been identified as prescribing out of line with guidance in primary care and work to improve this at individual practice level and wider is planned. An update has been requested from the medicines management team on the planned work to review the prescribing of proton-pump inhibitors in primary care continues as issues with these have been evident from reviews.

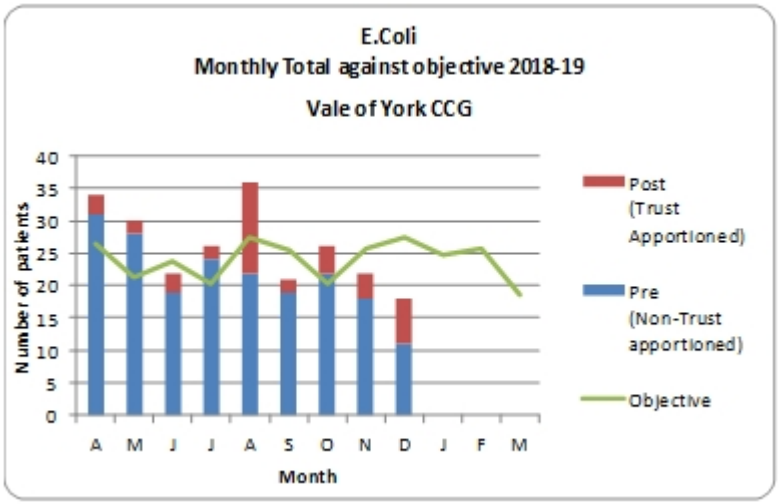
Escherichia coli (E Coli)

Escherichia coli Blood Stream Infections (E.coli BSI)

As previously reported the significant challenges of achieving a reduction in number of cases of at least 10% against 2016 numbers in line with 2018/19 NHS England recommendations continue across the region with no one reason evident.
However it has been agreed locally that Vale of York will participate in the NHSI Urinary tract infection (UTI) collaborative programme which Scarborough Ryedale CCG were approached to take part in due to being an outlier with the number of cases exceeding objective. It is hoped that this multi-agency quality improvement work will result in positive outcomes as it will focus on appropriate diagnosis and treatment of UTI, promotion of hydration and a reduction in the use and duration of urinary catheters. A meeting is in the process of being arranged with representation from all health and social care settings to introduce and progress this.
225 cases of E.coli BSI have been attributed to Vale of York CCG at the end of Quarter 3 2018/19. This is a decrease of 6 cases from the end of Q3 2017/18 and the CCG are currently 9 cases over objective.

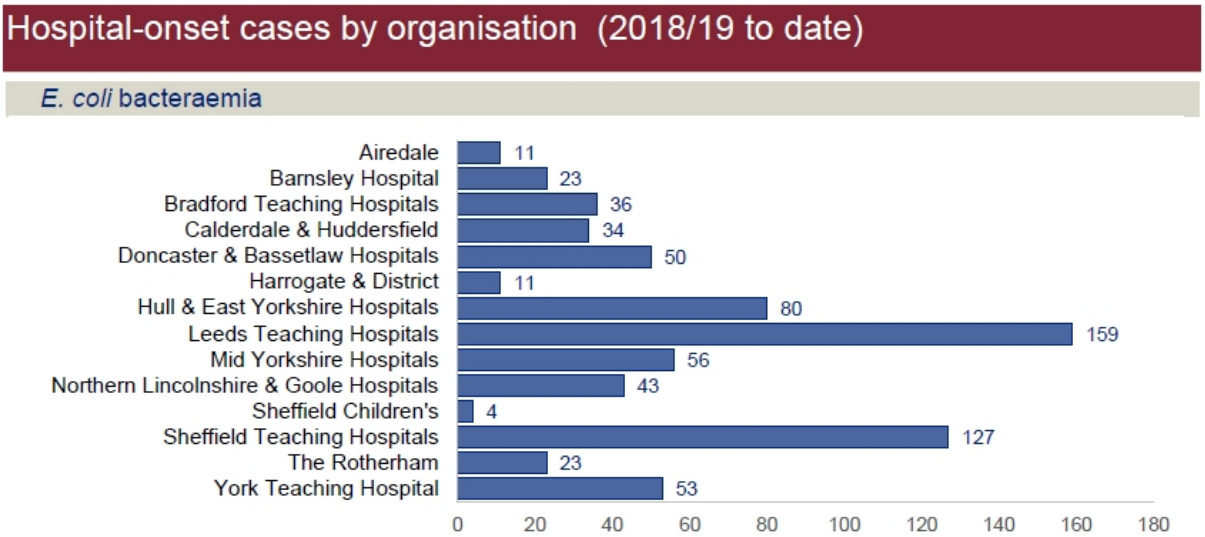
YTHFT have reported 53 cases of E.coli BSI at the end of Quarter 3 2018/19 which is a decrease of 8 cases reported based on the end of Quarter 3 2017/18.

As explained above the CCG cases are predominantly pre cases as demonstrated in the graph below which is consistent with the national picture.



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Position 18-19	Objective 18-19	Position 17-18
E Coli BSI															
Vale of York CCG Attributable Cases (All)	34	30	22	26	26	21	26	22	18				225		295
Objective	26	21	24	20	27	25	20	26	27	25	26	19		287	
Scarborough Ryedale CCG Cases (All)	8	11	11	13	11	17	12	9	15				107		140
Objective	7	6	8	11	6	7	8	9	6	10	9	8		95	
YFT Attributable Cases (All)	4	1	4	4	8	7	7	9	9				53		81

Graph: Yorkshire and Humber overview of hospital onset E.coli cases in acute providers up to December 2018



Flu

Flu is circulating as expected at this time of year. Ward/bay closures have been reported from hospitals in North and West Yorkshire. Both national and local GP consultation rates for influenza-like illness have increased slightly in week 3, and remain below the rates reported in the same week of the 2017/18 influenza season. The graphs below show the type of flu circulating by age range within Yorkshire and Humber.

Figure 8 Influenza A by age group and week
Source: SGSS

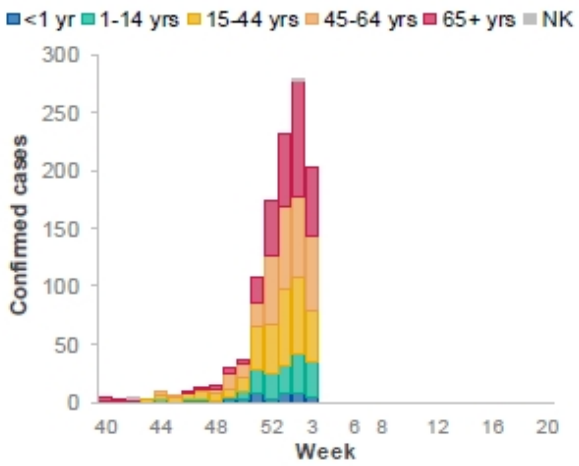
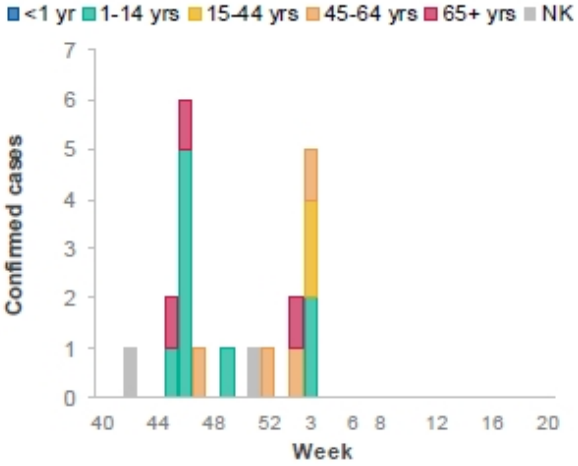


Figure 9 Influenza B by age group and week
Source: SGSS



An update on the current uptake of the influenza vaccination and comparison against last year's flu campaign is provided in the Screening and Immunisations section of this report.

Serious Incidents (SIs)

Key Issues from Provider Trusts

York Teaching Hospital Foundation Trust

Serious Incident Learning - Update

The improvements in management of the SI process continue due to the engagement and commitment to collaborative working demonstrated by the Deputy Director of Patient Safety with room for further ways to progress timely review and response to Serious Incident reports. Despite improvements in the number of outstanding queries on old SIs, obtaining responses to some still remains challenging for both the CCGs and the Trust. The Deputy Director for Patient Safety and Director of Healthcare Governance are meeting the Medical Director to ascertain a process for the escalation of this when they fail to gain a response from medical lead investigators who have clinical commitments. Since the Deputy Director of Patient Safety now attends the CCG SI panel she has been able to answer CCG

queries of recent reports and now a Governance Facilitator attends too so assurance and responses will be more contemporaneous and discussions to improve this are underway.

Never Events (NE)
At the time of preparation of this report for QPEC no further Never Events had occurred, however since that time the CCG were informed of two further Never Events relating to wrong site surgery. One incident involved the removal of the wrong mole, and the other related to a ureteric stent being inserted into the incorrect side. The Deputy Director of Patient Safety informed the CCG in a very timely manner in advance of receipt of the Steis notification and has been able to provide some additional detail.

On initial review it appears that all correct checking processes and procedures were followed in the stent insertion and the full investigation report will establish exactly how the incident occurred. Preliminary investigation into the incorrect mole removal has highlighted some actions outside of process. Both patients have had correct procedures undertaken and are fully aware of the incidents. Further updates will be provided as available.

Following the Head of Quality Assurance spending a day in a number of theatres at York site a further visit to orthopaedic theatres is scheduled for early March.

Colleagues from East Riding CCG have visited Bridlington theatres very recently and found the same level of consistent high standards. Quality colleagues from Scarborough Ryedale CCG have been to Endoscopy and although were assured by clinical safety procedures raised a significant concern about management of the referral process which is being escalated to the Quality and Safety Group.

Falls and Pressure Ulcers
CCG attendance at the falls and pressure ulcer panels continues.
Following on from the review conducted by The Deputy Director of Patient Safety into falls management and processes a report has been produced which has identified 35 actions. As a priority, targeted support for agency workers and reinvigoration of identification of patients at risk through safety huddles is being started for 6 months with additional actions added after that. The Trust's Chief Nurse is responsible for this improvement work which will be shared with the CCG.

A detailed review of pressure ulcers is now planned. As the CCG have highlighted concerns on the consistent themes evident from pressure ulcers so the review and subsequent actions will be awaited.

Tees, Esk and Wear Valleys Trust (TEWV)
TEWV continue to identify and report serious incidents, however it has been raised with their Head of Patient Safety and Director of Healthcare Governance that all York

and North Yorkshire CCGs have been de-logging cases which do not meet the criteria of the NHS England SI framework. TEWV are considering how to progress this, and as their reports are very lengthy suggestions on a more succinct investigation report commensurate with the level of the incident following an initial detailed review. Themes from recent cases continue to be size of caseloads for community teams, care planning, family involvement in care which are fed back and further assurance requested at the TEWV quality meeting.

Screening and Immunisations Update

The lack of local provision for cervical screening training and smear assessor training has been a cause for concern across the HCV. Local stakeholders have been considering how to increase access to cervical screening training within our area. A course has been commissioned at the University of Hull to cover the training of 80 students in two cohorts, to be delivered in February and September 2019. This is supported by the Primary Care Workforce and Training Hub. A register of cervical screening assessors is also being developed with training offered in January 2019 at the University of Hull. Funding has been secured to support backfill costs to practices for the release of nurses to fulfil the assessor role**.**

Influenza (Flu)
The CCG has been very active in supporting the sharing of aTIV vaccinations between practices due to the previously reported issues with supply. As the campaign begins to close supply of the vaccine for the over 65 has not been as short as expected with vaccine supplies still available. The CCG have kept a log of any surplus doses within the Vale of York and been signposting when necessary.

Vale of York has seen an increased uptake in vaccination of 2 and 3 year olds, which has almost doubled for 6 months to 2 years at risk compared to the previous years uptake. The health visiting service has been contacted to see if this can be further improved. However there are some practices where uptake is more than 5% lower than last year; these practices will be contacted to see if there are any reasons for this and any lessons learnt or support required.

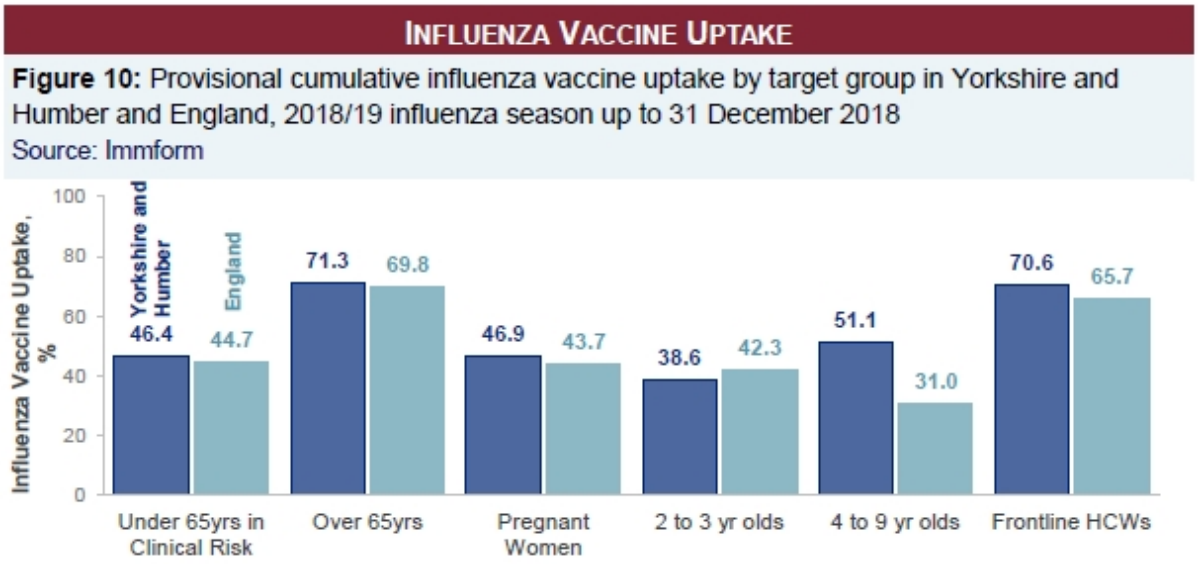
This year, uptake in pregnant women is slightly below previous year for both at risk and not at risk cohorts. Maternity services are being asked for any potential reasons into this.

The three charts below show uptake at a Yorkshire and Humber, CCG, and Practice level. As shown in the Practice level table, there is clear variation in uptake which will be explored further and support provided.

Practices have received communications regarding vaccine choices for next year's campaign.

A detailed multi-agency review look back exercise of this years successes and challenges is planned to achieve further improvements next year.

Uptake across Yorkshire and Humber up to 31st December 2018:



Uptake across Vale of York CCG up to w/e 27th January 2019:

	Current Uptake % FLU - Week 4 (w/e Sunday 27 Jan 2019)															
	65 and over		At risk - under 65s		At risk - (6mths to 2 years)		Children Aged 2		Children Aged 3		Pregnant Women - At-Risk		Pregnant Women - Not At-Risk		Pregnant Women - All	
% uptake comparison to last year	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19	2017-18	2018 - 19
NHS VALE OF YORK	75.3	75.1	49.0	48.3	21.8	39.5	50.3	52.6	51.6	53.2	72.2	68.5	55.9	52.2	57.5	53.7

Uptake % is equal to or better than the	GREEN
Uptake % is less than 5% below the comparator %	ORANGE
Uptake % is 5% or more below the comparator %	RED

Uptake by Vale of York CCG GP practice up to w/e 27th January 2019:

Cells highlighted in Green show above the national uptake target

Org Name	Summary of Flu Vaccine Uptake %					
	65 and over	Under 65 (at-risk	All Pregnant Women	All Aged 2 years	All Aged 3 years	
National uptake target	75%	55%	100% offer	48%	48%	
Pocklington Group Practice	75.5	54.1	59.2	44.6	58.2	
Millfield Surgery	77.0	51.9	60.8	75.8	62.1	
Priory Medical Group	73.9	42.8	49.1	42.7	42.8	
Escrick Surgery	73.6	49.7	52.2	64.2	78.6	
Dalton Terrace Surgery	71.1	49.5	59.0	30.4	42.5	
Haxby Group Practice (inc Gale Farm)	78.0	46.1	52.9	53.5	52.6	
Sherburn Group Practice	76.6	48.8	47.2	52.9	53.5	
Pickering Medical Practice	79.1	61.4	60.6	72.2	73.1	
Beech Tree Surgery	67.4	44.7	57.5	49.4	41.7	
Unity Health	71.3	34.8	57.4	43.9	50.0	
Tollerton Surgery	77.4	53.3	78.9	60.9	66.7	
Helmsley Medical Centre	74.1	58.4	50.0	78.1	48.4	
Old School Medical Practice	77.4	42.1	48.6	65.7	67.7	
South Milford Surgery	68.9	45.3	60.9	37.6	44.2	
Posterngate Surgery	82.3	58.8	61.0	57.9	54.9	
The Kirkbymoorside Surgery	73.9	58.5	59.1	61.5	59.6	
Stillington Surgery	83.1	50.3	55.6	62.5	73.9	
MyHealth	78.0	48.1	52.1	65.4	63.1	
Elvington Medical Practice	73.8	46.4	65.4	20.7	42.9	
York Medical Group	69.8	45.3	49.2			No data on ImmForm for child collection
Scott Road Medical Centre	79.3	62.1	60.0	53.5	60.7	
Jorvik Gillygate Medical Practice	75.0	48.4	47.1	60.6	61.6	
Front Street Surgery	70.2	43.8	61.3	60.6	63.2	
East Parade Medical Practice	77.7	54.9	50.0	63.6	55.6	
Tadcaster Medical Centre	81.5	57.1	56.3	71.9	62.7	
Terrington Surgery	71.0	51.7	75.0	30.0	30.0	
Total	**75.1**	**48.3**	**53.7**	**52.6**	**53.2**	

Maternity

Following the Local Maternity System Board decision to restructure with Executive attendance requested, Vale of York and other organisations have been unable to send representation to recent meetings. Both Vale of York and Scarborough and Ryedale CCGs have suggested previous attendees represent the organisations in the absence of Executive availability. After the first meeting of the delivery group and the decision for it to replace the work stream groups, the work stream groups have now been reinstated.

The CCG is attending a national update on progress against Better Births and a Humber Coast and Vale Perinatal NHSE update following allocation of wave 2 funding.

Maternity Voices Partnership

As the national maternity review Better Births describes how maternity services should be co-produced with women through Maternity Voices Partnerships (MVPs), and following CCG agreement to fund a lay chair of the York and District Maternity Voices Partnership, a lay chair has been appointed with the CCG providing administration and engagement support with the Head of Quality Assurance remaining as Vice Chair until a lay vice chair is nominated and supported.

Patient Experience Update

Vale of York CCG Complaints

18 complaints were registered in the CCG during November and December 2018:

- 14 complaints related to the new questions being asked to establish eligibility for the Patient Transport Service (PTS) provided by the Yorkshire Ambulance Service (YAS).
  The criteria for patient transport has not changed (set by the Department of Health & Social Care), however, patients are now being asked a different set of questions to ensure that it is robustly applied so that resources are available for patients with a medical need. Each request for transport is assessed independently and, even if patients have received transport in the past, they may not be eligible for future journeys unless their circumstances change.

  The complainants provide additional information as to why they feel they do meet the criteria for NHS-funded transport and this is reviewed in conjunction with the initial PTS assessment. 8 complainants were found to be eligible and transport was re-instated, usually with re-assessment in three months. 1 complaint is still open.

- 4 complaints related to communication/information and delays regarding Continuing Healthcare (CHC). 1 case is still open, of the other 3 complaints, 1 was partially upheld and 2 were not upheld.

Parliamentary & Health Service Ombudsman (PHSO)
The CCG currently has 5 complaints that have been referred to the PHSO. 3 complaints related to CHC and 2 from patients unhappy with the BMI policy for elective surgery. Copies of the complaint files and relevant records have been sent and we await decisions from the PHSO.

The PHSO notified the CCG in November 2018 of the outcome of their complaint investigation in which the CCG had acted as coordinator and liaison between a family and two provider organisations. The PHSO reported that they did not uphold the complaint against the CCG as they had found no failings in our service.

Vale of York CCG Concerns
162 concerns/enquiries were managed by the Patient Relations Team, these cover a wide ranging variety of topics, some of which may be relatively straightforward to answer or resolve, but many are more complex cases requiring investigation.

Recent contacts include:

- 71 contacts were from a persistent contactor which required no further action.
- 15 concerns/enquiries related to the CCG's BMI/smoking thresholds for elective surgery.
- 8 concerns/enquires about CHC.
- 7 contacts were seeking information/clarification relating to the transfer of anti-coagulation services from the hospital to GP Practices.

CCG activity for all types of contact (excluding that received from persistent contacters) during November and December is shown in the pie chart at the end of this section.

Compliments

- The Patient Relations Team received a compliment from a PTS complainant who thanked them for their help and kindness through the complaint process.

- A relative emailed to highly commend a CHC nurse assessor for her professional approach.

Action arising from complaints/concerns

Accessible Health Standards

The Patient Relations Team and the Head of Engagement were made aware, by the York Blind & Partially Sighted Society - YBPSS, (from January 2019 renamed as MyInsight York) that some members have had recurrent issues in receiving information from York Teaching Hospital NHS Foundation Trust in a format they can read. The YBPSS Business Manager was concerned that Trust staff did not always seem to be aware of the process for ensuring information is accessible or complying with the Accessible Health Standard.

The CCG's Patient Experience Lead shared these concerns with relevant staff at the Trust who ensured the issues were resolved for the individual patients referred to. The Trust confirmed that "flags" had been added to the patient database which would automatically alert staff to the individual's requirements. Assurance was also sought on how the Trust would improve the service going forwards.

Their action plan (which the CCG shared with YBPSS) includes:

- the Facilities Department (who are responsible for Accessible Information) are developing a more detailed Standard Operating Procedure (SOP) which will be shared amongst the Department to ensure all staff are aware of the importance of this flag, and that staff are aware of what to do should they encounter it. This will also be available to the wider Trust staff via the Trust website where all SOPs are available for guidance,
- raising awareness of the process within the Trust and consider making the Accessible Information eLearning mandatory for all staff,
- the Matron responsible for the Trust specialist nurses is briefing the team about the need to provide information that their patients can easily read/understand, such as larger print,
- Accessible Health Standards will be discussed at the next quarterly specialist nurse forum.

Ophthalmic Emergency Triage Service

Following feedback from GPs (to the CCG and the Trust) about difficulties getting through to the nurse practitioner during busy periods, the service has increased nurse practitioner capacity and implemented a new dedicated GP hotline with voicemail function. This will ease congestion on the lines and offer an alternative way

for GPs to transmit their referral, which does not require them to wait on the line, or call back again. The service is also working towards being able to accept referrals via nhs.net in the near future.

FP10 Prescriptions

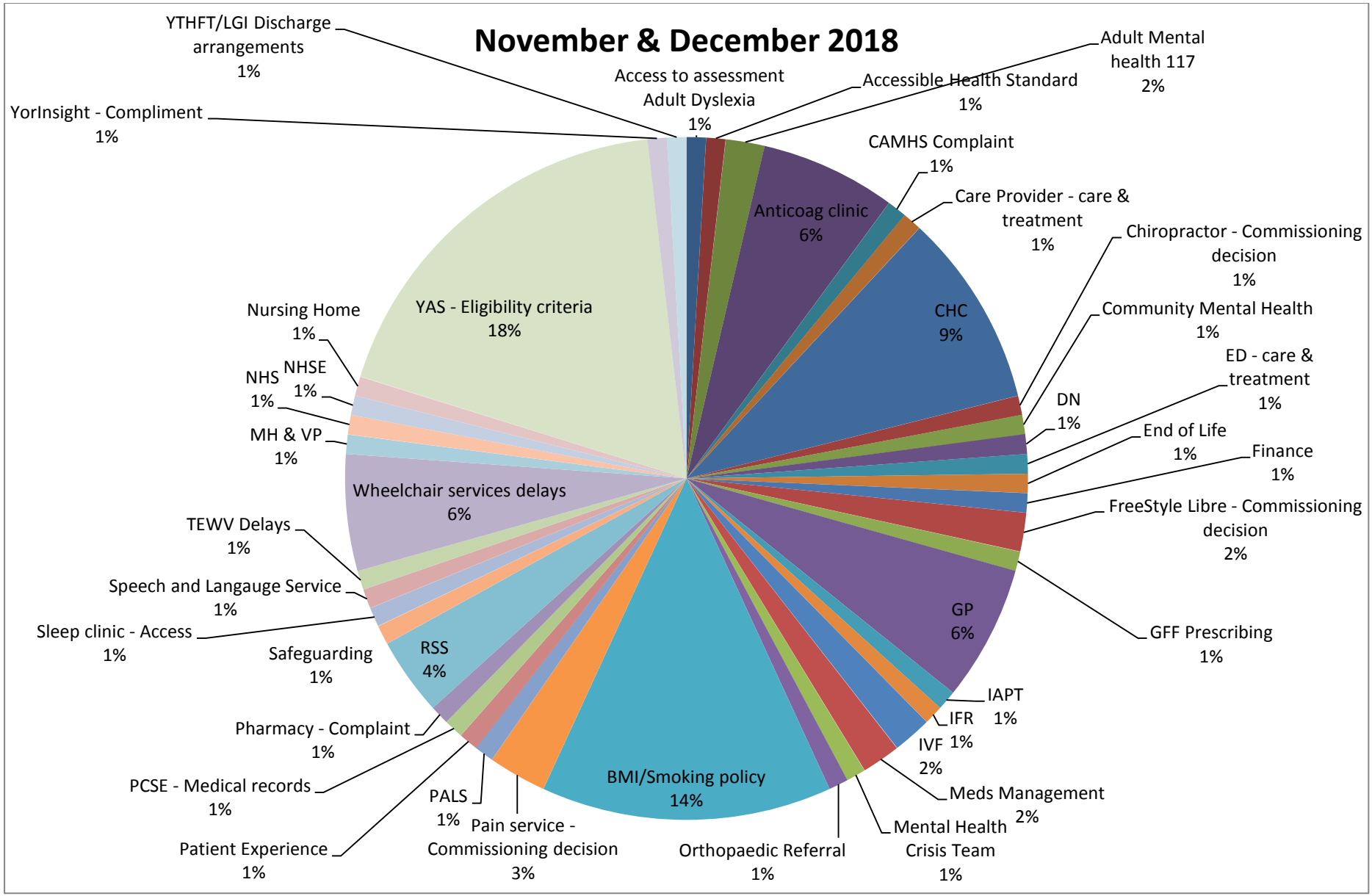
GPs reported that they had been asked on several occasions to prescribe opiate painkillers at short notice, because patients had been discharged from Ramsay (Clifton Park) Hospital without a prescription. The CCGs medicines management team were already aware of this issue and provided the hospital with prescription pads so that they can ensure patients are discharged with an appropriate prescription.

Other Sources of Patient Feedback

These include Healthwatch, Friends & Family Test, Care Opinion and the NHS Choices website. Providers (in primary and secondary care) review themes, trends or potential issues, in conjunction with formal complaints and concerns made directly to them, so that themes and trends can hopefully be identified early, escalated and resolved where possible.

Below are the current hospital ratings available at the time of writing, based on feedback by users on NHS Choices. Providers not listed have not yet been rated. GP Practices are listed individually on the website.

Hospital	Rating (out of a score of 5)	Number of ratings
York	4.5	214
Scarborough	4.5	103
Clifton Park	5	15
Whitecross Rehabilitation	5	1
Nuffield York	3	3


November & December 2018
YTHFT/LGI Discharge arrangements 1%
YorInsight - Compliment 1%
Access to assessment Adult Dyslexia 1%
Accessible Health Standard 1%
Adult Mental health 117 2%
CAMHS Complaint 1%
Care Provider - care & treatment 1%
Chiropractor - Commissioning decision 1%
Community Mental Health 1%
ED - care & treatment 1%
DN 1%
End of Life 1%
Finance 1%
FreeStyle Libre - Commissioning decision 2%
GFF Prescribing 1%
IAPT 1%
IFR 1%
IVF 2%
Meds Management 2%
Mental Health Crisis Team 1%
Orthopaedic Referral 1%
Pain service - Commissioning decision 3%
PALS 1%
Patient Experience 1%
PCSE - Medical records 1%
Pharmacy - Complaint 1%
Safeguarding 1%
Sleep clinic - Access 1%
Speech and Langauge Service 1%
TEWV Delays 1%
Wheelchair services delays 6%
MH & VP 1%
NHS 1%
NHSE 1%
Nursing Home 1%
YAS - Eligibility criteria 18%
Anticoag clinic 6%
CHC 9%
GP 6%
RSS 4%
BMI/Smoking policy 14%

Patient Engagement Update

CCG Improvement and Assessment Framework Patient and Community Engagement Indicator

The CCG is rated for its compliance with statutory guidance on patient and public participation in commissioning health and care through the 'Patient and Community Engagement Indicator' in the CCG Improvement and Assessment Framework (IAF).

The indicator evidences the CCG's implementation of the statutory guidance on patient and public participation in commissioning health and care.

This guidance sets out 10 key actions for a CCG on how to embed involvement in its work:

1. Involve the public in governance
2. Explain public involvement in commissioning plans/business plan
3. Demonstrate public involvement in annual reports
4. Promote and publicise public involvement
5. Assess, plan and take action to involve
6. Feedback and evaluate
7. Implement assurance and improvement systems
8. Advance equalities and reduce health inequalities
9. Provide support for effective involvement
10. Hold providers to account.

In 2017/18 NHS Vale of York CCG was rated as 'good'. The framework and criteria for this indicator remains the same for 2019/20 and will be submitted as part of a self-assessment tool, based on information that appears on the CCG's website. NHS England has published Guidance for CCGs to support them with the evidence submission process for the indicator in 2018/19.

The Head of Engagement has attended a Patient and Public Engagement IAF workshop in Leeds in January and is attending the series of seminars produced by NHSE in preparation for the self-assessment audit.

The timescale for assessment and submission is as follows:

CCGs prepare evidence of engagement in line with the statutory guidance on patient and public participation in commissioning health and care using the criteria outlined in the evidence template received from NHS England in January. CCGs work with local people and communities where possible to identify and prepare evidence.

January 2019 - March 2019

CCGs identify and submit evidence using the evidence template. CCGs include a 'description of change' wherever they indicate that a criterion is met in 2018/19 that was assessed as unmet in 2017/18 (or vice versa). Submissions are signed off by the Accountable Officer of the CCG.

Final date for submissions: 1pm, 8 March 2019

An initial score (and related RAGG* [Red, Amber, Green, Green Star] rating) is auto-generated from each submission. NHS England undertakes national assessment using the published indicator framework to agree scores and RAGG* ratings. A process of moderation is undertaken by a panel led by NHS England and including other members of the Patient and Community Engagement Indicator Advisory Group, prior to confirmation of final scores. The scores generated by this process are final.

March 2019 - May 2019

CCG Accountable Officers receive the outcome of their Patient and Community Engagement Indicator assessment prior to publication. Final scores for the indicator are published on the MyNHS website as part of the CCG ratings under the CCG Improvement and Assessment Framework.

July 2019

Domains measured against, score in 2017-18 and suggested improvements for 2019-20.

Domain	Indicators	VOY CCG rating 2017-18	Areas where VOY CCG could provide more evidence its website for 2019-20 to increase the rating to 'outstanding'
A. Governance	Involve the public in governance Implement assurance and improvement systems Hold providers to account	Good	Make public parts of Governing Body meetings easily accessible to the public. More evidence that the Governing Body is assured about public involvement activity and the difference it has made. Illustrate how the CCG reviews public involvement activity across its providers and takes action in response.
B. Annual reporting	Demonstrate public involvement in Annual Reports	Good	Make the annual report accessible and appealing. (This year we had a new engagement annual report).
C. Day-to-day practice	Explain public involvement in commissioning plans Promote and publicise public involvement Assess, plan and take action to involve Provide support for effective engagement	Good	Display information about how the CCG supports members of the public who are involved. Highlight where public documents are written in plain English and produced in appropriate/accessible formats for the community. Demonstrate more clearly where the CCG uses a range of targeted outreach approaches, including working with the voluntary and community sector.
D. Feedback and evaluation	Feedback and Evaluate	Good	Provide increased evidence of the difference that public involvement has made to commissioning, decision making and/or services.

E. Equalities and health inequalities	Advance equality and reduce health inequality	Good	Clearer evidence of how the CCG considers equalities and health inequalities when planning and implementing its approach to public involvement. Showing how demographic monitoring is in place for public involvement and is used to inform improvement.

Communications and engagement strategy 2019-22

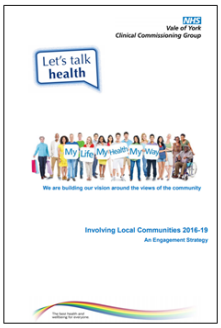
An initial high level draft of the new communications and engagement strategy is due to go to Governing Body on 7 February 2018.

Initial feedback received: November 2018 – January 2019

- Key stakeholders: VCSE organisations such as Selby AVS and York CVS, Healthwatch York and North Yorkshire, Older People Advocacy York (OCAY), York Carers Centre, York College.
- Public: Website and comms workshop (29 January 2019) and Healthwatch Assembly (22 January 2019). Drop-in at West Offices (second Monday of the month).
- Governing Body GPs and Accountable Officer

Workshop 22 and 29 January 2019:

Refresh our strategy



NHS Vale of York Clinical Commissioning Group

Our priorities – 2019-20

- The CCG's priorities for 2019/20 build on work that has been done in 2018/19 while moving towards longer-term planning.
- In setting our priorities we have considered:
  - The health needs of our population
  - The views of the people we serve
  - Where we need to focus for improvement
- NHS Vale of York CCG is growing slowly and more are reaching the age where ill health leads to need for services.
- We have generally good health services but there are challenges in mental health, cancer services and maintaining access to General Practice – these are the priorities that our population has told us.
- There are significant levels of chronic disease including mental health problems. This is especially true in the areas of higher deprivation

NHS Vale of York Clinical Commissioning Group

Focus for improvement: Our priorities

- Strengthening GP services
- Community services – more seamless working between health and social care
- Mental health and wellbeing, esp. children's services
- Cancer and long-term conditions
- Focus on community:
  - Build services for populations that can focus on the specific health needs and challenges of an area
  - Work with the most vulnerable and those with greatest need
  - Prevention and self care – to support communities to stay healthy for longer
  - Targeting investment and services to areas with greatest need is essential

NHS Vale of York Clinical Commissioning Group

Our engagement principles

Inclusiveness	participation of all who have an interest in or are affected by a specific decision
Honesty and clarity	ensuring all involved understand how they can contribute and how decisions are made
Commitment	demonstrating a genuine attempt to understand and incorporate other opinions
Accessibility	different ways of engagement, ensuring people are not excluded
Accountability	respond within set timescales and report unambiguously on why contributions have/have not influenced outcomes
Responsiveness	open to idea of changing existing ways of working
Willingness to learn	those involved and those undertaking the engagement process must be willing to learn from each other
Productivity	at the start of any engagement process establish desired outcomes for improvement
Partnership approach	Where possible co-ordinate activities with other statutory and voluntary sector partners to engage efficiently and effectively and avoid any duplication.

NHS Vale of York Clinical Commissioning Group

Discussion on the existing engagement principles from 2016-19 strategy:

Inclusiveness	participation of all who have an interest in or are affected by a specific decision
Honesty and clarity	ensuring all involved understand how they can contribute and how decisions are made
Commitment	demonstrating a genuine attempt to understand and incorporate other opinions
Accessibility	different ways of engagement, ensuring people are not excluded
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Productivity	at the start of any engagement process establish desired outcomes for improvement
Partnership approach	Where possible co-ordinate activities with other statutory and voluntary sector partners to engage efficiently and effectively and avoid any duplication.

What our population has told us about these principles:

- Build **trust** and **relationships.** Have a more partnership approach
- **Regular communication**: around changes that are taking place – don't stop after consultation. Provide evidence that we have listened, responded and taken their views into account
- Allow **enough time for people to feedback** – otherwise it feels tokenistic. Important that people can see the results. Think about where, when and how are we going to feedback.
- **Language** is important: We need to create an easy read version of the principles.
- **Honesty:** We need to be honest with what can be done within budget
- **Reach out into the community:** Go out to people rather than expecting them to come to you. Ensure you gather a wide and diverse sample.

- **Be inclusive and accessible:** Consider how you access people who are socially isolated, or who are not represented by existing groups – eg homelessness/financial hardship, people with MH conditions
- **Listening, feedback, openness** and **transparency** need to be added
- All principles are important, but we need to ensure how they are implemented and adhered to.

We will be using this feedback to refresh our core engagement principles as part of the new strategy.

Next stages: Develop strategy based on feedback and publish first draft for public consultation (March/April 2019).

Listening to our community: You said, we did

Each month it is important to capture evidence of the difference that public involvement has made to commissioning, decision making and/or services.

Example one: Carers

You said: At a recent carer advisory group (CAG) meeting in the East Riding area a panel member raised an issue with signposting and information available for carers through their local GP service. They wanted to increase awareness with staff within GP practices about recognising and supporting carers, and promoting local carers' services available.

We did: We contacted MyHealth practice in Strensall and Stamford Bridge and met with the operations manager to discuss how we could help support carers. The operations manager was very proactive, and began to implement some changes immediately.

Resulting in:

- Two carers from East Rising CAG delivered a training session to the staff on the life of a carer to increase awareness of the challenges they face.
- A new carers' notice board in the surgery, including information about what is available for carers in the East Rising.
- The surgery is updating website with useful numbers and signposting info for carers.
- The surgery has offered the meeting room at Stamford Bridge surgery as a free space for carers groups to meet if they need to.

Example two: Helping you stay healthy and well

You said:

During our time spent out in our community collecting pledges from our population as part of the NHS 70, you said that you wanted to help stay healthy and well. You also commented that you would like more health information and advice information to help share within your communities.

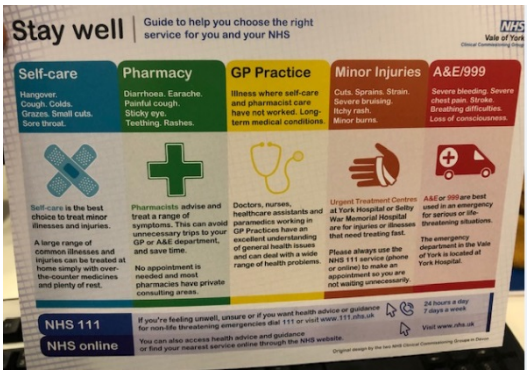
- "I pledge to collect and share leaflets to spread awareness of available services in the community and encourage their use"
- "I pledge to use the appropriate service to meet my needs, e.g. talk to a pharmacist before making a GP appointment or to call NHS111 before going to A&E."
- I pledge to keep looking after the residents of York through my job and make good relationships with other services in the NHS to enhance this."

We did:

We took part in the **self-care aware campaign, '**Help Us Help You' which encourages our community to take care of their health this winter.

Resulting in:

A multi-media campaign to help our population to stay well this winter. Through media, videos, newsletters, our website and social media and printed leaflets we launched the **help us help you campaign.**



The CCG teamed up with a number of Vale of York GPs to create a series of self-care videos, to help its population self-treat common illnesses such as cold and flu at home using over-the-counter medicines. These can be viewed here.

We produced a number of press releases and content which was shared around our community networks.

- https://www.valeofyorkccg.nhs.uk/winter/
- https://www.valeofyorkccg.nhs.uk/latest-news/post/vale-of-york-gp-provides-top-tips-for-staying-well-in-winter

Events and meetings

Date	Time	Event/meeting
5.12.18	10.00am-11.30am	Meeting with Yorkshire Ambulance Service to discuss patient experience, quality and improving engagement.
10.12.19	10.00am-12pm	Healthwatch and VOY CCG drop-in at West Offices Foyer.
6.12.18	9.30am-12.30pm	City of York Carers' strategy: Open consultation meeting.
6.12.18	10.00am-3pm	North Yorkshire Disability Forum. Paul Howatson and Victoria Binks discuss Wheelchair and community equipment feedback.
14.1.19	10.00am-12pm	Healthwatch and VOY CCG drop-in at West Offices Foyer
15.1.19	9.30am-11am	Head of Engagement meets with Catherine Scott (Healthwatch Manager)
16.1.19	10am-12pm	Carers Advisory Group: York Carers Centre and reps.
22.1.19	1pm-2pm	Stakeholder catch up: Head of Engagement meets with Catherine Scott (Healthwatch Manager) and Tracy Wallis, Health and Wellbeing Board

22.1.19	2pm-4pm	Healthwatch Assembly: NHS Vale of York presents on commissioning intentions, population health and community need, our priorities and consultation on the new engagement strategy.
23.1.19	10am-12pm	Maternity Voices Partnership. Maternity services group.
24.1.19	11am-12pm	Meet with patient story, mother and son (CHC patient story from April 2018).
29.1.19	3pm-4.30pm	Readability panel Workshop: New website and user feedback.
7.2.19	4pm-7pm	Rehab and recovery: Future model workshop and drop in – in partnership with TEWV

Care Homes and Adult Safeguarding Update

Care Homes and Safeguarding

Somerset House – Wheldrake, York - Country Court Care Homes – General Nursing/EMI – capacity 41 – occupancy 35. CQC inspection in December 2018 – report published – inadequate overall and in all domains. Suspended to new admissions. Safe-eyes visits completed in December. There are 15 residents receiving funded nursing care (FNC). The VoY CHC team are progressing review of these clients. Oversight is being provided by TEWV dementia liaison team; CYC safeguarding officers; CYC reviewing team; and CHC nurses.

William Wilberforce - Pocklington, York - Londesborough Court Limited – capacity 64 – occupancy 59 (in November 2018) – CQC inspection in November 2018 – report published January 2019 – overall inadequate – requires improvement in caring domain; all other domains rated as inadequate. The home is without nursing; the CCG do not fund any care for residents. The CCG quality lead has been supporting the home. Oversight is being provided by East Riding Council safeguarding team; and reviewing team.

Quality in Care Homes

Joint approach to support care homes and the domiciliary care sector
The Senior Quality Lead aims to play an active role in work that promotes quality care provision and resident experience. This includes support for domiciliary care organisations as well as Care Homes.

Quality Leads from NHS Vale of York CCG (VoY CCG) and Scarborough and Ryedale CCG (SRCCG) continue to work closely, ensuring a joined up approach to engage all stakeholders in work pertaining to care homes and domiciliary care. Work plans are aligned, identifying common themes to maximise impact. Aimed at preventing unnecessary admissions from care homes and promoting flow/ discharge, key schemes include the Capacity Tracker, mental health support, the hospital transfer pathway standards, 'React to Red', falls prevention, advanced care planning and identification of the deteriorating resident.

Representation at the Complex Discharge Steering Group and Unplanned and Emergency Care Steering Group continues.

Capacity Tracker
This is described as a 'web based capacity portal' developed by NECS (North of England Commissioning Support) in conjunction with NHS England North region and is aimed at reducing delayed transfers of care. The tool has been procured by NHS England and was implemented without charge. From April 2019 there will be a cost attached to use of the tool. The CCG is currently awaiting further information from NHS England regarding this before a business case can be considered.

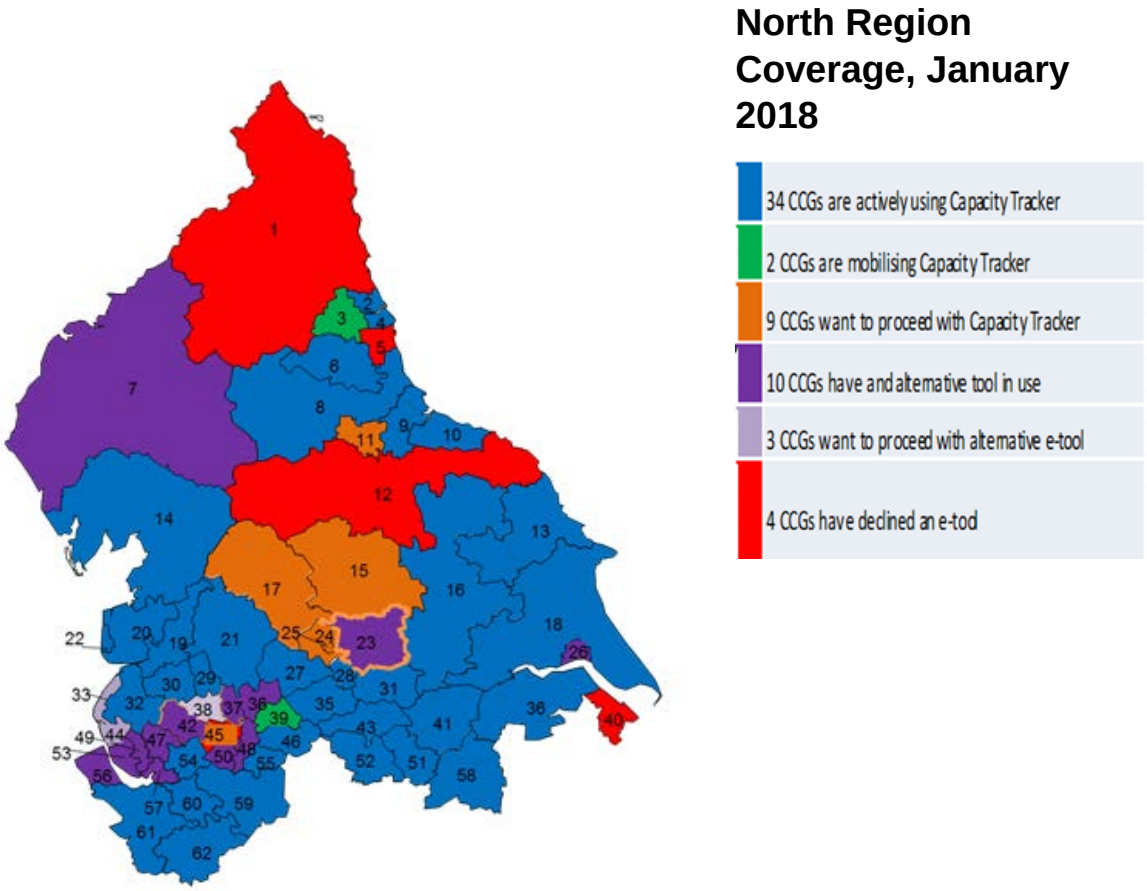
The tool aims to enable care homes to share 'real time' bed availability with NHS providers and Local Authorities. The tool is live and progressing alongside implementation in the East Riding CCG (ERCCG) and SRCCG. The CCG is leading on this initiative for the Vale of York with support from colleagues in North Yorkshire County Council (NYCC), City of York Council (CYC), East Riding County Council (ERCC) and YTHFT. At the current time the uptake of homes remains at 83% (53 residential and nursing homes with 44 registered, this excludes Learning Disability homes). Some homes have opted to decline the use of the tool (with valid reason). NECs are exploring how these homes are identified in reports so that the CCG can be assured 100% of all homes are registered and using if appropriate. At the current time of writing this paper of those registered 57% had updated within the last 10 days and 48% within the recommended 7 days. Messages around updating continue to be circulated as regularly and support offered to homes as appropriate.

There is on-going work with non-care home partners who are using the tracker. Improved engagement from the continuing healthcare team is encouraging and continued engagement from NYCC. York Integrated Care Team have expressed interest in supporting use of the tool and the nursing team all have accounts registered.

The CCG is contributing towards a user group to inform on development of the tool and to support adoption and spread at a regional level. Capacity reports which can be pulled from the system are not included in this paper as the data is not reliable at the moment due to reporting anomalies. NECS aim to trial the tracker for use with domiciliary care agencies and potentially develop public access. On the site there are also resources for homes to access such as NHS England Newsletters, guidance etc. .

As part of the winter resilience plan the use of the tracker is advocated by NHS England and it is important for teams to play a concerted effort in embedding the use of the tool. Identifying the tracker as a priority in the Complex Discharge Group to galvanise support from all stakeholders remains important. CYC have recently appointed a new brokerage post who will link with the CCG in terms of supporting the use of the tool with stakeholders. This role is a valuable opportunity to ensure consistent communication to users and valuable feedback gathered to inform conversations around its development.

There was an ask in November for all CCGs to be using a web based tool by January with a minimum of 50% inputting data weekly. This target has now been pushed back to February. The map below shows coverage in the North Region (January 2018).



(NHS England, 2018)

Hospital Transfer Pathway
The Red Bag initiative continues to progress jointly with SRCCG to ensure the plan for roll out is safe, effective and sustainable. Due to a number of challenges the project has required further time for completion which is now identified for March 2019. This aims to ensure timely flow of information across the admission and discharge processes. Engagement with the acute provider will be vital in the success of this project, key contacts are collaborating with both CCGs.

Identification of Deteriorating Residents
A Quality Improvement project to support the early identification and communication of deterioration in care home residents is progressing and gaining momentum, both locally and nationally. Currently 4 homes are engaged with this pilot and it is anticipated that the speed of spread will be increased following positive preliminary findings. This project includes the use of a softer signs tool combined with National Early Warning Score (NEWS) and Situation, Background, Assessment, Recommendation (SBAR) communication tool. Supported by the Improvement Academy it is anticipated to build on work published by Wessex Academic Health Science Networks (AHSN) and include sepsis awareness. There are already excellent examples where the tool has supported early intervention for residents. A paper containing case studies is being written to demonstrate early findings and impact. An invite to present at the national AHSN conference has been received and the opportunity to video an interactive case study to demonstrate the value of this work. The work is evolving as learning is gathered and the work will include mental health support. The Care Home and Dementia Team are engaged in the work and are currently exploring how this could possibly work to facilitate earlier referral of residents in need to them.

Following the successful Health Foundation award in October to extend the scope of identification of deteriorating residents work into the domiciliary care setting is progressing in a really positive way. There is a lot of interest in the work nationally which is encouraging.

A project nurse has now been recruited to facilitate the work. The care agency has issued communications to their staff regarding the work. Baseline data is being gathered and training to staff identified to be delivered by March 4th. The tool is currently being translated into an electronic form so that carers will be able to complete and communicate immediately with the hub to enable fats onward escalation. Tools and teaching resources have been developed.

A second conference as a follow up to one held in May 2018 is planned for June 2019. This will showcase achievements and learning from the projects, connect with other related work and aim to launch spread of the work to a wider audience.

End of Life Care
Joint work with colleagues from the Hospice and the Acute Trust to support provision of end of life care training continues to progress. This aims to ensure training is accessible and content standardised to staff within social care. The Senior Quality Lead also attends meetings to support and shape service provision across the CCG.

Falls
Focussed support for reducing falls in a care home continues which includes Safety Huddles. A number of homes have expressed an interest in becoming involved in this work and the Quality and Nursing Team are working with them.

The Senior Quality Lead is an active member of the Virtual Development Group for the NHS England Falls programme which will publish falls guides for care homes in the near future. The resources are close to completion but a date for launch not yet publicised.

Opportunities are being explored for funding programmes of work relating to prevention of falls both within care homes and in the wider community in collaboration with stakeholders from the universities, YAS and Public health. A workshop will be held on 13th March. The Senior Quality Lead has been invited to participate in a falls collaborative to be run by YAS. This will ensure the CCG are part of the falls work in community and good practice is shared across the patch. It is hoped that links between YAS and the CCG may be strengthened and in particular link the Clinical Leadership Fellow posts from each organisation to develop joint working and increase capacity.

React to Red
All care homes across the CCG have been offered the opportunity to participate in the React to Red programme (2 subsequently closed during the programme). 14 learning difficulty/mental health care homes declined/deemed themselves ineligible due to it not being appropriate for their client group – i.e. clients are active and mobile with very low risk of pressure damage.

2 care homes have declined to take part in the programme. 62 care homes and 2 extra care housing schemes are participating in React to Red. This includes approximately 1743 eligible staff, of which 1544 (89%) have received training and assessed as competent.

40 care homes and 2 extra care housing schemes have achieved full sign off with all staff trained and competent. Certificates have been awarded to recognise the success. 10 domiciliary care providers are taking part in React to Red and educational sessions have been delivered to tenants in 5 sheltered housing complexes. This means that a total of 79 care providers have engaged in the programme.

Post training evaluation continues to be positive with care staff reporting the training as easy to understand, improving baseline knowledge of pressure prevention, recognition and actions to take. Many homes are making pressure ulcer prevention training mandatory for care workers at induction and as part of an annual refresher. Feedback from care home managers continues to be positive, stating how the programme has improved the quality of care provided to their service users.

The programme will be completing at the end of March and an evaluation will be presented.

In January two articles have been published in one journal relating to pressure ulcer prevention written by the team and another is currently sat with an editorial board awaiting peer review.

Mental Health

Mental health support in care homes is important particularly as there will be a loss of beds due to reconfiguration of services in 2020. The Mental Health Services for Older People Team are working with the Senior Quality Lead to shift focus to prevention of admissions for those experiencing mental health issues in care homes and explore how care homes can be better supported to care for residents at home. A workshop held in December was successful on informing how this could be achieved, care home managers shared ideas for how they might be supported with caring for their residents and preventing unnecessary admissions. This will be repeated as it was a valuable opportunity to have open conversations. It will inform on how the mental health service can best respond to the care homes challenges and prevent delayed transfers of care and out of area transfers.

The Mental Health Services for Older People Team are a valued stakeholder who support the work of the CCG in engaging with care homes to promote care at home and this is exciting work. The team actively support in many aspects of the care home work programmes and contribute towards project plans ensuring mental health of those in care homes and domiciliary settings is considered.

Care Home Engagement

The Senior Quality Lead continues engagement to understand priorities of the different care homes and identify where support can be offered. This work ensures the care home strategy continues to reflect residents and carer's priorities, sharing progress and celebrating achievements. A refreshed work plan for 2019/2020 is currently under development. Care home managers contact the senior Quality Lead for support when faced with challenges associated with the care of residents, these relate to various reasons including medication, training, discharge, equipment. Referral pathways, CQC and safeguarding issues, safety alerts. There is a new resource from the AHSN, the 'Yorkshire Patient Experience Toolkit'. Alongside the Head of Engagement, the Senior Quality Lead will explore how this might be used within certain Quality Improvement programmes to ensure residents' voices are heard.

The Partners in Care Forum

The Partners in Care forum continues and is valued by all those who attend as an effective means of communication and building positive relationships. The next meeting is scheduled for February.

The forum is scheduled in collaboration with the NYCC Quality Improvement Team and SRCCG in order to maximise attendance and ensure as a wider team we are able to support each other. This is proving positive and constructive in building valued relationships.

The Partners in Care Lessons Learned Bulletin is now incorporated in the weekly bulletin and contains contributions from the social care sector to ensure it is relevant and appropriate to the audience. Once constructed, information regarding lessons

learned and safety alerts will also be held on the website for ease of access and as a reference for all.

Engagement with Primary Care
The Senior Quality Lead has continued work in the South locality with a GP to improve the efficiency of support offered to care homes by the practice. A trial commenced in January to improve accessibility to OT, Physio, dietetics and SALT teams by a cohort of care home managers. Following a three month trial referral process will be reviewed. Feedback has so far being positive. The identification of deteriorating residents work will be part of this offer to the care home and aims to link with the care home pharmacists once appointed. The use of softer signs tool and improving communication between health and social care staff also has the potential to be integrated in discharge process and with informal carers. Training was provided in December and aimed to not solely launch the project but also support carers particularly over the Christmas period.

In the centre of York the integrated care team are currently involved in a project to support care homes in early response from the GP teams. MDT visit care homes and perform ward rounds with the aim of faster response. This has been supported by the Senior Quality Lead in the beginning who continues to link with the team and offer support where required. The team are currently focusing on the implementation of advanced care planning in homes within central York.

Health and Social Care Joint Working
The Senior Quality Lead continues to link with local authority colleagues and CQC as required to support action and improvement plans or where concerns are raised. This continues to be proactive and supportive to the care homes, ensuring appropriate interventions can be facilitated. The Quality and Nursing team have contributed to supporting care homes who have received poor CQC ratings. NYCC have appointed a Quality Improvement Team and opportunities for joint working are being actively explored. This is facilitating joint work and support for programmes such as identification of deteriorating residents. All homes with a NYCC funded resident can access the team who are supporting improvement. This is work that has been praised by the CQC and feels like true joint approach to supporting care sector colleagues. Working alongside Skills for Care colleagues facilitates collaborative working with partner organisations and ensures quality education/ training provision and advice.

Workforce Development within Social Care
A bid for funding from HEE for a Clinical Leadership Fellow post has been successful and 100% funding has been awarded. The post has now been recruited to. This is an innovative opportunity for an exciting development role which will increase capacity within the CCG and ability to progress improvement work and impact on clinical outcomes. The senior Quality Lead will work closely with colleagues within the VOY CCG and also external such as the Improvement Academy to maximise opportunities for the post holder

The Senior Quality Lead and the Skills for Care Locality Manager will be supporting a local care home manger in establishing a task and finish group who aim to agree a charter of standards. The charter will articulate standards that can be expected from

the homes involved. This is evolving and looks to be progressing to develop as part of a registered manager network meeting. This ambition is to address promotion of positive perceptions locally of the care home sector with NHS colleagues and other stakeholders. It links with the national recruitment campaign and the Humber, Coast and Vale Excellence Centre promoting health and social care sector as a positive working environment.

Work with the Humber Coast and Vale Excellence Centre continues. The Senior Quality Lead is a member of the delivery group and the partnership forum. This allows representation of the CCG and helps shape development of the social care workforce across the region. The Senior Quality Lead is engaging in work to develop rotational apprenticeships. .

Support for managers with staffing issues continues as required. Often care managers will approach the Senior Quality Lead with queries regarding professional nursing concerns.

Equipment Selection in Community
Work to ensure the quality perspective and good governance processes are integral in the commissioning agreements for equipment is being led by the Chief Nurse for Hambleton, Richmondshire and Whitby CCG.

The Senior Quality Lead continues to chair a sub group of the Equipment Review Group (ERG) to consider provision of mattresses and seating. It is anticipated this should be for a period of 12 months to realise financial savings associated with the appropriate selection and use of mattresses which account for 50% of the spend. This work is at pace to ensure equipment provision particularly across the winter period is not compromised.

A case study looking at the benefits of using the Mercury Hybrid mattress within a Nursing Home commenced in December 2017. The findings have now been published by a journal in January and it is hoped will help inform on best practice

Connected Care Homes
Preliminary discussions have been held regarding a digital project aimed at promoting connectivity in care homes across the VOY and SRCCG anticipated to begin from April 2019. This is funded by the Health System Led Investment Fund (HSLIF) and is a 2.5 year programme. Care homes would be provided with a lap top, NHS mail account, secure connection and training. Numerous discussions have taken place over the past 18 months at the Partners in Care Forum including presentations by NHS Digital . There appears to be an appetite for increased connectivity with the NHS. Care home staff have openly discussed the enablers and challenges of providing NHS mail and access in homes and this project is welcomed.

Research and Development

Research Partnership Group (RPG) – Promotion of partnership working
The R&D Manager is supporting the possibility of shaping a proposal for Research for Patient Benefit (RFPB) award relating to falls prevention. This theme was chosen

following the RPGs discussions around the York Joint Strategic Needs Assessment (JSNA) from which a number of themes have emerged. The JSNA analysed and identified the current and future health and wellbeing needs of the local population. It helps to inform commissioning priorities that will help to improve outcomes and reduce health inequalities' across the city. Partner members from the VoY CCG, University of York, University of York St John, CYC, Yorkshire Ambulance NHS Foundation Trust, Tees Esk and Wear Valleys NHS Foundation Trust, NYCC and the NIHR will work together to inform on a potential feasibility randomised control trial (RCT).

Vale of York CCG Website – new 'Research, Evaluation and Innovation' page
The R&D Manager has prepared information for inclusion onto a new page of the VoY CCG website entitled 'Research, Evaluation and Innovation'. This will enable us to showcase research being undertaken at our General Practices, and praise the work of the research staff within practices and, innovation & evaluation being undertaken by the CCG. It will also provide and promote information to patients who may be interested in taking part in research and provide clarity of who to approach locally. It will also contain useful information about new research studies & useful websites for researchers.

Promotion and Supporting Research Locally
The R&D Manager continues to support local research partners and arranges publication of good news stories, new research projects information and promotion of local research events.

Adult Safeguarding

An update was given at February's Quality and Patient Experience Committee about all aspects of the Safeguarding Adults Designated team work streams. This included an update on the Learning Disability Mortality Review programme (LeDeR) programme, City of York and North Yorkshire Safeguarding Adults Boards, North Yorkshire & City of York Modern Slavery Partnership, Prevent Partnership Board and current safeguarding reviews.

Adult Mental Health

Dementia
Diagnosis rates decreased to 59.6% at the end of December 2018 from 60.1%.
A further review meeting by the NHSE Intensive Support Team (IST) took place on 10 January attended by the CCG and TEWV. The following actions were identified:

- The CCG and TEWV to reconcile diagnoses made by the memory service and recorded on GP practice registers as there appears to be a significant discrepancy between practice diagnostic rates and numbers diagnosed by the memory service.

- It was suggested that the CCG/TEWV scope the option of using psychology assistants to go into practices and care homes to identify patients who may have dementia. This has been trialled successfully in Tees.
- The consultant in old age psychiatry from TEWV agreed to deliver a session on dementia awareness to GPs at the protected learning event on 31st January 2019. This will be an opportunity to provide consistent messages on the benefits of timely diagnosis including; drug treatment, cognitive stimulation therapy, advance care planning, and available support services for patients, families and carers
- The 70% QOF target threshold for Care Plan Reviews provides a starting point for the CCG to monitor these in primary care. Care plans should be in place for everyone with dementia, and be regularly reviewed and updated, at least every 12 months, to remain relevant and responsive. Clinical evidence shows that formal care planning and other post-diagnostic support is positive for the patient and is expected to lengthen the time which they can live in the community.

In addition to the above, the CCG met recently with the Alzheimer's society and they have extended their offer of free dementia clinics for patients registered with a CCG GP. Currently these are held at three practices and patients/carers can be signposted to them.

The North Locality has submitted a bid to the Alzheimer's Society for a care coordinator post. Part of this role will be to review practice records to ensure dementia is correctly coded. This in turn will ensure support for older people living in predominantly rural areas.

Improving Access to Psychological Therapies (IAPT)
Following the NHSE IST review, an action plan has been developed by TEWV and agreed by the CCG. The action plan is intended to cover 3 specific objectives

- The service needs to provide sufficient capacity and increase referrals to meet and sustain the 18/19 locally agreed prevalence target of 15.39%
- The service needs to ensure it achieves and sustains the 50% recovery target.
- The service needs to reduce the existing backlog of patients waiting for second appointment to an acceptable level and ensure appropriate waiting times are maintained

TEWV has developed a communication strategy and launched a revised website. This information will target underrepresented groups (e.g. students, older people and people with long term conditions) with an offer of a pilot group/course to run in quarter 4.

The performance data gives no current assurance that the service is sustainable and it seems unlikely that the 22% access and 50% recovery rate in 2019/20 will be achieved without additional investment.

The CCG has asked TEWV to develop a trajectory for when improvements can be seen with the current capacity.

Improving physical healthcare for people living with severe mental illness (SMI) in primary care

An approach to reduce the stark levels of premature mortality for people living with serious mental illness (SMI), who die 15-20 years earlier than the general population is being developed by increasing early detection and expanding access to physical health checks in primary care. SMI refers to all individuals who have received a diagnosis of schizophrenia, personality disorder or bipolar affective disorder, or who have experienced an episode of non-organic psychosis.

Transformation funds have entered all CCGs' baselines to support this work beyond the currently incentivised assessments within the QOF.

CCGs are being asked to report quarterly on health checks in primary care. The new indicator specifies national reporting on a comprehensive physical health assessment; this includes completion of the recommended physical health assessments, follow-up and personalised care planning, engagement and psychosocial support.

The CCG is currently negotiating a payment structure for primary care with the LMC and a suggested model for commissioning.

Primary Care Mental Health Team

The central locality has developed and recruited to a primary care mental health team. Funded through the General Practice Forward View £3 per head funding, the team is made of 5 FTE staff including MH professional, OT, social worker and counsellor.

They provide assessment and treatment of patients with mental illness using a brief intervention model which offers up to 6 sessions with a practitioner. They see people with a range of conditions, for example with a history of mental health problems who would benefit from a brief intervention approach e.g. CBT and practical support and strategies aimed at improving their ability to function and therefore recover. They also make links with secondary services and aim to improve access.

Safeguarding Children

An update was given at February's Quality and Patient Experience Committee about all aspects of the Safeguarding Children Designated team work streams. This included an update on the North Yorkshire, City of York and East Riding Safeguarding Boards, the City of York Joint Targeted Area Inspections (JTAI) – Child Sexual Abuse in the Family Environment action plan, York Teaching Hospital Safeguarding team and Children in care.

Children and Young People

The children and young people's (CYP) senior quality lead is continuing with the review of commissioned services for children and young people who access healthcare and support across the Vale of York. This includes the interface with the healthy child service (Public Health) social care and education. Key areas of focus include:

- Children and Young people's Continence provision
- Short breaks for children and young people with SEND
- Special school Nursing and Community Children's Nursing
- Special Educational Needs and Disability (SEND)
- Wheelchair waits for children and young people

Children and Young people's Continence provision
The QPEC report in December 2018 detailed the multi-agency activity led by the CCG to establish the local need for a level 2 community paediatric continence service. Subsequently the CCG has agreed to fund a specialist practitioner post which will enable YTHFT to implement this provision. A service level agreement has been developed with defined outcomes in line with national standards that can be measured to evidence the effectiveness of the service. The aims of the service are to work within a seamless care pathway between the level 1 service (currently provided by the Healthy Child service) and the level 3 service (YTHFT) with a primary focus to promote continence for new and existing children who rely on containment products. The service level agreement is presently being reviewed with contracting colleagues at the CCG. YTHFT have welcomed this development and are keen to progress. It is hoped the service will be operational in May 2019.

Short breaks for Disabled Children and Young People
There are two elements to the local offer supporting short breaks for disabled children: Community short breaks and residential overnight breaks.

The CCG has led on communications between YTHFT and the City of York Disabled Children's service to develop and implement robust processes for ensuring children and young people are able to access their short breaks and health needs are met safely. This has included:

- A clinical webinar researched and hosted by the CCG to demonstrate a high quality delegation of care competency framework. The system combines an interactive web based training system with face to face teaching by nurses. The framework also clearly defines organisational lines of accountably and is underpinned by strong governance. YTHFT have agreed to purchase this

system and are keen to implement it as soon as possible (March 2019). Coventry and Warwickshire NHS Foundation Trust have developed the Interactive Web system which is widely used by NHS trusts across the UK. There are 38 delegated competencies covered.

- The CCG is directing and affirming the responsibilities of community children's nursing services provided by YTHFT to short breaks as described in the Children and families Act (2014) and SEND Code of Practice (2015). They have now verbally agreed that this is within the regular standards and scope of practice and have been advised by the CCG this will form part of a new service level agreement being developed by the CCG. The model of service delivery will not replicate the old system of a dedicated nurse but will offer a team approach to facilitate a more consistent approach with strengthened governance offering in- reach support to short breaks services when needed. This will also involve complex case management.

- The CCG has set up and chairs a working party with key members from City of York Council and YTHFT to develop protocols around this agenda. A joint policy is recommended to ensure collective governance in the safety, standards and quality of short breaks. This will strengthen integration of services.

- The Senior Quality Lead for Children and Young people will work alongside the deputy director for children's services to review and update job descriptions of carers who undertake delegation of care. This is an essential part of the risk management processes for short breaks.

- The CCG attends and contributes to the discussions and planning around the new centre of excellence in York which is being developed in York. Short breaks are included in this provision when completed.

City if York Council has advised that this work has contributed to a much better than anticipated outcome from a recent CQC inspection of short breaks (December 2018). This outcome is based on areas of development that had already been identified and improvement plans being in place before the inspection

Special School Nursing and Community Children's Nursing

The December 2018 QPEC report gave an overview of a community children's nursing service transformation plan that will be required to ensure the CCG is assured that local health provision for children and young people is delivering high quality care in line with national standards and meeting statutory responsibilities.

The CCG continues to meet with YTHFT who provide these services and engagement is improving with acknowledgment of the need for change. YTHFT have now verbally agreed to work collaboratively with the CCG in the service redesign which is envisaged not to require any financial investment. Instead, the focus will be on the redeployment of resources from areas with little or no impact to be utilised to improve quality and extended provision in other areas. A specific example of this is the redesign of the special school nursing services to offer holistic all year round support to children with complex health needs. This may decrease the need to access GP services and hospital attendances.

A new service specification and service level agreement developed by the CCG will be proposed and early indications from YTHFT are this will be welcomed. Any challenge will be addressed through continued engagement and co-production of the strategy.

Special Education Needs and Disability (SEND)

In addition to the transformation plan with YTHFT which will significantly improve the contribution of health to SEND, the Senior Quality Lead for CYP is now contributing to City of York Council's integrated commissioning group and the YorOK board meetings. These meetings describe the local area needs across health and social care and attempt to adopt collaborative strategic approaches that will examine the viability and potential effectiveness of system wide solutions. Although not exclusively for children and young people it is relevant and essential in ensuring SEND needs are considered when developing strategic direction.

The CCG is in the process of being involved in its first EHCP tribunal, the first hearing is in March 2019 and outcomes will be fed back at a later date.

The Senior Quality Lead for CYP continues to work alongside the children commissioning specialist at the CCG on the SEND agenda

Additional note from the YorOK meeting (January 2019) Public health have been asked to advise the CCG on the sexual health prevention strategies, specifically around rates of Chlamydia.

Wheelchair waits for children and young people

Wheelchair waiting times for children and young people aged 19 and under were a cause for concern in December 2018 with eight children waiting longer than fourteen weeks, four of whom were waiting longer than 18 weeks. On-going liaison with the wheelchair provider has resulted in an improvement in this and figures presented on 25th January 2019 reported the total number of children waiting over fourteen weeks has reduced to two, both of whom are set for completion mid-February. The provider has agreed to inform the CCG if wait times increase again and the Senior Quality lead for CYP will request bi- monthly updates of wait times regardless.

Children and Young People's Mental Health (CYPMH)

The CCG working with all partners across the local area has published its refreshed Local Transformation Plan
(LTP) https://www.valeofyorkccg.nhs.uk/data/uploads/publications/future-in-mind/ltp-2018-submission.pdf : this updates the original plan which runs 2015-2020/2021 and sets out how the local area will deliver the principles and actions set out in Future in Mind, and the 5YFV for Mental Health. From 2019, it will also reflect the NHS 10 year plan. The focus of work in 2018/2019 reflects priorities across the local area and will be

Easier Access to Early Support

- Peri-natal support working with maternity services, health visitors and school nursing services, to ensure that all families receive advice and support for emotional and mental health
- Ensure clarity around offers of support across all agencies
- Ensure that communication and information for families is supportive working with increased involvement of voluntary sector.
- Effective staff training and information to respond
- Mental Health Champions

Specialist Support for Those Who Need It

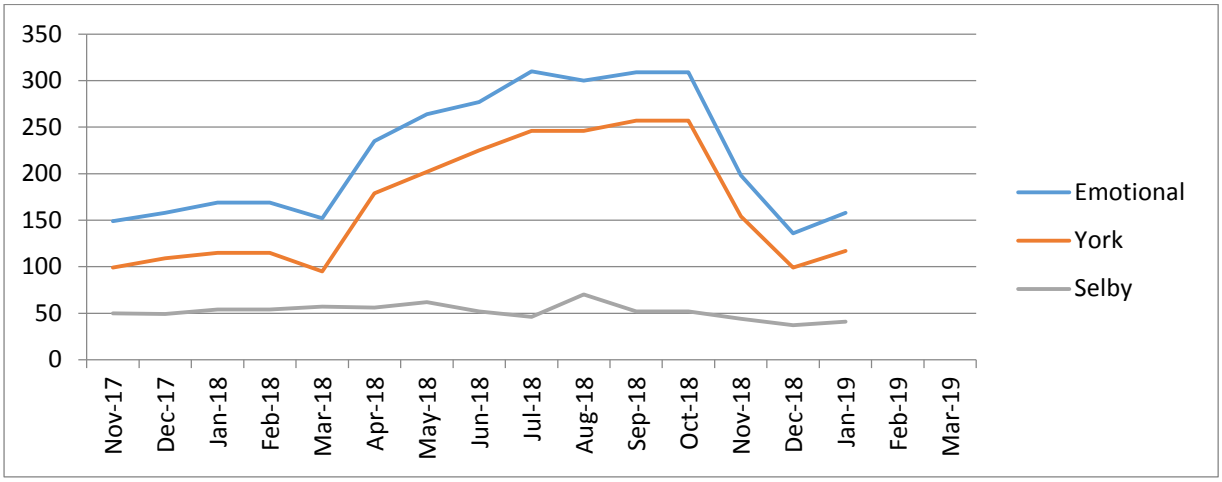
- Ensure support for vulnerable groups of children and young people offers the best possible support: those with complex needs
- Roll out programme of task and finish groups for vulnerable groups
- Developing online support alongside face to face
- Addressing long waiting lists
- Complete roll out of TCP systems and work to ensure robust and joined up pathways of support across all agencies
- Ensuring pathways of support are clear and agencies are working well together

Ensuring Transparency, Joint Commissioning and Partnership Working

- Explore scope of services in future to shape joint commissioning
- Workforce development plan across the area o Strengthening training and awareness for primary care about services for emotional and mental well-being
- Mental Health Data Set: ensure all qualifying serves are able to report activity to establish the true extent of local delivery
- Improved information for primary care

The CCG is awaiting feedback from NHS England on the refreshed LTP; if received by the meeting, it will be shared. The CCG submitted the quarterly update on progress with the LTP, which shows progress against a broad range of actions set out in the LTP. It is expected that NHS England and the Department for Education will expect a continuance of the LTP in some form after 2021, focused on the aims of the NHS 10 year plan, which includes schools based mental health support, improved crisis intervention and support, and increased access to mental health support.

TEWV introduced a revised pathway of support for children and young people on the emotional pathway (including depressions and anxiety) with lower level needs in September/October 2018. This is proving successful in reducing the numbers of children and young people waiting long periods of time for commencement of treatment, through the introduction of group work sessions: group work is now the standard offer to all those accepted onto the emotional pathway for whom this might be suitable intervention. The January 2019 figures show there were 158 children and young people waiting, down from 309 in October 2018 when the new pathway commenced. Anecdotal information from TEWV indicates that a very high number of children and young people do not then require individual 1:2:1 therapy.



Numbers waiting on the emotional pathway to January 2019

The effects of the additional investment into the CYPMH emotional pathway should also start to be seen by end Q4 as the new staff become fully operational: waiting times and numbers should continue to fall, and we will be able to start to report to Committee on the average waiting times for the first time.

However, waiting times for other pathways, such as ADHD and family therapy remain very long and attention now has to be paid to these as well.

Also, waiting times for initial comprehensive assessment continue to be low against target. In December 2018, performance was 59% having an assessment within 9 weeks of referral against a contractual target of 90%. Although low, it was an improvement on the previous couple of months. Of those missing the target, half

(21) were assessed within 10 weeks: we are discussing with TEWV the operation of the pathway to clarify if there are further steps TEWV could take to speed up this appointments for assessments: this improves performance and also reduces waiting time before acceptance onto pathways of support.

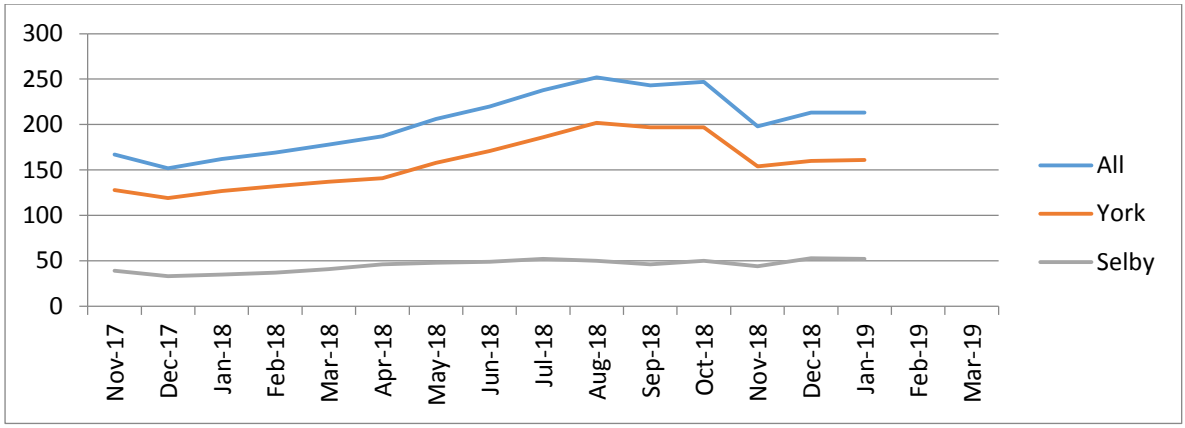
Numbers of children and young people referred into the eating disorder service continue to increase with 69 referrals year to December 2018, with a very high increase in urgent referrals, from 6 in the year to Q3 2017/2018 to 21 to Q3 2018/2019: we are asking TEWV for further details around this increase. However, despite the sharp increase, staff are responding well and 60% overall across both the routine and urgent referral pathways are assessed and start appropriate treatment within the target time, reflecting the very hard work of staff to see patients and start treatment. Those who miss the target are now generally cases where the young person and their family choose to delay assessment or start of treatment. A meeting was held in January, Chaired by Dr Kevin Smith, to consider the way forward for developing an area approach to undertaking physical health checks for those with eating disorders: it was agreed by all parties that Primary Care do have a role in physical monitoring and a shared care agreement would be jointly developed. A full day workshop will be planned for this in Q4/Q1. This will be led by TEWV with key stakeholders involved.

Despite long waiting periods to commence treatment, TEWV's performance is well ahead of the national target for treating children and young people with mental health disorders: to Q3, TEWV treated 42% of those with a diagnosable mental health disorder against the national target for 2018/2019 of 32%. In addition, the School Well-Being Service in City of York will treat a further 300 children and young people during the full year, and this the overall performance for NHS funded services will be in the range of 45%-48%.

Autism assessment and diagnosis

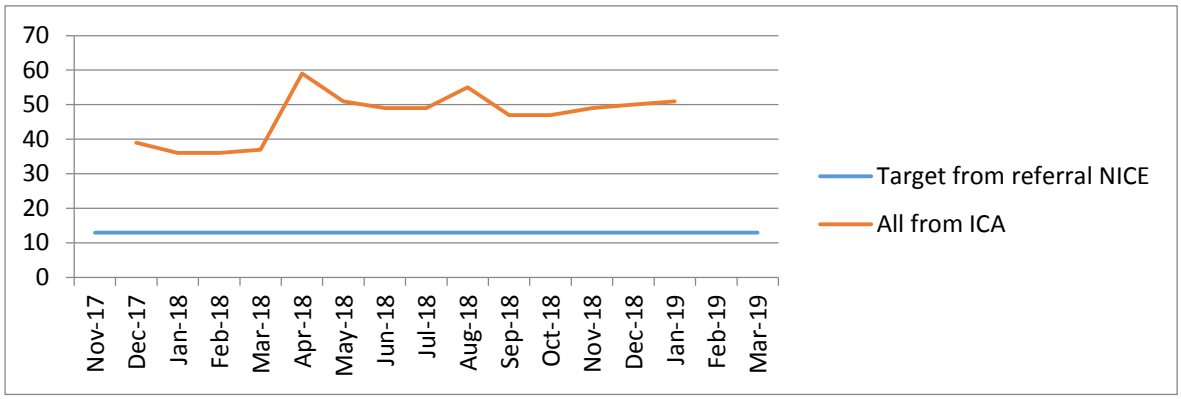
The CCG invested additional non-recurring funds into the assessment and diagnostic service in 2018, and expects around 65 additional assessments by the end of Q4.

However, referrals into service remain high, with 212 for the year to Q3. One result is that despite the additional investment, the number awaiting assessment has increased again, with 213 waiting at the end of December 2018



Numbers waiting for autism assessment

Average waits also remain high, currently at 51 weeks



Average waits for full assessment, following initial assessment

We have been looking at the full pathway for the assessment and diagnostic service, and are investigating the conversion rate: this is the percentage of children and young people diagnosed with autism following full assessment. This figure is 59% year to Q3, and compares unfavourably with other services in the region, which have conversion rates of between 75% and 90%. The indication is that there are assessments which are unnecessary, and that the initial screening or assessment may not be sufficiently robust to filter out these cases. Visits to and discussions with other assessment services in the region have highlighted areas to focus on, including the quality of the screening tools used and the skillset of the staff involved: autism requires specific skills and these require testing against the approach TEWV has for deploying staff to the initial assessment appointment. These issues are being raised with TEWV. We are also discussing with local authority colleagues the gaps in knowledge or approach within schools to respond to special educational needs at an early stage.

We are also reviewing the York pathway with the York Parent Carer Forum: three meetings since October have drawn out a broad range of comments, criticism and praise around the whole pathway across health, social care and most importantly, education. It is not surprising that the key issues relating to health (which here

comprise the assessment and diagnostic process) are the waiting times, lack of communication during the waiting period, and a strong desire for interim advice to help parents manage their children positively. The next stage is a meeting to plan responses and improvements across the local system.

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Vale of York
Clinical Commissioning Group

Item 14

Chair's Report: Executive Committee

Date of Meeting	5 December 2018 2 and 16 January and 6 February 2019
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee has been:

- Taking an overview of service pressures and resilience during the winter period and monitoring any potential impact on the financial position of the CCG.

- Reviewing a number of commissioning statements and issues. These included:

  - Level 2 children's continence
  - Stoma appliances
  - Freestyle Libre
  - Cataracts
  - Shoulder arthroscopic decompression
  - Chronic Fatigue Syndrome

Additionally the Committee has reviewed a number of service areas where assurance was required. These included Dementia and Early Intervention in Psychosis (EIP).

The Committee received the follow-up report to the York system review from the Care Quality Commission and noted that a joint meeting with partners was being arranged to discuss what actions will be required.

The Committee also developed an outline timetable and process for 2019/20 planning with briefings being prepared for the Governing Body ahead of the March 2019 meeting in public.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Finance and Performance Committee

Date of Meeting	20 December 2018 24 January 2019
Chair	David Booker

Areas of note from the Committee Discussion

20 December

- The Committee expressed concern about the apparent lack of accuracy around quality of the data and financial implications in the management of continuing healthcare by NHS Scarborough and Ryedale CCG. NHS Vale of York CCG's Chief Finance Officer was requested to conduct a robust review and report back to the January meeting. NHS England would continue to be appraised of the issues.

24 January

- The Committee notes with regret that, despite verbal commitment to the system planning approach proposed by the CCG given at the multi partner meeting on 15 January, York Teaching Hospital NHS Foundation Trust's initial planning had been prepared on the basis of Payment by Results which resulted in an income expectation of outturn plus c.10% or £23m in the context of the CCG having received £22m total growth for core services. Clearly this represented a serious concern for the system.

- NHS Vale of York CCG will not submit a financial plan to NHS England that it cannot achieve. The CCG has created a reasonable and achievable multi-year financial plan to support full system balance and which addresses some of the service issues the CCG is responsible for resolving.

  An urgent meeting is requested between the CCG's senior staff and the regulator to consider the implications for system balance and regulation.

- The Chair of the Committee and Dr Nigel Wells, CCG Clinical Chair, will write to the Chair of York Teaching Hospital NHS Foundation Trust to express concern at this development.

  The CCG is committed to continuing to work collaboratively with all system partners as required by NHS England.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 16

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	24 February 2019
Chair	Keith Ramsay

Areas of note from the Committee Discussion

The Committee:

- Noted the actions being taken in respect of prescribing budgets.
- Noted the importance of aligning community services with primary care in the NHS Long Term Plan.
- Agreed changes in GP contract payments.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

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Item Number: 17

Name of Presenter: Dr Kevin Smith

Meeting of the Governing Body

Date of meeting: 7 March 2019

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Commissioning Committee Recommendations

Purpose of Report
For Information

Reason for Report

These are the latest recommendations from the Medicines Commissioning Committee – December 2018 and January 2019

Strategic Priority Links

☐Strengthening Primary Care
☐Reducing Demand on System
☐Fully Integrated OOH Care
☐Sustainable acute hospital/ single acute contract
☐Transformed MH/LD/ Complex Care
☐System transformations
☐Financial Sustainability

Local Authority Area

☐CCG Footprint
☐City of York Council
☐East Riding of Yorkshire Council
☐North Yorkshire County Council

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

For information only

CCG Executive Committee have approved these recommendations

Responsible Executive Director and Title	Report Author and Title
Dr Kevin Smith Director of Primary Care and Population Health	Jamal Hussein, Senior Pharmacist Faisal Majothi, Senior Pharmacist

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee December 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA547: Tofacitinib for moderately to severely active ulcerative colitis		Tofacitinib is recommended, within its marketing authorisation, as an option for treating moderately to severely active ulcerative colitis in adults when conventional therapy or a biological agent cannot be tolerated or the disease has responded inadequately or lost response to treatment. It is recommended only if the company provides tofacitinib with the discount agreed in the commercial arrangement.	RED	Estimate 15-20 patients a year across both VoY & ScR CCGs. Tofacitinib = £4900 pa per patient vs £8000-£9000 pa per patient for other biologics. No cost impact to CCGs expected.
NHSE commissioned Technology Appraisals – for noting					
2.	TA545: Gemtuzumab ozogamicin for untreated acute myeloid leukaemia		Gemtuzumab ozogamicin, with daunorubicin and cytarabine, is recommended as an option for untreated de novo CD33-positive acute myeloid leukaemia (AML), except acute promyelocytic leukaemia, in people 15 years and over, only if: • they start induction therapy when either the cytogenetic test confirms that the disease has favourable, intermediate or unknown cytogenetics (that is, because the test was unsuccessful) or when their cytogenetic test results are not yet available and • they start consolidation therapy when their cytogenetic test confirms that the disease has favourable, intermediate or unknown cytogenetics (because the test was unsuccessful) and • the company provides gemtuzumab ozogamicin according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
3.	TA546: Padeliporfin for untreated localised prostate cancer		Padeliporfin is not recommended, within its marketing authorisation, for untreated, unilateral, low-risk prostate cancer in adults.	BLACK	No cost impact to CCGs as NHS England commissioned and NICE did not recommend.
Formulary applications or amendments/pathways/guidelines					

4.	Cannabis Based Medicinal Products (CBPM) for epilepsy or nausea & vomiting caused by chemotherapy	MCC noted the following: Regulations restrict prescribing of cannabis-based products for medicinal use to only those clinicians listed on the Specialist Register of the General Medical Council. Only the following patient groups may be currently considered appropriate for CBPM on a case by case basis (when other treatments weren't suitable or had not helped) and prescribed in line with interim professional guidance from RCP and British Paediatric Neurology Association (BPNA). - Children with rare, severe forms of epilepsy (Epidiolex® - unlicensed is the product recommended by the BPNA. - Adults with vomiting or nausea caused by chemotherapy Any prescribing for these indications should be by secondary care only. General Practitioners are legally not able to prescribe cannabis-based products for patients in primary care. N.B. Cannabis extract (Sativex®) for MS-related muscle spasticity is already listed as BLACK on the formulary as not approved by NICE.	No status at this time as no licensed product available and not routinely commissioned	Assume no cost impact to CCGs as probably NHS England commissioned for Children with rare, severe forms of epilepsy.
5.	Cannabis Based Medicinal Products (CBPM) for pain	Not recommended based on RCP advice and Faculty of Pain Medicine advice and GPs should not refer to secondary care to consider use of CBPM for this indication. See above general comments.	BLACK	No cost impact to CCGs as not recommended at this time.
6.	Pentasa and Salofalk Enemas Formulary Application Salofalk 2g /59mL enema	Agreed to add to formulary with Pentasa as 1st choice as most cost-effective and Salofalk 2nd choice after trial of Pentasa has failed.	GREEN	**Product** | **Monthly secondary** | **Monthly primary**

	Pentasa 1g/100mL enema			<table><tr><td></td><td>**care cost (inc VAT)**</td><td>**care cost (Drug Tariff)**</td></tr><tr><td>Salofalk 2g /59mL enema</td><td>£100 (Hospital contract price)</td><td>£119.68</td></tr><tr><td>Pentasa 1g/100mL enema</td><td>£81.60</td><td>£70.92</td></tr></table>
7.	Haleraids	Agreed to change to RED and update formulary to say not available in Drug Tariff or on NHS Prescription.	RED	No significant cost to CCGs expected as not available for prescribing in Drug Tariff
8.	Kyleena® Long Acting Injectable Contraception	Agreed to approve as GREEN drug as per NYCC Comissioning Position Statement. Kyleena® should only be considered as alternative option to Mirena in women seeking contraception for 5 years and who have post insertion pain with an IUD, or who are found to have physical constraints such as a narrow cervical canal, e.g. following treatment to the cervix such as LLETZ (large loop excision of the transformation zone) that may have caused fibrosis and narrowing of the cervical canal. Patients should be made aware of the relative failure rates with Kyleena® compared to Mirena® as part of making an informed choice about which product is most suitable for them.	GREEN	Kyleena £76 for 5 years cover (£15.20/yr) Mirena £88 for 5 years cover (£17.60/yr) Jaydess £69 for 3 years cover (£23.07/yr) Kyleena would be a more cost effective option in women who wish to have contraception for 5 years and/or for those who require a smaller device.
9.	Naloxegol – clarification on formulary indication	Agreed to update formulary to reflect NICE guidance and approved for use in line with NICE TA 345- naloxegol for treating opioid induced constipation, in those who have not responded to at least 1 full dose laxatives and dietary advice. Previously formulary stated after	GREEN	No significant cost to CCGs expected as no significant changes made.

		at least 2 full dose laxatives.		
10.	Hydroxycarbamide Shared Care Guideline	Update of expired shared care guideline. Clarified that GP should check specialist has done monitoring before issuing prescription.	Amber SCG	No significant cost to CCGs expected as no significant changes made.
11.	Cinnarizine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
12.	Cyclizine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
13.	Haloperidol	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
14.	Levomepromazine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
15.	Prochlorperazine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
16.	Hyoscine Hydrobromide	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
17.	Betahistine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
18.	Ketamine	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
19.	Codeine Phosphate	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
20.	Diamorphine	Agree a RAG status for this formulary drug which currently has no status	Amber SR	No significant cost to CCGs expected as all the proposals are current practice.
21.	Dihydrocodeine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the

				proposals are current practice.
22.	Dipipanone+ cyclizine (Diconal)	Agree a RAG status for this formulary drug which currently has no status	Black	No significant cost to CCGs expected as very little prescribed currently
23.	Meptazinol (Meptid) injection	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
24.	Morphine Sulphate	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
25.	Oxycodone (Injection)	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
26.	Oxycodone (Oral) Immediate Release	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
27.	Oxycodone (Oral) Modified Release	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
28.	Pethidine injection	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
29.	Phenytoin (neuropathic pain)	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
30.	Sodium Valproate (migraine)	Agree a RAG status for this formulary drug which currently has no status	Amber SC (using TEWV SC)	No significant cost to CCGs expected as all the proposals are current practice.
31.	Domperidone	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
32.	Propranolol (migraine)	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
33.	Topiramate	Agree a RAG status for this formulary drug which currently has no status	GREEN	No significant cost to CCGs expected as all the proposals are current practice.

34.	Verapamil (migraine)	Agree a RAG status for this formulary drug which currently has no status	Amber SR (Not on RSS)	No significant cost to CCGs expected as all the proposals are current practice.
35.	Amitriptyline (migraine)	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
36.	Pizotifen (migraine)	Agree a RAG status for this formulary drug which currently has no status	Amber SR	No significant cost to CCGs expected as all the proposals are current practice.
37.	Clonazepam inj (status)	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
38.	Diazepam inj+ rectal (status)	Agree a RAG status for this formulary drug which currently has no status	Red (rectal Green)	No significant cost to CCGs expected as all the proposals are current practice.
39.	Lorazepam inj (status)	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
40.	Amantadine Hydrochloride (Symmetrel)	Agree a RAG status for this formulary drug which currently has no status - PD and unlicensed use for fatigue in multiple sclerosis.	Amber SR	No significant cost to CCGs expected as all the proposals are current practice.
41.	Bupropion Hydrochloride (Zyban)	Agree a RAG status for this formulary drug which currently has no status	Commissioning position in primary care is variable according to the location of the GP practice. York = RED, NYCC = AMBER SR	No significant cost to CCGs expected as all the proposals are current practice.
42.	Nicotine Replacement	Agree a RAG status for this formulary drug which currently has no status	Commissioning position in primary care is variable according to the location of the GP practice. York = RED, NYCC = AMBER SR	No significant cost to CCGs expected as all the proposals are current practice.

43.	Varenicline	Agree a RAG status for this formulary drug which currently has no status	Commissioning position in primary care is variable according to the location of the GP practice. York = RED, NYCC = AMBER SR	No significant cost to CCGs expected as all the proposals are current practice.
44.	Benzylpenicillin inj	Agree a RAG status for this formulary drug which currently has no status	Green (suspected meningitis)	No significant cost to CCGs expected as all the proposals are current practice.
45.	Flucloxacillin	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
46.	Amoxicillin	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
47.	Pivmecillinam	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
48.	Cefalexin	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
49.	Cefotaxime inj	Agree a RAG status for this formulary drug which currently has no status	Green (suspected meningitis)	No significant cost to CCGs expected as all the proposals are current practice.
50.	Ceftazidime inj	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
51.	Ceftriaxone inj	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.
52.	Cefuroxime inj	Agree a RAG status for this formulary drug which currently has no status	Red	No significant cost to CCGs expected as all the proposals are current practice.

53.	Oxytetracycline	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
54.	Azithromycin	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
55.	Clindamycin	Agree a RAG status for this formulary drug which currently has no status	Amber SR	No significant cost to CCGs expected as all the proposals are current practice.
56.	Trimethoprim	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
57.	Nystatin	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
58.	Terbinafine	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
59.	Aciclovir	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
60.	Chloroquine	Agree a RAG status for this formulary drug which currently has no status	RED	No significant cost to CCGs expected as all the proposals are current practice.
61.	Primaquine	Agree a RAG status for this formulary drug which currently has no status	RED	No significant cost to CCGs expected as all the proposals are current practice.
62.	Quinine Sulphate	Agree a RAG status for this formulary drug which currently has no status	RED	No significant cost to CCGs expected as all the proposals are current practice.
63.	Pyrimethamine	Agree a RAG status for this formulary drug which currently has no status	RED	No significant cost to CCGs expected as all the proposals are current practice.
64.	Metronidazole Trichomonacides	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.

65.	Metronidazole Antigiardial drugs	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
66.	Mebendazole	Agree a RAG status for this formulary drug which currently has no status	Green	No significant cost to CCGs expected as all the proposals are current practice.
67.	RMOC Guidance on Lioythyronine	Agreed to add link to guidance in formulary	-	-

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee January 2019

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	Nil				
NHSE commissioned Technology Appraisals – for noting					
2.	TA548: Decitabine for untreated acute myeloid leukaemia (terminated appraisal)		NICE is unable to make a recommendation about the use in the NHS of decitabine for untreated acute myeloid leukaemia because no evidence submission was received from Janssen. The company has confirmed that it does not intend to make a submission because there is unlikely to be sufficient evidence that decitabine is cost-effective use of NHS resources in this population.	BLACK	No cost impact to CCGs as NHS England commissioned and NICE did not recommend.
3.	TA549: Denosumab for preventing skeletal-related events in multiple myeloma (terminated appraisal)		NICE is unable to make a recommendation about the use in the NHS of denosumab for preventing skeletal-related events in multiple myeloma because no evidence submission was received from Amgen. The company has confirmed that it does not intend to make a submission because there is unlikely to be sufficient evidence that denosumab is cost-effective use of NHS resources in this population.	BLACK	No cost impact to CCGs as NHS England commissioned and NICE did not recommend.
4.	TA550: Vandetanib for treating medullary thyroid cancer		Vandetanib is not recommended, within its marketing authorisation, for treating aggressive and symptomatic medullary thyroid cancer in adults with unresectable, locally advanced or metastatic disease.	BLACK	No cost impact to CCGs as NHS England commissioned and NICE did not recommend.
5.	TA551: Lenvatinib for untreated advanced hepatocellular carcinoma		Lenvatinib is recommended as an option for untreated, advanced, unresectable hepatocellular carcinoma in adults, only if: • they have Child–Pugh grade A liver impairment and an ECOG performance status of 0 or 1 and • the company provides it according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.

6.	TA552: Liposomal cytarabine–daunorubicin for untreated acute myeloid leukaemia	Liposomal cytarabine–daunorubicin is recommended, within its marketing authorisation, as an option for untreated therapy-related acute myeloid leukaemia or acute myeloid leukaemia with myelodysplasia-related changes in adults. It is recommended only if the company provides it according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
7.	TA553: Pembrolizumab for adjuvant treatment of resected melanoma with high risk of recurrence	Pembrolizumab is recommended for use within the Cancer Drugs Fund as an option for the adjuvant treatment of stage III melanoma with lymph node involvement in adults who have had complete resection. It is recommended only if the conditions in the managed access agreement for pembrolizumab are followed.	RED	No cost impact to CCGs as NHS England commissioned.
8.	TA554: Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged up to 25 years	Tisagenlecleucel therapy is recommended for use within the Cancer Drugs Fund as an option for treating relapsed or refractory B‑cell acute lymphoblastic leukaemia in people aged up to 25 years, only if the conditions in the managed access agreement are followed.	RED	No cost impact to CCGs as NHS England commissioned.
Formulary applications or amendments/pathways/guidelines				
4.	Tinidazole (amoebicide)	Agree a RAG status for this formulary drug which currently has no status.	AMBER Specialist Recommendation	No significant cost to CCGs expected as all the proposals are current practice.
5.	Diloxanide	Agree a RAG status for this formulary drug which currently has no status. Currently no licensed product available in UK.	RED	No significant cost to CCGs expected as all the proposals are current practice.
6.	Pyrimethamine (Toxoplasmosis)	Agree a RAG status for this formulary drug which currently has no status. Currently no licensed product available in UK.	RED	No significant cost to CCGs expected as all the proposals are current practice.
7.	Spiramycin (Toxoplasmosis)	Agree a RAG status for this formulary drug which currently has no status.	RED	No significant cost to CCGs expected as all the proposals are current practice.
8.	Actipatch®	Agreed to not recommend the use of Actipatch® for management of localised musculoskeletal pain on the NHS. Should patients wish to use the device it can be purchased over the counter.	BLACK	No cost impact as not recommended.

		The group was concerned that the published clinical evidence was not sufficient to demonstrate the product's efficacy, and evidence from high quality randomised controlled trials was lacking. There are no RCTs comparing the efficacy of Actipatch® with other pharmacological or non-pharmacological interventions for localised musculoskeletal pain.		
9.	Erenumab Free of Charge Medicines Scheme	The MCC agreed to recommend that CCGs support the Free of Charge Scheme use of Erenumab in this patient cohort and the CCG will review the commissioning position when a NICE TA is issued. Erenumab would be used in patients with chronic migraine only who have not responded adequately or tolerated at least 3 different preventors, including botulinum toxin. Tight inclusion criteria will include : • Diagnosis of chronic migraine and experiencing 15 or more headache days/month, 8 of which must be migraine. • Age 18 to 65 years old • Medication Overuse Headache will be managed or excluded. • Response will be assessed after 12 weeks These are patients in whom botulinum toxin has not been tolerated or effective and there are currently no further treatment options available to them. The frequency of their headache is debilitating and has a significant detrimental effect on quality of life and ability to work. Exclusion criteria: • Under 18 and over 65 • Pregnant or breastfeeding • Episodic Migraine Erenumab is licensed for the prevention of migraine in in adults who have at least 4 migraine days per month. Therefore the above	RED	No cost impact or financial risk to CCGs at this stage other than political pressure from patients should Erenumab not receive positive NICE TA approval in the future. CCG is making no financial commitment to fund this drug in the future unless positive recommendation NICE TA issued. <u>Positive recommendation NICE TA issued</u> FOC supply will continue until funding arrangements are in place OR 90 days from published NICE TA, whichever is sooner. <u>No NICE TA issued</u> The FOC scheme for existing patients will continue for up to 36 months after 30th Sept 2019 if no NICE guidance has been issued by that date OR when positive guidance is issued, whichever is sooner. No new patients will be permitted to enter the scheme after 30th Sept 2019. <u>Negative NICE TA recommendation</u> Existing patients will continue for up to 36 months from the date of guidance OR if the patient falls outside the final criteria approved by NICE. Approximately 5 new patients per month across both hospital sites until publication of NICE TA or commissioning agreed. At this stage, before the NICE Technology Appraisal (TA) has been issued, the intention

		inclusion criteria are much more restrictive than the licence, pending publication of NICE guidance. NICE TA for botulinum toxin in headache supports the use of botulinum in chronic migraine, defined as headaches on at least 15 days per month of which at least 8 days are with migraine. Eligible patients must sign a form as part of informed consent process acknowledging the provision of drug is via a free of charge access scheme, and future provision of the drug is not guaranteed depending on NICE guidance. The CCG as the responsible commissioner will review the commissioning position when NICE TA is issued. If NICE do not mandate the provision of the drug through a TA the CCGs will consider the appropriateness of continuing to support its provision free of charge or otherwise. As the product is new and not established the MCC expects secondary care clinicians to formally audit the benefits of the drug in patients in whom it is tried to establish greater understanding of its place in therapy and help inform future decisions. (N.B this recommendation is specific to this free of charge scheme only and it should not be expected that all free of charge schemes will be supported). *Post MMC: NICE published on 10.1.2019 its Appraisal consultation document: Erenumab for preventing migraine. In it Erenumab is not recommended for use in the NHS. This appraisal is out for consultation until 31.1.2019 and NICE meets again on 14th Feb 2019.*		would be to limit treatment to the most severely affected until NICE guidance is issued and commissioning agreed. The Specialist Nurse at York has kept a register of all patients receiving botulinum toxin for migraine prophylaxis since the service was established in March 2014. • 309 patients in total included on the register from March 2014 to Dec 2018. • 228 patients have been discharged of which 70 patients were Non-Responders. Reasons for “Non Responders” included a) Pregnancy b) refused further cycles c) DNA 2nd cycle d) less than 30% improvement. • 81 patients currently active having Botox of these 18 have only had 1 cycle

		There is still no expected publication date for the NICE TA. It is important to note that is may not be final NICE guidance. *For people who have had at least 3 previous treatments, the clinical trial evidence shows that erenumab 140 mg works better than best supportive care for preventing chronic migraine. Erenumab 70 mg also works better than best supportive care, but not as well as erenumab 140 mg. For preventing episodic migraine, the 140 mg dosage may work better than best supportive care, but the 70 mg dosage does not. There is no evidence directly comparing erenumab with botulinum toxin type A in chronic migraine or another oral preventive treatment in chronic or episodic migraine. Also, there is uncertainty about whether erenumab works in the long term.* *For chronic migraine, the cost-effectiveness estimates for erenumab are higher than what NICE normally considers acceptable when there is substantial uncertainty. For episodic migraine the estimates are much higher than what NICE considers a cost-effective use of resources. So erenumab is not recommended for preventing chronic or episodic migraine.*		

Vale of York
Clinical Commissioning Group

Item 18.1

Chair's Report: Joint Acute Commissioning Committee

Date of Meeting	24 October 2018
Chair	Simon Cox

Areas of note from the Committee Discussion

Lay Chair

Meeting held to agree recruitment of lay chair for the committee. Agreed that Chair would be on a rotating basis and shared across the three CCGs.

Clinical Reference Vehicle

Clinical oversight group will be shared group between commissioner and provider. This would be developed over the coming weeks.

Aligned Incentives Contract

This would be peer reviewed to see what lessons could be learned and how to progress in the coming months and year.

East Coast Review

Agreed that the committee would have a role over the East Coast Review and that this would be developed, including the governance arrangements, prior to the next committee.

Expert Consulting

Workshop to progress on 21 November 2018. Report back later.

Elective Care

Repatriation plan for orthopaedic short and medium term stays needs to be agreed. Consideration of using PWC days to facilitate this.

A deep-dive on ophthalmology due to take place in December which will be monitored through the performance group under AIC. Quality and Safety group will also monitor this as the clinical risk assessment is still outstanding.

A fifth deep-dive has taken place in relation to dermatology services. A proposal paper has been escalated to System Transformation Board on 22 October and a further paper will be submitted to relevant CCGs to support Dermatologists and two week wait referrals.

Urgent and Emergency Care

A&E Delivery Board has been renamed Health and Care Resilience Board and will be focused on financial recovery and system performance.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

Vale of York
Clinical Commissioning Group

Item 18.2

Chair's Report: Joint Acute Commissioning Committee

Date of Meeting	28 November 2018
Chair	Phillip Hewitson

Areas of note from the Committee Discussion

Clinical Reference Vehicle

This was approved as a clinical vehicle to support the work of the aligned incentives contract approach and the acute system. This would be a small oversight group comprising of the medical and nursing leads from the three CCGs with attendance from the Acute provider. Further consideration needed over who would Chair the meeting and this would be discussed at the first meeting of this group.

East Coast Review

Feedback expected by 29 November 2018 and that four clinical models had been shortlisted.

Agreed that the governance arrangements would be analysed by the Joint Acute Commissioning Committee and recommendations made to the Governing Bodies of each CCG for decision. There would be a single strategy for Quality Impact Assessing and this would be reviewed by finance leads for any potential financial impact to be understood. Communications and Engagement would be led by the Joint Acute Commissioning Committee in due course.

Expert Consulting

The workshop on 21 November 2018 had a good level of attendance and engagement. Work on progressing this would continue and the engagement from primary and secondary care needed to continue to transform the service.

Elective Care

A task and finish group is scheduled for 5 December 2018. PWC will facilitate with the focus being system capacity and waiting time standards. STB will also discuss repatriation at STB on 30 November 2018.

The topic of a virtual fracture clinic was raised and noted that this would require additional investment but clinicians would welcome it. Further quality and safety risk

assessments needed to be undertaken before taking this forward.

The backlog review on ophthalmology clinical risk has been undertaken resulting in a workshop in early December. A deep-dive is due on 5 December and after that a discussion can take place regarding the scoring system for referrals and whether raising the threshold would help manage activity growth for cataracts and glaucoma.

Urgent and Emergency Care

Resilience/Winter Plan almost agreed with York Teaching Hospitals NHS Foundation Trust.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None