Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

5 April 2018, 9.30am to 11.30am

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

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

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 22	Minutes of the meeting held on 8 March 2018	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 23 to 28	Accountable Officer's Report	To Receive	Phil Mettam – Accountable Officer
6.	Pages 29 to 40	Risk Update Report	To Receive	Phil Mettam – Accountable Officer
STRATEGIC – 10.20am				
7.	Pages 41 to 57	Joint Committee for Acute Commissioning		Phil Mettam – Accountable Officer

FINANCE AND PERFORMANCE – 10.30am				
8.	Pages 59 to 73	Financial Performance Report 2017/18 Month 11	To Receive	Tracey Preece – Chief Finance Officer
9.	Pages 75 to 90	Draft Financial Plan 2018/19	To Approve	Tracey Preece – Chief Finance Officer
10.	Pages 91 to 129	Integrated Performance Report Month 10	To Receive	Phil Mettam – Accountable Officer
ASSURANCE – 11.05am				
11.	Pages 131 to 151	Consideration of Director Declarations including 'Going Concern Status' for the 2017/18 Accounts	To Agree	Tracey Preece – Chief Finance Officer
12.	Pages 153 to 182	Health and Safety Policy	To Ratify	Michelle Carrington – Executive Director of Quality and Nursing
RECEIVED ITEMS – 11.20am				
13.	Pages 183 to 209	Executive Committee Minutes: 3 and 17 January, 7 and 21 February 2018		
14.	Pages 211 to 222	Finance and Performance Committee Minutes: 22 February 2018		
15.	Pages 223 to 234	Medicines Commissioning Committee Recommendations: 14 February and 14 March 2018		
NEXT MEETING				
16.	Verbal	9.30am on 3 May 2018 at West Offices, Station Rise, York YO1 6GA	To Note	All

CLOSE – 11.30am
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 rearranged from 1 to 8 March 2018 at Priory Street Centre, York

Present

Keith Ramsay (KR)	Chairman
Dr Louise Barker (LB)	Clinical Director
David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Jenny Brandom (JB) on behalf of Michelle Carrington	Deputy Chief Nurse
Dr Emma Broughton (EB)	Clinical Director
Dr Paula Evans (PE)	GP, Council of Representatives Member
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Andrew Phillips (AP)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health

In Attendance (Non Voting)

Abigail Combes (AC) – for item 6	Head of Legal and Governance
Michèle Saidman (MS)	Executive Assistant

Apologies

Dr Stuart Calder (SC)	GP, Council of Representatives Member
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Shaun O'Connell (SOC)	Joint Medical Director
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Four members of the public attended.

KR referred to the recent death of Professor Alan Maynard, the CCG's first Lay Chair, who had played a significant role locally, nationally and globally in health economics. A minute's silence was held in memory of Alan Maynard's contribution to health services.

The following matters were raised in the public questions allotted time.

1. Chris Mangham

With proposed cuts of over £14m in the 2018/19 CCG budget how are health care services going to improve?

PM responded by referring to the CCG's Commissioning Intentions for 2018/19 at agenda item 7. He explained that these set out the aim of 2018/19 being the start of change in the local health care system characterised by establishing a framework that would contain costs. Growth would be targeted at providing greater access to primary care and mental health services closer to home, identified as priorities through the extensive public engagement events in 2017. The overall intention was to improve all services but to focus on these two areas within the resource restrictions whilst continuing to work with York Teaching Hospital NHS Foundation Trust, which PM noted had recently been re-assessed by the Care Quality Commission as Good in respect of providing responsive care.

In response to Chris Mangham referring to the extensive NHS cuts and concern about greater access to primary care appointments during the week PM explained that all CCGs were required to achieve a level of efficiency in 2018/19 and for NHS Vale of York CCG this was £14m. The CCG had reviewed all services and identified that the greater opportunities were in releasing costs from hospital services to invest in the community. PM noted the challenges associated with achieving the £14m efficiencies in 2018/19 in addition to those in 2017/18 and proposed that a further engagement event be arranged for discussion with members of the public.

AP joined the meeting

2. Steve Smith

How prepared are the CCG for the implementation of GDPR (General Data Protection Regulation)? Have they done work with GP Practices, in particular to cover the loss of income from no longer being able to charge for Subject Access Requests?

KS responded that the CCG, like all public bodies, had been undertaking work relating to the new regulations and noted the associated complexity. The CCG was working with eMBED, including providing staff training. KS expressed confidence in the progress to date.

In terms of GP Practices KS reported on discussions with both the CCG and with NHS England with potential for the roles to be shared.

KS noted that this legislative change was required without any additional funding. However, Practices were developing their action plans and the CCG was working with them in this regard.

Prior to commencing the agenda KR noted that this would have been SP's last Governing Body meeting and expressed appreciation for her contribution to the CCG as Lay Member and Audit Committee Chair. SP was now chairing NHS Harrogate and Rural District CCG's Audit Committee.

KR referred to the redesign of the Governing Body and welcomed Dr Nigel Wells who was in attendance prior to taking up post as Clinical Chair of the CCG from 1 April 2018. KR noted that this was the last meeting for the GP members of the Governing Body and expressed appreciation to LB, EB, SC, PE and SOC noting that a number of them had been in the role from the start of the organisation.

PE joined the meeting

AGENDA

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

As noted above.

PM additionally noted that he would follow up with City of York Council concerns about SS's attendance level at Governing Body meetings.

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 4 January 2018

The minutes of the meeting held on 4 January were agreed.

The Governing Body:

Approved the minutes of the meeting held on 4 January 2018.

4. Matters Arising from the Minutes

Safeguarding Children Annual Report 2015/16: JB reported that the work relating to reviewing capacity requirements for commissioning the children's agenda was ongoing. She additionally noted that MC had responded to a question from a member of the public about focus on children and a prospective report on joint commissioning focusing on children.

Integrated Performance Report - Utilisation Management Review and community bed review: PM reported that a detailed discussion had taken place at the Executive Committee about working more closely with neighbouring CCGs,

including NHS Scarborough and Ryedale CCG, to develop an approach to urgent and unplanned care. This would contribute towards securing the £14m efficiency and development of schemes closer to home that would reduce costs to the system. This would be monitored by the Executive and System Transformation Board.

Accountable Officer's Report - Proposal for review of clinical networks and processes across the organisations within the Sustainability and Transformation Plan footprint: PM referred to the Clinical Chair appointment which would enable opportunities for local clinical networks.

Accountable Officer Report – Rollout of free wi-fi capability to GP Practices: TP reported that the target date of the end of December 2017 had not been met but the project was progressing and would be complete by the end of March 2018.

The Governing Body:

Noted the updates and associated actions.

5. Accountable Officer's Report

Prior to presenting his report PM thanked a number of members for their various contributions. As this was KR's last meeting as Chair of the Governing Body PM expressed appreciation for his significant contribution to the CCG and welcomed the fact that KR was remaining as a Lay Member.

PM reiterated appreciation of SP's work noting in particular that a good Audit Committee Chair was invaluable to a financially challenged organisation. SP was staying on for the two forthcoming Audit Committee meetings to complete the annual accounts process.

In expressing appreciation to LB, EB, SOC and AP for their contributions PM acknowledged the difficulty of a time of transition. He thanked LB, EB, SOC and AP for their work and highlighted the respect for them in the clinical community. PM hoped that they would continue to contribute to the CCG's work.

PM referred to the continuity PE had provided prior to his arrival and noted that the regulators had commended her contribution at that difficult time. PM also expressed appreciation of SC's support. He noted that PE would continue as Chair of the Council of Representatives.

PM presented the report which provided an update on turnaround, legal Directions and the CCG's financial position; strategic issues and planning; Council of Representatives meeting; Better Care Fund update; the Care Quality Commission York Local System Review; York Armed Forces Covenant; NHS England Commissioning Capability Programme; Humber, Coast and Vale Sustainability and Transformation Partnership; Emergency Preparedness, Resilience and Response assurance 2017-18; and national issues. PM's report also paid tribute to Professor Alan Maynard.

PM referred to the CCG's £22.5m deficit forecast financial position for 2017/18 noting the stabilisation in the context of the £23m deficit in 2016/17. He emphasised this achievement as many CCGs locally and nationally had significantly deteriorating financial positions and also the fact that NHS Vale of York CCG had historic debt. However, whilst commending the achievement, PM noted that the deficit would be carried forward in to 2018/19 and the CCG was still in special measures.

PM reported that the legal Directions had been addressed with the exception of the financial position. Discussions were now taking place with the regulator regarding the potential to move out of legal Directions.

PM referred to the requirement for a further £14m of efficiencies in 2018/19 emphasising that clinician to clinician engagement was key to achieving savings across the system. He noted that the draft 2018/19 Financial Plan would be submitted later in the day with a position that was better than for some time.

With regard to the Council of Representatives PE reported that two GP Locality Governing Body representatives had been appointed: Dr Andrew Field for Central Locality and Dr Helena Ebbs for North Locality. A representative for the South Locality was still to be identified. Partner organisations were attending Council of Representatives meetings: a representative from City of York Council and the Macmillan Community Cancer Care Coordinator for North Locality GP Practices had presented at the February meeting. A member of East Riding of Yorkshire Council was attending a future meeting and an invitation had been extended to North Yorkshire County Council.

In respect of the Better Care Fund PM welcomed the fact that the Section 75 Agreement had now been signed with City of York Council. This confirmed pooling of funds for the 2018/19 plan.

PM highlighted recommendations from the Care Quality Commission York Local System Review noting that the report was published on their website. Key messages included the need for the whole system to move towards seven day services and for the improvement in relationships between the CCG and City of York Council to continue. PM reported that a York Place Board, chaired by Mary Weastell, Chief Executive of City of York Council, was being established. This would have cross sector membership with the aim of one plan being developed for the city.

PM welcomed the opportunity to participate in NHS England's Commissioning Capability Programme. He advised that the CCG would work with City of York Council for the programme to strengthen closer working. It would also be used to strengthen closer working with other partners, notably NHS Scarborough and Ryedale CCG.

PM expressed appreciation to Sharron Hegarty, Head of Communications and Media Relations, for the information on a range of national issues. In respect of the NHS Improvement revised Never Events Policy and Framework and updated Never Events list JB advised that this would be implemented from 1 April 2018; reporting would be through the Quality and Patient Experience Committee.

The Governing Body:

Received the Accountable Officer's Report.

STRATEGIC

7. Commissioning Intentions 2018/19

In presenting the CCG's Commissioning Intentions for 2018/19 PM noted that they were consistent with the views expressed by the public at the engagement events in the summer of 2017. The document had been widely circulated, including to partners, provider organisations and the City of York, North Yorkshire and East Riding Health and Wellbeing Boards.

PM explained that the Commissioning Intentions signalled the CCG's commitment to change priorities for the future model of care with prioritisation of primary care and mental health services. He reported that City of York Council was supportive of the move to an asset based model of care in the community with care provided as close to home as possible. PM noted that depending on the ambition of the plan the timescale would be three to ten years.

PM highlighted the potential for capital to be required for General Practice to increase infrastructure to enable them to focus on the frail elderly, urgent care in the community and longer appointments. He explained that at the same time discussions would continue with York Teaching Hospital NHS Foundation Trust to consider the impact of this change and containing of costs on them, not only in York but across their other sites.

PM advised that partner providers, including Tees, Esk and Wear Valleys NHS Foundation Trust, were supportive of this change of approach. He had also been in discussion with the local MPs who were fully supportive of the Commissioning Intentions notwithstanding the challenge of the finite resources.

PM expressed appreciation to Lisa Marriott, Senior Account Manager for New Care Models Programme/Five Year Forward View at NHS England, who had developed the Commissioning Intentions.

DN noted an error relating to dementia diagnosis in primary care. She explained that the CCG's current performance was 60% with the aim of reaching the national target of 66.7% and LB, who had been supporting Practices in this work, emphasised the need for levels to be sustainable. This required clinical time to undertake reviews and carry out duty of care.

Members discussed the refreshed focus on mental health. LB and DN confirmed that Tees, Esk and Wear Valleys NHS Foundation Trust had begun building relationships in the three localities and their priorities aligned with those of the CCG. DN highlighted that this was also in the context of the nurse workforce facing recruitment challenges.

Further discussion included welcoming of the integrated approach but recognition of the need for confidence and trust between partners to achieve transformation and emphasis that providers were required to reduce capacity for the system to succeed in moving services out of hospital into the community. In this regard KS referred to the public engagement and the work to develop an Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust which aimed to take costs out of the system but ensure that the hospital was maintained for patients who required such care. A long term solution for out of hospital care would only be achieved through collaborative working. With particular reference to mental health patients KS highlighted that long term change would enable government funding to focus on this priority. AP and LB additionally noted that data sets were now available to inform improved A and E attendance coding and narrowing of the service gap.

KR referred to the transformation in mental health services in the context of development of the new mental health hospital and also sought clarification regarding community bed provision in the localities. In respect of the latter KS explained that York Teaching Hospital NHS Foundation Trust had undertaken a number of reviews of community beds. As commissioners the CCG was looking to identify most appropriate areas of investment and best use of facilities. GP Practices in Ryedale, South Hambleton and NHS Scarborough and Ryedale CCG were considering working together with regard to facilities and NHS Vale of York CCG was working with Humber NHS Foundation Trust regarding community beds at Malton Hospital. A review with the localities would be undertaken to ascertain services currently provided and service requirements.

In respect of previous concerns relating to children with special education needs and school nursing in York, JB reported that City of York Council was developing a Healthy Child Programme but noted workforce challenges, citing the example that only three school nurses had been transferred across. She highlighted that the CCG's role was to ensure both service provision and improvement through working with both City of York Council and other providers.

PM reiterated that the plan was for a three to ten year timescale and reported that the CCG had been advised recently of national capital funding for which submissions were required in the next few months through the Sustainability and Transformation Partnership. A first assessment was required within a few weeks. PM highlighted the tight timescales to access such allocations in the context of public and clinical engagement being able to influence decisions.

In terms of monitoring implementation KS explained that the Commissioning Intentions would in effect be the financial plan. KR proposed an update on the Commissioning Intentions be provided at the CCG's Annual General Meeting.

The Governing Body:

Ratified the 2018/19 Commissioning Intentions.

8. Joint Committee for Acute Commissioning

PM explained that the proposal to establish a Joint Committee for Acute Commissioning was intrinsically linked with developing a new commissioning and contracting framework with York Teaching Hospital NHS Foundation Trust, namely an Aligned Incentives Contract. If this approach could be established to replace the current payment by results activity based model it would be preferable for their other commissioners, particularly NHS Scarborough and Ryedale CCG, to use the same framework. A single committee to oversee contracts with York Teaching Hospital NHS Foundation Trust was therefore the next logical step.

PM advised that establishment of a joint committee would mean, should the new contracting arrangements be established early in 2018/19, a common contracting framework would be in place with York Teaching Hospital NHS Foundation Trust for NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs. PM assured members that a governance proposal would be presented for consideration by the Governing Body in this event.

The Governing Body:

Noted the proposal to establish a Joint Committee for Acute Commissioning.

FINANCE AND PERFORMANCE

9. Financial Performance Report Month 10

TP highlighted that the forecast outturn of £22.5m deficit was now a straight forecast of the anticipated year-end position noting the two main areas of risk were being managed: firstly, the year-end agreement with York Teaching Hospital NHS Foundation Trust of £195.1m for activity and in settlement of the disputes and challenges; this included a year-end settlement agreement for other main associated commissioners as part of the arrangement. TP reported secondly that a common methodology had been agreed by the four North Yorkshire CCGs for continuing healthcare and mental health out of contract spend. This approach, which was supported by audit, used embedded policies and processes to identify accurate spend. DB noted that Internal Audit had provided assurance at the Audit Committee the previous day that no further major issues had been identified to date relating to continuing healthcare. DN added that she was working closely with the Finance Team advising that backdated claims were still being received but not at the same level as previously.

TP noted that since publication of the report the forecast underlying position had improved from £22.4m to £21.5m deficit. The previous cumulative deficit of between £50m and £60m was now £40m and the position was stabilising not deteriorating.

TP referred to the Financial Recovery Board, a joint forum of NHS Vale of York and NHS Scarborough and Ryedale CCGs, which provided rigorous review of Quality, Innovation, Productivity and Prevention (QIPP) and all requirements to deliver the financial position. Two meetings had taken place and reporting was to the Finance and Performance Committee.

TP highlighted the significant achievement to date of c£8m QIPP which was three times more than 2017/18 delivery. Discussion ensued as to how this had been achieved and whether it could be sustained. Achievement had notably been through optimising health outcomes but also rigorous programme management, appointment of and support from the Turnaround Director, joint working with NHS Scarborough and Ryedale CCG and closer working with York Teaching Hospital NHS Foundation Trust and other partners. An Aligned Incentives Contract would establish services based on cost and value and lower system costs required the CCG QIPP and the York Teaching Hospital NHS Foundation Trust Cost Improvement Programme to be aligned.

TP informed members that she would present the draft Primary Care Direct Commissioning budgets for 2018/19 at the March meeting of the Primary Care Commissioning Committee and the full draft Financial Plan to the April Governing Body, noting that both the Finance and Performance Committee and Governing Body in private had seen the planning assumptions. She advised that the planning guidance had been issued in late February after the finalisation of the Commissioning Intentions but would be incorporated in to the Financial Plan. The figures were currently subject to confirm and challenge.

TP reported that growth money for 2018/19 was now c£12m in light of an additional £3m, however the efficiency target remained. She also explained that the CCG's control total was £14m deficit and, subject to submitting a plan to deliver this and certain criteria, the CCG was permitted to overspend by the £14m and would be able to access sustainability funding at the equivalent level. Work was taking place across the system to reduce costs and close the gap in a more transparent approach than previously. TP noted that a health system meeting, including the regulators, was taking place on 9 March. She also advised that the CCG was required to respond to 10 key questions which she would provide for members.

TP explained that detailed work was taking place on the contractual framework, including risk share arrangements, for presentation to the Governing Body on 5 April. This would include both investments previously agreed for primary care and also investments for the Commissioning Intentions. Setting a plan which delivered the CCG's £14m deficit control total would enable access to £14m for investment.

The Governing Body:

1. Received the Financial Performance Report as at month 10.
2. Noted the update on development of the 2018/19 Financial Plan.

10. Integrated Performance Report Month 9

PM introduced the report which comprised performance headlines, performance summary against all constitutional targets, and programme overviews relating to planned care, unplanned care, mental health, learning disability and complex care, primary care and annexes providing core supporting performance information.

PM noted that the CCG continued to meet the cancer two week wait and cancer 62 day treatment targets, respectively 93% and 85%.

With regard to A and E four hour performance AP reported that a lessons learnt workshop planned by the A and E Delivery Board was being rearranged following postponement due to the recent bad weather.

AP highlighted validated December 2017 information within the report relating to unplanned care noting that calls to NHS 111 and GP out of hours had significantly increased but this had not been reflected in A and E attendances. He noted anecdotally that GPs were reporting a reduction in influenza and respiratory infections and that urgent care centres were reporting extreme pressures. In respect of the latter EB advised that an urgent care dashboard was being developed.

AP reported that Operational Pressures Escalation Levels (OPEL) during the bad weather had affected the four hour target. He also noted other contributory factors included staffing across the system for a number of reasons. AP emphasised however that the system had coped well under extreme pressure and expressed appreciation to front line staff for their dedication.

In respect of the 66.7% target for dementia diagnosis DN highlighted that, although diagnosis was recorded on GP systems, achievement required support from the whole system in terms of diagnosis, support, review and care. She noted that the NHS England Intensive Support Team had reviewed the pathway and a system approach was being adopted to address the gaps through an action plan that was “owned” by City of York Council and Tees, Esk and Wear Valleys NHS Foundation Trust and the CCG. DN explained that LB was providing direct support to Practices to increase coding but further support was required. She also highlighted that market capacity for care homes for dementia placements was challenging. DN advised that she felt assured about the progress toward improving dementia diagnosis rate but reiterated the need for a whole system approach. She also noted that Caroline Alexander, Assistant Director of Delivery and Performance, was reviewing the performance indicators to inform and enable clinical conversations. LB added that there was a need for education noting that each Practice now had a Dementia Champion and KS, recognising this, highlighted the need for a longer term solution in General Practice..

DN reported that the latest data for Improving Access to Psychological Therapies performance showed improvement. She reminded the Governing Body that the CCG had agreed an outturn of 15% with Tees, Esk and Wear Valleys NHS Foundation Trust for 2017/18 as opposed to the performance target of 16.8% This was as a result of the CCG recognising the need to adjust due to the work required when Tees, Esk and Wear Valleys NHS Foundation Trust was awarded the contract. DN advised that they had expressed confidence that the 15% target would be achieved by 31 March 2018. She noted that the NHS England Intensive Support Team was also providing assistance in respect of Improving Access to Psychological Therapies and had recognised the need for the system to be redesigned. The backlog was reducing through a sub-contracting

arrangement but there was a national shortage of workforce with this skill set. DN also highlighted that the performance target for 2018/19 had increased significantly to 19% therefore consideration was required from the financial and clinical workforce perspectives as to how this could be achieved.

In terms of Child and Adolescent Mental Health Services DN reported that the CCG was working closely with Tees, Esk and Wear Valleys NHS Foundation Trust and seeking more granular information for numbers of referrals, waiting times for triage and waiting times for first appointments. DN referred to a CCG Quality Visit to these services and asked LB to give her clinical view of the visit. LB outlined that the services were good but waiting times and pressures on staff were a concern in such as the eating disorders service. She noted positive clinical quality visits to Lime Trees and the Child and Adolescent Mental Health Service in Selby and the innovative work in establishing the Single Point of Access to address challenges.

DN explained that the two continuing healthcare indicators which were subject to close monitoring were the number of acute Decision Support Tools undertaken in hospital, as these patients would be unlikely to be ready to have their longer term care needs assessed at this stage. DN explained that a pilot scheme was running until 31 March 2018 whereby two continuing healthcare nurses had worked with the York Teaching Hospital NHS Foundation Trust Discharge Support Team on Discharge to Assess and completion of Decision Support Tool in 28 days. This had been successful partnership working with the social work team which was being evaluated with a view to a proposal for continuation being presented to the Executive Committee. DN noted that Decision Support Tools would continue in hospital for such as cases of advanced dementia where a 28 day placement followed by a further move may not be appropriate. DN advised that, although NHS England had required an action plan, she was assured by the progress in this indicator.

DN noted that performance was also monitored against the target of 28 days from referral to Decision Support Tool with a requirement of 80% being achieved by 31 March 2018. She advised that this was improving but that patients were currently being tracked manually due to system issues following the transition from the Partnership Commissioning Unit to the CCG. Work was taking place with the Business Intelligence team to address this with a new system however the transfer of data would be required.

TP referred to the slight drop in 18 week referral to treatment performance in December due mainly to cancellation of elective activity and the local and national winter plans. This, together with the CCG's agreement with York Teaching Hospital NHS Foundation Trust to manage emergency activity, plus the impact of influenza, bed closures and ringfencing of beds, had resulted in a further drop in January. TP reported that, following the stocktake of the elective care activity, a draft plan had been developed in line with the new guidance. This required the waiting list at the start of 2018/19 to be maintained throughout the year.

PM highlighted the need to focus on financial recovery and stability, meeting constitutional standards and patient safety and commended the progress.

The Governing Body:

Received the Integrated Performance Report as at month 9.

STANDING ITEMS CONTINUED

AC joined the meeting

6. Risk Update Report

In presenting the Risk Update Report AC referred to the new arrangements whereby risks were being reported to, and managed by, the Finance and Performance Committee and Quality and Patient Experience Committee with escalation to the Governing Body where required.

AC reported that following the Quality and Patient Experience Committee on 8 February, the Quality Team had reviewed the risks, as referred to in the report. There were no risks that required escalation to the Governing Body.

AC highlighted that the five corporate risks detailed as events under the January Governing Body Risk Report had been de-escalated to managed risks. She noted that the risk identified during December relating to the multi-specialty bed provision in the Ryedale area had materialised and was being reviewed by the Finance and Performance Committee.

AC sought and received permission to undertake a review of the corporate risks with the operational leads to identify whether they could be de-escalated and managed elsewhere rather than via the Governing Body.

In response to KR referring to concern expressed at the Finance and Performance Committee relating to the anti- coagulation service, KS explained that the risk had related to the service model in place. Work was taking place to ensure continuation of the service in Practices where it was provided through offering increased funding and to identify a default provider for patients of Practices who did not provide the service. KS confirmed that managers of the hospital based service were supportive of the plan to move the service to the community but this would take time. The issue was the point at which during the transition the hospital service became unviable.

The Governing Body:

1. Received the Risk Update Report.
2. Noted that AC would review the corporate risks with the operational leads to identify whether they could be de-escalated and managed elsewhere.

ASSURANCE

11. Standard Operating Procedure for the Approval of Commissioning Thresholds

In SOC's absence KR referred to discussion of this item at the Part II Governing Body meeting in January.

PM expressed appreciation to SOC for his work in developing the Standard Operating Procedure for approval of commissioning thresholds.

The Governing Body:

1. Formally approved the governance process as proposed.
2. Delegated authority to the Executive Committee, for them to decide commissioning thresholds on behalf of the Governing Body. Exception to this would be where Executive Committee felt that there were significant financial/political/public interest/reputational risks to implementing a policy they would pass approval to Governing Body for the decision.

12. Quality and Patient Experience Report

JB 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.

JB highlighted the Yorkshire and the Humber General Practice Nursing Awards which had taken place on 5 March. She commended the achievements of Practice Nurses from the CCG who had won 10 of the 24 awards.

With regard to children in care JB reported that the Designated Nurse Safeguarding Children was working closely with a private provider in North Yorkshire in response to concerns that child sexual exploitation support training for staff working with young people thought to be at risk did not appear to be taking place although the provider promoted the home as a specialist therapeutic environment for such young people. The Named Nurse for Looked After Children, employed by Harrogate and District NHS Foundation Trust, also continued to provide support. JB also highlighted that the Designated Professionals were developing a more detailed reporting system regarding health assessments for children in care which would provide greater assurance. Reporting would be through the Quality and Patient Experience Committee.

JB reported that City of York Council had served notice on their contribution to the shared Harrogate District Foundation Trust Community Infection and Prevention Control service hosted by Harrogate and Rural District CCG from

1 April 2018. This carried significant risk to the on-going management and support of infection prevention and control outbreaks across care homes within the City of York Council boundary and had the potential to adversely affect patient outcomes as well as increased hospital admissions. JB explained that the service specification had already been revised before this decision was known and highlighted the risk it posed to de-stabilising the shared contract.

In response to JB noting that infection prevention and control was not a statutory function for the Local Authority, discussion ensued in the context that there was certainly both a moral and accountability issue and a need for transparency in terms of the funding. In addition to this being a safety risk it was a reputational risk for the CCG. KS additionally noted concern that City of York Council did not provide funding for tuberculosis prevention in the community. PM and KS agreed to formally escalate the Governing Body's concerns to the City of York Council Corporate Director as a matter of urgency noting the potential consequences for care homes, member Practices and our population.

In response to EB expressing concerns about 2018/19 planning for influenza vaccination, KS explained the national decision and assurance that supplies would be available. The CCG would provide updates to General Practice, including in respect of national guidance.

JB noted that whilst norovirus had remained a continued presence both in York Teaching Hospital NHS Foundation Trust and in the community the number of community outbreaks across the Vale of York to date had been lower than in 2016/17. She also referred to the increased incidence of influenza noting challenges for the provider in terms of cohorting strains and resultant bed closures. The vaccination programme had however gone well and the CCG was working with General Practice to understand where further support should be offered. JB also noted increased uptake of influenza vaccination in pregnancy.

In respect of Serious Incidents and the four Never Events at York Teaching Hospital NHS Foundation Trust JB reported that detailed discussion had taken place at the Quality and Patient Experience Committee to seek assurance that learning was embedded to avoid recurrence. She also advised that MC and the Chief Nurses from NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs had met with the York Teaching Hospital NHS Foundation Trust Associate Medical Director. Ongoing work included: the potential to undertake detailed clinical visits, particularly across theatres; review of audit data, particularly relating to the World Health Organisation safer surgery check list; and requesting York Teaching Hospital NHS Foundation Trust's Never Event internal audit report which they had not yet shared. Members discussed further concerns about this information and noted the potential, in view of the Governing Body redesign, for progress to be made through clinician to clinician discussions.

JB referred to the quality visits to Tees, Esk and Wear Valleys NHS Foundation Trust, as discussed at item 10 above, noted the Patient Engagement Team

support and the introduction of patient stories at the Quality and Patient Experience Committee. She noted the regulatory inspection assurance advising that the report to the next Quality and Patient Experience Committee would detail the outcome and actions of the Care Quality Commission's Inspection Report on York Teaching Hospital NHS Foundation Trust which provided an assessment of 'Requires Improvement' across the whole organisation. In conclusion JB also highlighted the Care Homes Work Plan for 2018/19 commending the ongoing work in this sector.

The Governing Body:

1. Received the Quality and Patient Experience Report.
2. Noted that PM and KS would formally raise concerns with City of York Council in respect of infection prevention and control provision.

14. North Yorkshire Safeguarding Adults Board – Annual Report 2016/17

JB noted the need for consideration of the sequential reporting of the Safeguarding Adults and Safeguarding Children Annual Reports presented to the Governing Body for information.

The Governing Body:

Received the North Yorkshire Safeguarding Adults Board – Annual Report 2016/17.

13. NHS Vale of York CCG Personal Health Budgets Policy

In presenting the report which sought to address the CCG's requirement to increase the number of people holding a Personal Health Budget in accordance with NHS England's commitment, DN emphasised the benefits of this approach, with particular reference to some long term conditions and noted that it also supported the Commissioning Intentions. Following the dissolution of the Partnership Commissioning Unit, the CCG was now responsible for Personal Health Budgets. DN was proposing that the policy be approved for a six month period as the existing arrangements were currently being reviewed.

DN advised that the policy would be managed by Sarah Kocinski, Commissioning and Transformation Manager, supported by a Registered Nurse with continuing healthcare experience.

The Governing Body:

Approved the Personal Health Budgets Policy for six months.

RECEIVED ITEMS

The Governing Body noted the following items as received:

Unconfirmed Minutes

15. Executive Committee Minutes of 6 and 20 December 2017.

16. Finance and Performance Committee Minutes of 21 December 2017 and 25 January 2018.

17. Primary Care Commissioning Committee Minutes of 24 January 2018.

18. Quality and Patient Experience Committee Minutes of 14 December 2017 and 8 February 2018.

19. Medicines Commissioning Committee of 13 December 2017 and 10 January 2018.

20. Next Meeting

In referring to the date of the next meeting KR advised that NW would be on holiday and that the deputy within the CCG Constitution was the Audit Committee Chair, who was not available. Referring to his own and DB's conflict of interest KR sought and received approval from the other Governing Body members for a Lay Member to act as chair at the April meeting. This was an interim arrangement pending recruitment of a new Audit Committee Chair for which the advertisement had now been published.

The Governing Body:

1. Noted that the next meeting would be held at 9.30am on 5 April 2018 at West Offices, Station Rise, York YO1 6GA and would be chaired by either DB or KR in NW's absence.
2. Agreed that either KR or DB would act as chair for the meeting on an interim basis pending recruitment of a new Audit Committee Chair.

Follow Up Actions

The actions required as detailed above in these minutes are attached at Appendix A.

A glossary of commonly used terms is available at:

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

Appendix A

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 8 MARCH 2018 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
2 February 2017	Safeguarding Children Annual Report 2015-16	• Consideration as to whether the Governing Body had an appropriate level of focus, particularly in terms of clinical capacity, on work relating to children and young people	MC	Ongoing
7 September 2017		• Review of capacity requirements for commissioning the children's agenda was ongoing	MC	Ongoing
4 January 2018		• Capacity to be informed by the 2016/17 Designated Professionals for Safeguarding Children Annual Report	MC	Ongoing
8 March 2018				Ongoing

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
4 January 2018	Accountable Officer Report	• Confirmation to be provided as to whether the end of December 2017 target date for the rollout of free wi-fi capability to GP Practices had been achieved	TP	31 March 2018
4 January 2018	Integrated Performance Report Month 8	• Proposal for a revised Governing Body committee structure to be developed	AC	
8 March 2018	Apologies	• Concerns about SS's attendance level at Governing Body meetings to be followed up with City of York Council	PM	
8 March 2018	Risk Update Report	• Corporate risks to be reviewed with the operational leads to identify whether they could be de-escalated and managed elsewhere	AC	
8 March 2018	Quality and Patient Experience Report	• Concerns to be formally raised with City of York Council in respect of infection prevention and control provision	PM/KS	Letter to SS sent 20 March 2018

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 5 April 2018

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 which have taken place since the last Governing Body meeting and any associated, 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: 5 APRIL 2018

Accountable Officer's Report

1. Turnaround, Legal Directions and the CCG's Financial Position

1.1 The CCG has now agreed with NHS England the process and timescales for exiting Legal Directions and Special Measures, acknowledging formally the progress the organisation has made over the past 12 months, notably in terms of the organisational leadership and effectiveness and the stabilisation of its financial position. The proposed timeline for exiting Legal Directions is the end of quarter 2 in 2018-19 and exiting Special Measures by the end of quarter 3. These are subject to the submission and assurance of an Operational and Financial Plan for 2018-19 which meets the financial control total for the CCG and the national planning requirements.

1.2 The audit report for quality assurance for the CCG also reported 'Significant Assurance' providing further validation of the strong delivery, governance and assurance processes now in place at the CCG.

1.3 The CCG has now agreed all its 2018-19 contracts with all providers in line with national planning deadlines.

1.4 The joint system recovery programme will be established by 30 April 2018 through the Aligned Incentive Contract [AIC] framework and will capture all priority pieces of work required to deliver the transformation of acute care in the Vale of York / Scarborough and Ryedale system from 2018-19 onwards.

2. Strategic issues and planning

2.1 The CCG continues to work with all partners to agree a fully aligned set of activity plans with providers which will deliver the financial and performance recovery targets required to bring the system back into balance. The final activity, financial and operational plans, including the 2018-19 Winter Plan will be submitted to NHS England on 30 April.

2.2 The refreshed 2018-19 Operational Plan will be presented to the Executive Committee for its approval on behalf of the Governing Body in April 2018. It will be presented to the Governing Body in May 2018.

3. Council of Representatives meeting

3.1 Among the agenda items at the meeting on 15 March 2018, members received the Accountable Officer's briefing and presentation regarding updates to the CCG's Constitution.

3.2 Members also received an update on work to re-set the CCG Governing Body and ratified the appointment of three GP members to represent the population and practices in the North, South and Central localities of the Vale of York.

4. Better Care Fund update

4.1 The City of York Better Care Fund Performance and Delivery Group has continued to develop the local approach to governance and assurance, integration and addressing delayed transfers of care.

4.2 Plans to improve seven day working and weekend discharges have been mobilised following the grant of additional financial resources by NHS England.

4.3 Completion of the Better Care Fund return for quarter 4 is underway and will be submitted by the deadline of 20 April 2018.

5. Emergency Preparedness, Resilience and Response

5.1 Winter pressures continued to impact on performance and bed capacity at York Teaching Hospital NHS Foundation Trust (YTHFT) throughout February and March 2018. Ward 23 at York Hospital was designated as a flu ward, and a number of routine operations had to be cancelled due to high bed occupancy. Throughout this period YTHFT frequently reported OPEL level 3 – Severe Pressure. To help expedite patient discharges and issue regular updates to primary care and other partners, the CCG participated in daily system conference calls and attended operations meetings with YTHFT on the days when the system was particularly under severe pressure.

5.2 The CCG's on-call director rota has been finalised for the Easter period. Due to upcoming changes in the Executive Team, and to ensure that the CCG has robust director level on call cover, the governance arrangements and on-call rota is currently under review.

5.3 Members of staff have participated in a recent Counter Terrorism Event facilitated by City of York Council and represented the CCG at the North Yorkshire and Humber Health Sub-Group. .

6. National issues

6.1 NHS England and NHS Improvement have announced its steps to bring the two organisations closer together. Subject to each boards' approval of more detailed proposals, the organisations will begin to establish new working arrangements from September 2018. These include increased integration and alignment of national programmes and activities – one team where possible, the integration of NHS England and NHS Improvement regional teams, to be led in each case by one regional director working for both organisations, and

a move to seven regional teams to underpin this new approach. A more joined-up approach will:

- enable more effective working,
- break down traditional boundaries between different parts of the NHS and between health and social care,
- set clear, consistent expectations for providers, commissioners and local health systems
- use NHS England and NHS Improvement's collective resources more effectively and efficiently to support local health systems and the patients they serve,
- remove unnecessary duplication and improve the impact of work,
- deliver more for the NHS together than by working separately.

6.2 The General Data Protection Regulation (GDPR) is set to replace the existing Data Protection Act on 25 May 2018. It will require all organisations, which process personal data to meet higher data protection standards. Some of the new requirements of GDPR will be appointing a data protection officer, the ability to demonstrate that you are complying with the new law and higher penalties for those not following the rules.

6.3 NHS RightCare has produced a call to action video with former National Medical Director Professor Sir Bruce Keogh to address sepsis. This video calls for all commissioners, clinicians and health economies in England to come together to address and reduce the variation found in the care of sepsis for all patients with the aim of improving outcomes and quality of life. In spring 2018, NHS RightCare will publish a full scenario detailing a sub-optimal, but realistic, care pathway against an optimal pathway and the measures that can be applied to improve identification, treatment and outcomes.

6.4 The case for accelerating the spread of integrated care, as a clear priority for all working in health and care, is set out in evidence submitted by NHS England and NHS Improvement, to the Health Select Committee inquiry on integrated care. The progress in joining up health and care is highlighted with examples of improvements by health and care partnerships working closely with patients, local communities, local government and frontline staff. The evidence has been published on the Parliamentary website

6.5 Significant changes in the understanding of public health and the potential for public health teams to broaden their reach in tackling the social determinants of health are at the heart of a new report by the Local Government Association. The Public Health Transformation Five Years On documentation includes eight case studies on the wide range of ways public health is transforming how it operates. The LGA has also produced a series of 'must know' guides on integrated care for leaders of adult social care.

6.6 NHS England, Diabetes UK and Public Health England are launching their first Diabetes Prevention Week this April. The campaign, which runs from 16 to 22 April 2018, aims to raise awareness of Type 2 diabetes, how to prevent it, associated complications and at-risk groups - as well as inform the public about the Healthier You: NHS Diabetes Prevention Programme.

6.7 The Standard Contract for 2017-19 requires the full use of the NHS e-Referral Service (e-RS) for all consultant-led first outpatient referrals. From 1 October 2018, providers will no longer be paid for activity from referrals not made through e-RS. Across the NHS, local organisations are working collaboratively to ensure this is achieved. A range of resources are available to help trusts switch off paper referrals.

6.8 The NHS Standard Contract was updated in January 2018 to update the Contract in line with legislative and policy changes. With the General Data Protection Regulation (GDPR) coming into force on 25 May 2018, a further National Variation is now required. NHS England has now published, for consultation, proposals for in-year National Variations to the NHS Standard Contract 2017-18 and 2018-19.

6.9 The General Practice Forward View committed to more than £100m of investment to support an extra 1,500 clinical pharmacists to work in general practice by 2020-21. Over 580 clinical pharmacists are already working in general practice and to date NHS England has approved funding to increase to 1,170 clinical pharmacists across 3,229 GP practices. NHS England has invited CCGs, GP practices and other providers of primary care medical services to apply for funding on an ongoing basis to help recruit, train and develop more clinical pharmacists.

6.10 The Minister for Safeguarding and Vulnerability has launched a Trusted Relationships Fund (£13m over four years), targeted at vulnerable young people between the ages of 10-17 years old at risk of community based exploitation and abuse. Local authorities are asked to bid in partnership with health organisations and other public sector groups with expertise in protecting young people from abuse and exploitation, including local health organisations.

6.11 Revised national guidance on prescribing responsibilities across primary and secondary/tertiary care has been published. Developed by a stakeholder-led Task and Finish Group chaired by Dr Keith Ridge, Chief Pharmaceutical Officer for England, this new guidance supersedes the previous guidance (EL (91) 127), last published in 1991. This person-centred guidance aims to provide clarity on the responsibilities of all professionals involved in commissioning and prescribing across primary, secondary and tertiary care,

and to provide support in developing shared care agreements and in the transfer of care; thus ensuring the best quality of care for patients.

6.12 The Department of Health and Social Care has announced the NHS-funded nursing care standard rate is being increased to £158.16 from 1 April 2018.

6.13 NHS England is helping to kick-start preparations for Experience of Care Week, an international initiative, which this year runs from 23 to 27 April, to celebrate the work that is happening across health and social care to keep improving experiences of care for patients, families, carers and staff.

6.14 The 2017-18 Statement of Requirements which sets out the steps for health and care organisations to take to demonstrate implementation of the 10 National Data Security Standards recommended by Dame Fiona Caldicott (National Data Guardian), is now available. CCGs, as NHS organisations responsible for their corporate IT services, must comply with the requirements. As commissioners of GP IT services, CCGs must ensure commissioned GP IT providers are contractually required to comply with these requirements.

6.15 Hard Truths, the government's response to the 2013 Francis Inquiry and The Clwyd-Hart Review, identified a need for a standardised way of assessing complainants' experiences. Working with Picker, the Parliamentary and Health Service Ombudsman (PHSO) and providers, NHS England has developed a standardised survey and toolkit. They aim to track the quality of complaints handling, as set out in the PHSO `My Expectations', support organisations to survey complainants experience and support improvements to local systems and complaints handling.

7. Recommendation

7.1 The Governing Body is asked to note the report.

Item Number: 6

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 5 April 2018

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.

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 emerging risks have been escalated to Governing Body

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	Pennie Furneaux, Risk and Assurance Manager

Annexes

Annex A: Events
Annex B: Corporate Risk Register March 2018

GOVERNING BODY

RISK UPDATE REPORT

5 APRIL 2018

1. CCG IMPROVEMENT AND ASSESSMENT FRAMEWORK PERFORMANCE

1.1. The previous IAF Dashboard was published on the 1st February2018 and related to Quarter 2 2017/18.

1.2. An updated dashboard is pending publication.

2. CORPORATE EVENTS

2.1 One risk has materialised as an event during March 2018 and escalated to Governing Body as follows:

- The CCG has failed to achieve a 1% surplus as required by NHS England. (Commissioners are required to hold back 1% of their income in a risk reserve to help balance overspends elsewhere in the NHS.) The CCG is therefore has no access to draw-down funds for non-recurring expenditure in 2018/19 and is required to submit a financial recovery plan.

2.2 A full update is provided at **Annex A**

3. CORPORATE RISK UPDATE REPORT

3.2. Risks are managed through the CCG's risk registers which are monitored in line with the CCG's Risk Management Strategy and Policy. Risks are reviewed, as a minimum, on a monthly basis.

Profile of Corporate Risks Escalated to Governing Body as at 15th March 2018

3.3. The current corporate risk heat profile is provided on the next page and risks are rated according to the perceived impact and likelihood of occurrence, the CCG operates the NHS standard 5 by 5 risk matrix.

Vale of York CCG Risk Matrix					
	Probability				
Impact	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

- Amber – high risk
- Red – extreme risk

3.4. The CCG's Governing Body has agreed a risk appetite approach which refers to tolerance in the following four categories:-

- Safety risk – The risk that the CCG will not be able to deliver services which are safe for patients.
- Compliance risk – The risk that the CCG will not comply with the requirements of legislation and regulation including the NHS Constitution.
- Financial risk – The risk that the CCG fails to operate within its allocation and therefore operate in deficit.
- Service Delivery risk – The risk that the CCG is unable to deliver services to patients and is linked to the risks above.

3.5. The Governing Body agreed the CCG's approach to risk at the January 2018 meeting of the Governing Body, this is summarised below:

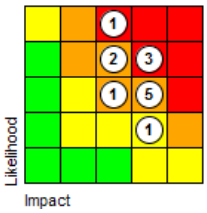
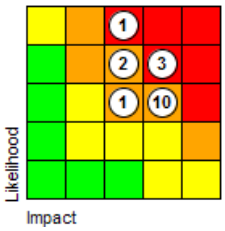
	Finance	**Compliance**	**Safety**	**Service delivery**
Averse	Minor loss < £1000	Trivial, very short term single non-compliance	Insignificant injury (no intervention)	Negligible impact/unnoticed by service users
Cautious	Small loss £1,001-£10,000	Small, single short-term non compliance	Minor injury (local intervention)	Small impact/small inconvenience
Moderate	Moderate loss £10,001 - £100,000	Sustained single or a few short-term non-compliances	Moderate injury (professional intervention)	Medium level impact/moderate inconvenience
Open	Significant loss £100,001 - £1,000,000	Multiple sustained non-compliances	Major injury (hospital stay)	Significant impact/serious inconvenience
Hungry	Substantial loss > £1,000,000	Multiple, long-term, significant non-compliances	Fatal injury	Substantial/complete service failure

3.3 The CCG's current corporate risk profile is detailed below; there is no change in position since the last meeting in respect of "red" risks.

3.4 Four risks have been de-escalated from Governing Body monitoring as follows:

- Development of CCG General Practice Strategy & Vision; due to being managed to within accepted risk tolerances
- General Practice capacity. The CCG's focus now is on supporting localities and services. (Risk no longer applicable and archived.)
- Estates management risk has been fully scoped under Risk Ref: PRC.PROGRAMME.05 Estates and Technology Transformation Fund Strategy and is managed and monitored by Finance and Performance Committee.
- CCG may failure to retain key staff to ensure continuity and system-wide stability.(Improvements noted in sickness absence and vacancy rates. Risk mitigated to accepted tolerance level and reviewed by Finance and Performance Committee)

3.5 Full details of all corporate risks escalated to Governing Body for consideration are detailed at **Annex B**

Current Profile		**Profile at last meeting**	
	**Headline Red Risks:** • Delivery of QIPP schemes • Maintaining expenditure within allocation • Delivering the Local Digital Roadmap agenda • Failure to meet the Planned Care 18 Referral to Treat target		**Headline Red Risks:** • Delivery of QIPP schemes • Maintaining expenditure within allocation • Delivering the Local Digital Roadmap agenda • Failure to meet the Planned Care 18 Referral to Treat target

CORPORATE EVENTS

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
ES.17 There is a potential risk that the CCG will fail to deliver a 1% surplus. NHS England requires commissioners to hold back 1% of their income in a risk reserve to help balance overspends elsewhere in the NHS.	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.	Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	The CCG is implementing the transformational programmes identified as part of its MTFS laying the foundations for the delivery in future years with effect from 1st April 2018. This process has been supported by the internal confirm and challenge sessions for each work stream area and the high-level plans have been shared with York Teaching Hospital NHS Foundation Trust. The CCG continues to work with the hospital and Scarborough and Ryedale CCG to build on the aligned incentives principles that have been agreed. There is now a clear reconciliation of the system plans and the gap is clearly understood by all partners. A detailed joint cost reduction programme of work now needs to be completed in order to jointly agree how the system gap will be closed.	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		28-Mar-2018

CORPORATE RISK REGISTER 2017/18

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
ES.01 There is a potential risk that identified QIPP schemes and transformational programmes of work may fail to deliver quantified savings	The CCG QIPP plan and targets for 17/18 are complex and challenging. The national QIPP support programme report (confirmed at the Q4 16/17 assurance meeting with NHSE) as the most challenged QIPP programme in England. Unplanned care programmes particularly have a large and complex QIPP target over the next three years requiring significant partnership and transformational change. The impact for the CCG as an organisation is that it does not meet its statutory duties to meet all financial rules placed upon it and adequately commission the services the local population require, making best use of the funding it receives.	The impact for patients of not delivering QIPP and transformational programmes of work is that the CCG is unable to move the funding it receives from current contracts and services, and invest in improved service models that support the needs of people which are emerging and in different places in the Vale of York.	The established programme management arrangement and performance management framework in place within the CCG brings together all work streams and actions to drive QIPP and system transformation based around five programmes (unplanned care, planned care, primary care, MHLD & complex care and enabling & quality). All Executive leads are responsible for delivery or mitigating the risks around delivery of their QIPP plans. The Executive Team are responsible for identifying new QIPP opportunities and decision-making around financial savings where QIPP projects are not delivering at the scale or pace required to deliver the quantified savings	Monthly financial recovery boards continue to review all current QIPP schemes and the forecast position for Year-end will be reported to Finance and Performance Committee each month. The financial priorities ('QIPP') under Aligned Incentives Contract framework [AIC] for 2018/19 which support the CCG in driving financial efficiency, performance and quality improvements in services delivered for local people have been identified and are now being reviewed with York Trust and other partners in terms of the impact on system cost reduction, productivity gain and There was confirmation that the CCG had delivered 56% of forecast QIPP target in 17/18 reported to Finance and Performance Committee and this was significantly higher than QIPP delivery of 16% in 16/17. There has also been considerable financial and programme delivery governance assurance reported by both the new Turnaround Director and NHSE local assurance and delivery teams. This has been support by strong audit assurance reporting across contracting, financial and performance assurance.	Caroline Alexander	Executive Director Service Transformation	16	8		15-Mar-2018
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	The CCG has a forecast deficit of £22.5m as at Month 11 reporting. This includes an agreed year-end position with York Teaching Hospital NHS Foundation Trust. The Contracting team are in the process of trying to reach year-end agreements with all acute providers, where possible, although some have confirmed they simply wish to trade out. The position also includes an agreed process with the North Yorkshire CCGs to manage the	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		14-Mar-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
				Complex Care areas of spend. The CCG is implementing the transformational programmes identified as part of its MTFS laying the foundations for the delivery in future years with effect from 1st April 2018. This process has been supported by the internal confirm and challenge sessions for each work stream area and the high-level plans have been shared with York Teaching Hospital NHS Foundation Trust. The CCG continues to work with the hospital and Scarborough and Ryedale CCG to build on the aligned incentives principles that have been agreed. There is now a clear reconciliation of the system plans and the gap is clearly understood by all partners. A detailed joint cost reduction programme of work now needs to be completed in order to jointly agree how the system gap will be closed.						
PLC.05 Constitution target – Planned Care - VoYCCG failure to meet 18 week RTT target	The % of patients on a completed admitted pathway within 18 weeks should equal or exceed 90%. This is a constitution target and failure to meet this target could result in patient safety concerns and financial penalties. The constitution splits this measure into three parts for admitted, non-admitted and incomplete pathways, this internal measure for the risk register is based on admitted adjusted pathways. Data source is the monthly RTT report produced by the CSU.	Delays in patients receiving treatment	YHFT are updating Recovery Plan and reporting actions to Unplanned Care Steering Group and CMB. Applied to NHS England for additional funding to assist with the backlog caused by winter pressures.	January 2018 performance was 85.3% against 92% target. Winter and flu pressures have continued throughout January and February 2018. Backlog has increased to 4000 patients due to cancelled operations caused by bed pressures at York Hospital.	Fliss Wood	Executive Director Service Transformation	16	12		15-Mar-2018
ES.04 Local Digital Roadmap: The CCG may not develop adequate enabling programmes of work to	There is a potential risk of lack of allocated staff resource and technical expertise with the CCG to deliver the programme within required deadlines. The impact may be that progress fails to meet national requirements or attract funding. If stakeholders do not share the digital system vision and commit to		The CCG needs to clarify STP and local level Governance arrangements, exec sponsorship, and implementation resource to ensure delivery of the Local Digital Roadmap. Steps have been taken to	Formal agreement still needed around resource and governance structures to support this programme. Potential shared resource with Scarborough Ryedale CCG to be agreed	Shaun Macey; Phil Mettam	Accountable Officer	15	9		13-Mar-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
deliver the Local Digital Roadmap agenda.	delivering the local digital roadmap the CCG may be unable to access funding opportunities and this may result in delays in delivering the national requirements.		engage with STP digital programmes, however, this needs to be formalised. An LDR Partnership Steering Group has been formed. Governance arrangements have been agreed. The CCG's Exec sponsorship is to be confirmed. Implementation of adequate resource to ensure delivery of the Local Digital Roadmap.							
ES.15 There is a potential risk of inability to create sustainable financial plan	Financial modelling of allocation, demographics, tariff changes, business rules, investments, cost pressures, inflation and outturn creates an unaffordable financial challenge.		Medium Term Financial Strategy Heads of Terms Joint QIPP programme Capped Expenditure Programme	The CCG is implementing the transformational programmes identified as part of its MTFS laying the foundations for the delivery in future years with effect from 1st April 2018. This process has been supported by the internal confirm and challenge sessions for each work stream area and the high-level plans have been shared with York Teaching Hospital NHS Foundation Trust. The CCG continues to work with the hospital and Scarborough and Ryedale CCG to build on the aligned incentives principles that have been agreed. There is now a clear reconciliation of the system plans and the gap is clearly understood by all partners. A detailed joint cost reduction programme of work now needs to be completed in order to jointly agree how the system gap will be closed.	Michael Ash-McMahon	Executive Director Chief Finance Officer	12	5		14-Mar-2018
ES.23 There is a potential risk that the CCG receives a qualified external audit opinion	There is a risk that the financial management and position of the organisation is such that it will require a qualified external audit opinion.		Subject to delivery of agreed financial plan as and when accounts signed off.	Work is on-going to return the CCG to financial balance over the medium term, but with changes to the CEP proposals there is a risk that a qualified VfM audit opinion will be given throughout the 2017/19 contracting period.	Michael Ash-McMahon	Executive Director Chief Finance Officer	12	4		14-Mar-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
ES.32 Lack of wider stakeholder support for delivery of plans	Articulation of a clear vision that all stakeholders support. The impact for the CCG is that it is dependent on strong joint working with many of its partners and from local people in order to effectively address the financial deficit and transform services to improve population health.	The impact for patients is that they are unable to understand how services are and will be delivered to meet their needs and improve their health now and into the future. Local people will not be able to understand the public health needs locally and how people need to, and can be enabled to, care for themselves more effectively and maintain good health for longer.	The CCG has now transitioned into delivery of its 2017/18 programmes as outlined in the Operational Plan. Many of the work streams are being developed collaboratively with partners including the programmes for unplanned care and planned care which are being jointly scoped and delivered with YTHFT under the Heads of Term for the contract. Additionally, the CCG will work to clearly identify the impact (benefits and improvement in outcomes) on the local populations in each of the three ACS localities as requested at CYC Scrutiny meeting in March 2017. This includes a request from the CCG to partners to jointly consider how the system will support (fund or otherwise) non-recurrent investments required to support system delivery. This will be shared on a regular basis as the programmes are developed. The CCG AO meets regularly with the local councillors across the VoY locality in order to engage around the system challenges and how the CCG is enabling the system transformation. Councillors have offered support to the CCG Engagement programme as the CCG engages with local people and organisations. The first	The CCG continues to work with partners to develop the detailed joint programme which will deliver the ambition articulated in the approved Vale-Scarborough system medium-term plan. The financial plan for 5 years that must be delivered through the medium term system plan is currently being further developed in light of the confirmed allocations to the CCGs and there is a requirement for a refreshed financial, activity and operational plan for the CCG to be approved by 30th April for submission to NHSE and the HCV STP. The CCG's Commissioning Intentions for 2018/19 have also been approved and shared with providers and partners.	Caroline Alexander	Executive Director Service Transformation	**12**	**12**		15-Mar-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
			lay member summit was held on Friday 7th April.							
ES.34 There is a potential risk that the Constitution may not be fit for purpose and adequately define statutory duties.	The current constitution does not reflect structure. Whilst in legal directions interim arrangements were acceptable. Now Accountable Officer has been recruited on a permanent basis the CCG needs to start to resolve this. Whilst the structure does not reflect the constitution the decision making power of the CCG is more restricted and potentially open to challenge.		The CCG constitution review is underway to reflect the current structure. Currently the CCG is operating within the confines of legal directions and therefore has mitigated the risk of the outdated constitution however the CCG needs to develop an appropriate constitutional framework as a matter of urgency. There remain some outstanding matters for resolution before the constitution can be approved by Council of Members and sent to NHSE for approval.	A revised version of the Constitution is being prepared to reflect the appointment of a clinical chair.	Abigail Combes; Helena Nowell	Accountable Officer	12	4		15-Mar-2018
JC.28 Constitutional Target-Cancer 14 Day Fast Track	Failure to meet the constitutional target for at least 93% of cancer fast track patients to be seen within 2 weeks. This also has the potential to impact on the 62 day Cancer target.	Delay in diagnosis may impact on the staging of the cancer and potential poorer patient outcomes, and more complex care required.	A new Dermatology consultant started work in February 2018 which will assist with skin referrals.	Narrowly missed the target in December 2017 of 92.5% against 93% target. Unvalidated data for January 2018 is 94.4%.	Fliss Wood	Executive Director Service Transformation	12	8		15-Mar-2018
JC-PROG.01 Dementia - Failure to achieve 67% coding target in general practice.	Non delivery of mandatory NHSE 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/PCU 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	The dementia coding target for local practices still presents a challenge. There will be a renewed push to drive the coding over the coming weeks prior to the year end. The clinical director will help those practices with the biggest challenge to overcome this. Further work is on-going in terms of encouraging practices to drive performance and achieve better outcomes for service users with dementia. NHS England dementia summit meeting will take place 8th March 2018 for the CCG.	Paul Howatson	Executive Director Service Transformation	12	9		04-Mar-2018
UPC.10 Constitution target – Urgent Care - VoYCCG	The % of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge should equal or exceed 95%. This is a constitution target and	Impact on patient experience and potentially patient safety if patients are not seen in a timely manner.	The Winter Plan has been signed off by the A&E Delivery Board and is being mobilised with a target to achieve 92% bed	There is still limited improvement in performance over the February period compounded by poor weather creating discharge and flow difficulties at the start of March	Becky Case	Executive Director Service Transformation	12	8		05-Mar-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
failure to meet 4 hour A&E target	failure to meet this target could result in patient safety concerns and financial penalties.		occupancy. Ambulance handovers at YHFT - plan agreed with YAS to manage and escalate when experiencing high volume of ambulance arrivals to prevent delays. The Finance and Performance Report provides a full update every month.	2018. YTHFT have commissioned Ernst & Young to review internal flow over the next three months which may support transformational change. Externally systems partners are managing the current level of demand, however long term care placements remain in short supply due to the local demographics and working population. NHSE are leading a winter review on 12th March 2018. All partners and regions are contributing.						
JC.19 Constitution Target - Planned Care - Cancer 62 day waits	85% or above of patients should receive their first definitive treatment within 62 days of an urgent GP referral for suspected cancer. Those waiting longer than 62 days are appropriately reviewed and managed.	Delays in patients receiving diagnostics and cancer treatment which may result in worse outcomes.	YHFT is prioritising timed pathways with under performance on 62 Day targets focusing on Lung and Upper GI. As a result of the YHFT audit against the 10 High Impact Changes additional funding has been received to increase MRI and CT scan capacity. RCAs are undertaken on all 62 Day breaches and 104 day clinical harm reviews which are reviewed by the YHFT Cancer Board.	In December 2017 87.2% against 85% target. Unvalidated data for January 2018 shows 85.1%. The target has been achieved in three consecutive months.	Fliss Wood	Executive Director Service Transformation	9	6		15-Mar-2018
ES.09 Vacancies in the Executive Team may potentially impact delivery of CCG objectives	There is a lack of capacity to delivery key strategic programmes, in particular executive lead for Primary Care development and transformation. This may lead to difficulties in developing a Primary Care strategy and promoting work streams to fully develop care pathways outside hospital settings with the appropriate contractual frame works to drive forward transformation and improve quality. A range of options have been implemented to cover these gaps.			The Director for Primary Care, Population Health is supporting the CCG two days per week and is due to commence substantive employment with the CCG from April 2018. The Primary Care Team has been established to lead Primary Care Development and Treatment	Phil Mettam	Accountable Officer	8	8		15-Mar-2018

Item Number: 7

Name of Presenter: Simon Cox/Phil Mettam

Meeting of the Governing Body

Date of meeting: 5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Joint Committee for Acute Commissioning

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

Reason for Report

To present draft terms of reference and workplan for moving to a Joint Committee for Acute Commissioning

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 paper and approve the move to a Joint Committee for Acute Commissioning. The Governing Body is also asked to receive and comment upon the draft workplan.

Responsible Executive Director and Title	Report Author and Title
Phil Mettam – Accountable Officer	Abigail Combes – Head of Legal and Governance

Report on Acute Commissioning System

Governance Paper

Introduction

This paper is written to advise NHS East Riding of Yorkshire CCG ("ERYCCG"), NHS Scarborough and Ryedale CCG ("SCRCCG") and NHS Vale of York CCG ("VOYCCG") on the potential governance arrangements for closer working across the acute commissioning sector. This paper should be considered legally privileged and therefore should not be shared outside the CCGs without consultation with each Chief Officer as this would waive privilege on behalf of all.

ERYCCG, SCRCCG and VOYCCG all have acute commissioning contracts with York Teaching Hospital Foundation Trust ("YTHFT").

ERYCCG, SCRCCG, VOYCCG and YTHFT have all been placed into the National Health Service England ("NHSE") and National Health Service Improvement ("NHSI") programme, 'capped expenditure'. It is unclear at this stage what status this programme has and direction has been sought from NHSE/NHSI. What is apparent is that the direction from both NHSE and NHSI is that NHS partners must work as a system to reduce cost.

This paper is intended to outline the potential governance structures available to support the system working and make a recommendation as to which will be most effective at this time.

Options

Contract Management Board

ERYCCG, SCRCCG, VOYCCG and YTHFT currently have contract management boards to manage their acute contracts. These have come together to form one contract management board although there are currently three different contracts in place.

Contract Management Board arrangements could oversee the move to one contract however service specification/KPIs etc would need consideration by Governing Body of each CCG.

In this arrangement each CCG would be required to approve any changes to formula or thresholds separately and each decision except where they relate specifically to managing performance issues within the contract would need to be approved separately by each CCG. This would mean co-ordination of Governing Body meetings and each CCG would need to confirm the reporting mechanisms internally to enable more strategic changes to be made.

Joint Committees

Joint Committee structures were introduced by the amendments to the National Health Services Act 2006, amended in 2014 with the introduction of s14Z3. Essentially this was a mechanism whereby CCGs were formally enabled to delegate decision making from the Governing Body to a formal committee. The membership of the committee could include other commissioners (ie other CCGs) and enables collective strategic decisions which are binding on the CCGs.

The delegation can be in one of two ways, it can either be through reporting to the Governing Body of each CCG prior to the decision being made to establish what can be agreed at the Joint Committee, or a work plan can be agreed which will enable the joint committee to work within the agreed work plan and make whatever decisions are required to deliver the aims of the workplan without the need to revert back to the CCG governing body.

The terms of reference could allow for YHTFT (and Local Authority Partners) to be in attendance at the Joint Committee if that were deemed to be required.

The joint committee would require robust terms of reference and the workplan would need to be sufficiently detailed to enable the Governing Body to determine whether it was appropriate to delegate decision making to the committee.

To support the joint committee it would be appropriate to consider the use of a Section 75 agreement between the CCGs to establish pooled budgets and the financial management around that.

Committee in Common

This would be a possible means of supporting the process with Governing Bodies meeting virtually to discuss and determine outcomes and decisions. This would require the arrangement of meetings on the same day with a means of linking the meetings so that they are held together and decisions are made together. This would require all to agree on the decision and outcome before matters could be actioned and may require the convening of extraordinary meetings. This has been used as a tool successfully elsewhere for example in audit committees where the agenda is generally standard and items for discussions are not particularly fluid in nature.

Establish a Health and Social Care Trust

This would be the establishment of a separate legal entity which would deliver the services under the acute contract with the management from the partner agencies. This is particularly effective where there is a view that health and social partners will come together to commission services. That said the process to set this up is long and complexed and requires Department of Health approval. It may be that this is something to consider in the long term.

Recommendation

Although there is some work to be undertaken in terms of establishing the Joint Committee structure, the formal delegation of decision making powers to this committee would reduce the requirement to report to the Governing Body as regularly as the contract management board mechanism.

A joint committee would also appear a stronger statement to partners that the Commissioners intended to unify as one voice for the delivery of better and more cost effective services on the patch.

As the staffing structure has been established to include a Chief Officer and Senior Appointments it would seem appropriate that this ought to be an autonomous structure across the organisations and the joint committee with a s75 agreement would support this to deliver savings and different care outcomes whilst still reporting into the Governing Body of each organisation on progress on the work plan. A pooled budget would need to be held by one of the CCGs on behalf of the others, it would make some sense for this to be held by the CCG who has the Chief Finance Officer oversight of the work.

Updated position

The paper was sent to NHS East Riding CCG Senior Management Team, NHS Scarborough and Ryedale CCG Business Committee and NHS Vale of York CCG for comment. The primary concerns arising from that were:-

- NHS East Riding CCG were to be members of the committee
- NHS East Riding CCG were not formally in the capped expenditure programme
- NHS East Riding CCG and NHS Scarborough and Ryedale CCG both requested that a clinical member of each Governing Body be listed as a member of the joint committee
- NHS Vale of York CCG requested that a Lay Member of each CCG Governing Body be listed as a member of the joint committee.
- All requested additional detail in relation to the workplan and therefore the matters which would be delegated to the Joint Committee for decision and those which would remain with the CCG. As a result an initial draft workplan has been produced and the terms of reference updated to reflect these comments.

Joint Committee of Clinical Commissioning Groups

NHS East Riding of Yorkshire CCG

NHS Scarborough and Ryedale CCG

NHS Vale of York CCG

Acute Commissioning

Terms of Reference

1. Introduction

1.1 The NHS Act 2006 (as amended)("the NHS Act") was amended in 2014 to allow Clinical Commissioning Groups (CCGs) to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee. The Legislative Reform Order ("LRO"), which amended section 14Z3 (CCGs working together) of the NHS Act, was passed by Parliament and the reforms took effect from 1 October 2014. The reforms mean that CCGs will no longer find it necessary to operate work around arrangements such as committees in common, encouraging integration and co-working.

Joint Committees are a statutory mechanism which give CCGs an additional option for undertaking collective strategic decision making.

In addition, the NHS Act provides, at Section 13Z that some of the NHS England's functions may be exercised jointly with a CCG and that functions exercised jointly in accordance with that Section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

Individual CCGs will still remain accountable for meeting their statutory duties. The aim of the LRO is to encourage the development of strong collaborative and integrated relationships and decision making between partners.

1.2 The Joint Committee of the Clinical Commissioning Groups ("Joint Committee") is a joint committee of: NHS East Riding of Yorkshire CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG; with the primary purpose of commissioning acute services which are provided by York Teaching Hospitals NHS Foundation Trust.

1.3 The health leaders across NHS East Riding of Yorkshire CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG ("the system CCGs") have collectively committed to change the way certain elements of health care is provided in the acute sector to deliver high quality care within the resources available.

The intention would be to develop high quality care and deliver consistent clinical standards in the acute sector within the financial envelope which is available over the geographical patch.

1.4 Guiding principles:

- The needs of patients in the system CCGs area will have priority over organisation interests
- NHS and Local Authority Commissioners and provider will work collaboratively and urgently on system reform and transformation
- Costs will be reduced by better co-ordinated care pathways
- Waste will be reduced, duplication avoided and activities stopped which have limited value.
- Patients, wherever possible, will be discharged promptly from hospital and cared for in their own home or local care facilities
- Develop strong working relationships between health and social care commissioners with clear aims and a shared vision putting the needs of the population first
- The CCGs will maintain and further develop closer working relationships with the local community, workforce, and voluntary/independent sectors.

2. Statutory Framework

The NHS Act which has been amended by Legislative Reform Order 2014/2436 provides at Section 14Z3 that were two or more CCGs are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.

The CCGs named in paragraph 1.2 have delegated the functions set out in schedule 1 to the Joint Committee

3. The Role of the Joint Committee

The Joint Committee's primary purpose is to arrange and commission acute services on a York Teaching Hospitals NHS Foundation Trust footprint. This will include monitoring and managing performance against constitutional targets and managing demand within the system.

The Joint Committee will initially work to identify the areas of work where a 'system' approach will be beneficial to the outcomes for patients and making the best use of public finances. Ultimately, the Joint Committee will work within the framework set out in the workplan which will have been approved by the Governing Body of each of the system CCGs from June 2018 and thereafter a workplan will be refreshed on a quarterly basis.

The role of the Joint Committee therefore shall be to carry out the functions relating to making decisions about future acute services undertaking formal public consultation as necessary and making decisions on the issues which are the subject of the consultation in relation to the commissioned services. The workplan will provide delegated decision making powers to the Joint Committee on behalf of the three Commissioners. This will be reflected in each CCGs constitution and scheme of delegation as appropriate.

NB: It is the responsibility of each member CCG to ensure that their Governing Body is appropriately briefed and clear on what is delegated to the Joint Committee and that the Governing Body is provided with regular updates on the

business of the Joint Committee so that they are clear on the implications of the decisions made. Implementation of the decisions will be the remit of each member CCG.

4. Geographical Coverage

The Joint Committee will comprise:

- NHS East Riding of Yorkshire CCG
- NHS Scarborough and Ryedale CCG
- NHS Vale of York CCG

NHS England may be involved where Specialised Commissioning is involved.

5. Membership and Attendance

- Chief Officer NHS Scarborough and Ryedale CCG
- Chief Officer NHS Vale of York CCG
- Chief Officer NHS East Riding of Yorkshire CCG
- The Chief Officer nominated by the member CCGs to have responsibility for overseeing the work of this committee. This person will only have one vote on the committee.
- Chief Finance Officer NHS Scarborough and Ryedale CCG
- Chief Finance Officer NHS Vale of York CCG
- Chief Finance Officer NHS East Riding of Yorkshire CCG
- Executive Director of Nursing NHS Scarborough and Ryedale CCG
- Executive Director of Nursing NHS Vale of York CCG
- Executive Director of Nursing NHS East Riding of Yorkshire CCG
- GP Governing Body Member from NHS Scarborough and Ryedale CCG
- GP Governing Body Member from NHS Vale of York CCG
- GP Governing Body Member from NHS East Riding of Yorkshire CCG
- GP Member from NHS Scarborough and Ryedale CCG
- GP Member from NHS Vale of York CCG
- GP Member from NHS East Riding of Yorkshire CCG
- Assistant Director of Programme Management will be in attendance

- Assistant Director of Service Transformation will be in attendance
- Head of Legal and Governance will be in attendance
- Chair and Vice-Chair will be elected by the members but must be from different member CCGs. The Chair should be a lay member of one of the member CCGs.
- Deputies can attend on behalf of members provided they have the appropriate delegation to make decisions on behalf of their respective CCG.
- Local Authority Partners can attend by invitation but will not play a role in decision making
- York Teaching Hospital NHS Foundation Trust can attend by invitation but will not play a role in decision making

6. Meetings and Voting

6.1 The Joint Committee shall adopt the standing orders of NHS Vale of York CCG in so far as they relate to the:

- Notice of meetings
- Handling of meetings
- Agendas
- Circulation of papers
- Conflicts of interest (together with complying with NHSE Statutory Guidance)

6.2 All decisions of the Joint Committee must be unanimous

6.3 **Quorum**

At least one full voting member from each CCG must be present for the meeting to be quorate.

There must be at least two GP members not from the same CCG present for the meeting to be quorate.

6.4 **Frequency**

Meetings will be monthly commencing April 2018

6.5 **Transparency**

Meetings of the Joint Committee shall be held in public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

6.6 **Participation at Meetings**

Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review information and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

The Joint Committee has the power to establish working groups and any such groups will be accountable to the Joint Committee.

Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders above unless separate confidentiality requirements are set out for the Joint Committee in which case these shall be observed.

Secretariat support will be provided on a rotating basis in accordance with the location of the meeting. The secretariat support will include:-

- Circulating agenda and associated documents 5 days prior to meetings
- Work with Communication leads for each CCG to publicise the meeting/agenda on CCG website
- Circulate minutes and the decision log within 3 working days of meeting to all members
- Present the minutes, decision log and action log to the Governing Body admin lead to report into each CCG Governing Body.

7. Reporting to the CCGs and NHS England

Joint Committee will make regular written reports to the member Governing Bodies and NHS England and review the aims, objectives, strategy and progress and produce an annual report for the member Governing Body. The Chief Officer nominated to oversee the work of the committee will take responsibility for ensuring this report is available however each CCG will be responsible individually for ensuring this report is presented to their Governing Body for approval in a timely fashion.

8. Withdrawal from the Joint Committee

Should this joint commissioning arrangement cease to be necessary, the Governing Body of any of the member CCGs can decide to withdraw from the arrangement. This withdrawal to be on such terms as are agreed between all the CCG members of the Joint Committee.

9. Decisions

9.1 The Joint Committee will make decisions within the bounds of its remit

9.2 The decisions of the Joint Committee will be binding on the member CCGs

9.3 Decisions of the Joint Committee will be published on each member CCG website

10. Review of Terms of Reference

These terms of reference will be formally reviewed by the CCGs named in 4 above in April of each year, following the year in which the Joint Committee is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

Signatures:

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Date:……

Dr Gina Palumbo

Chair of Governing Body

NHS East Riding of Yorkshire CCG

……..

Date:……

Jane Hawkard

Chief Officer

NHS East Riding of Yorkshire CCG

……..

Date:……

Dr Phil Garnett

Chair of Governing Body

NHS Scarborough and Ryedale CCG

……..

Date:……

Simon Cox

Chief Officer

NHS Scarborough and Ryedale CCG

……..

Date:……

Keith Ramsey

Chair of Governing Body

NHS Vale of York CCG

……..

Date:……

Phil Mettam

Accountable Officer

NHS Vale of York CCG

Joint Commissioning Committee of NHS Scarborough and Ryedale CCG, NHS Vale of York CCG and NHS East Riding of Yorkshire CCG

Annual Workplan April 2018-April 2019

Decision making authority level definition:

Level 1: where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs

Level 2: where health and social care commissioning areas and operational functions affect/impact on the population covered by NHS Scarborough and Ryedale CCG, NHS Vale of York CCG and NHS East Riding of Yorkshire CCG (or wider) are considered by the Committee and any decision(s) undertaken by the Committee form the basis of endorsements and recommendations to the Governing Bodies of each of the member CCGs, and other decision making bodies.

Level 1 Workplan

Area	Key areas of work	Role of the Committee
Committee Administration and Operation	• Holding of Committee meetings • Committee Agendas and papers • Committee minutes • Review of progress against Annual Workplan • Quarterly Committee report to the CCG Governing Bodies • Committee Self-assessment	• Publication of notice of meetings • Approval and publication of Committee Agendas and papers • Approval of Committee minutes and ensure publication of minutes on each CCG website • Approval of progress against Workplan and ensure publication within each CCG annual report of pregress • Approval of Quarterly and annual committee reports to each CCG Governing Body • Review self-assessment

Demand Management	• Outpatients – reduction in capacity required for outpatient clinic capacity • Patient Optimisation – thresholds and restriction on procedures of limited clinical value. Non-urgent referrals supported to optimise health before treatment.	• Make recommendations about reduction of face to face outpatient consultations • Make recommendations regarding shared care protocols with primary care
Sustainability and productivity	• Site consolidation – opportunities to streamline and consolidate outpatient and elective services. • Emergency and urgent care pathway improvement – oversight and consolidation of the improvement programme to achieve the 95% ED target and manage the likely increase in demand occurring in the medium-term.	• Discuss and recommend changes to pathways in emergency and elective care. • Oversight of improvement programme • Reporting on progress on improvement plan.
Cost Reduction	• Market and supply management – Reduction of demand for non-NHS capacity elective medical procedures. • Prescribing and devices restrictions – consideration of utilisation of over the counter medications and cessation of prescription of these drugs; closer adherence to prescribers on NICE guidelines and changes to formulary.	• Receive and approve plans for a reduction in non-NHS elective care processes • Receive and approve formulary decisions for medications and equipment.

Level 2 Workplan

Area	Key areas of work	Role of the Committee
Demand Management	• Outpatients – reduction in capacity required for outpatient clinic capacity	• Recommend physical site changes to Governing Bodies
Sustainability and productivity	• Service consolidation – opportunities to streamline and consolidate outpatient and elective services. • Emergency and urgent care pathway improvement – oversight and consolidation of the improvement programme to achieve the 95% ED target and manage the likely increase in demand occurring in the medium-term.	• Consider and recommend any changes to geographical location of services affecting patient care delivery • Report any changes to the improvement plan
Cost Reduction	• Market and supply management – Reduction of demand for non-NHS capacity elective medical procedures. • Prescribing and devices restrictions – consideration of utilisation of over the counter medications and cessation of prescription of these drugs; closer adherence to prescribers on NICE guidelines and changes to formulary.	• Consider and recommend any site closures

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Item Number: 8

Name of Presenter: Tracey Preece

Meeting of the Governing Body

5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Report Month 11

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 2017/18 as at the end of February 2018.

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)

The CCG has effectively fully mitigated a number of key variable / risk areas including York Teaching Hospital NHS Foundation Trust, Continuing Healthcare, Funded Nursing Care and Mental Health Out of Contract expenditure. Those that remain are of a much lower value and risk of variation. Although these are covered off within some of the broader risks described in Covalent it is worth noting them specifically here:

- Acute and Prescribing trading positions that vary to plan
- Discussions are on-going with NHS Property Services with regards to the 2017/18 charging schedules for all properties, with the exception of West Offices.

Recommendations

To note the financial performance of the CCG and the achievement of key financial duties for 2017/18 as at the end of February 2018.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece, Chief Finance Officer	Michael Ash-McMahon, Deputy Chief Finance Officer Rachel Cooke, Interim Head of Finance

Appendix 1 – Finance dashboard
Appendix 2 – Running costs dashboard

NHS Vale of York Clinical Commissioning Group Financial Performance Report – ***Executive Summary***

Report produced: March 2018

Financial Period: April 2017 to February 2018 (Month 11)

Summary of Key Financial 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					7.5	6.7	0.9	G→
In-year total expenditure does not exceed total allocation (Programme and Running costs)					454.7	477.2	(22.5)	R→
Better Payment Practice Code (Value)	95.00%	99.48%	4.48%	G↑	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	97.67%	2.67%	G↓	95.00%	>95%	0.00%	G
Cash balance at year end is within 1.25% of monthly drawdown								
CCG cash drawdown does not exceed maximum cash drawdown					469.3	477.2	(7.9)	R↓

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	6.7	5.9	0.6	G↓	7.3	6.7	0.6	G→
Programme spend within plan	416.6	427.8	(11.2)	R↑	453.8	470.6	(16.8)	R→
Actual Surplus / (Deficit) within plan (In-year)	(5.8)	(16.3)	(10.5)	R↓	(6.3)	(22.5)	(16.2)	R→
Actual Surplus / (Deficit) within plan (Cumulative)					(30.1)	(46.3)	(16.2)	R→
Cash balance at month end is within 1.25% of monthly drawdown (£k)	417	258	159	G				
QIPP delivery (see section 8)	12.9	7.1	(5.9)	R↓	14.4	7.4	(7.0)	R→

See Detailed Narrative for supporting information.

Key Messages

- **Financial Plan:** the CCG continues to report against a planned deficit of £6.3m.
- **Forecast:** the outturn deficit of £22.5m is now just a straight forecast of the anticipated year-end position and remains in line with the previously reported risk adjusted forecast.
- **Underlying position:** the forecast underlying position has stabilised and actually improved to £21.1m against the 2017/18 opening underlying position of £22.4m in the 31st March 2017 plan submission.
- **Month 11 Year-to-date:** the Month 11 position is away from plan by £10.5m. This is an improvement on Month 10 of £1.7m driven primarily by additional allocations.
- **Financial Recovery Board:** the meetings continue to take place, and the most recent agenda and action notes have gone to F&P Committee. Governance arrangements are being finalised.

- **Forecast Expenditure Summary:** (see sections 3, 5 & Appendix 1)

Dashboard Heading	Overall Forecast £m
YTHFT	195.1
Other Acute Commissioning	45.0
Mental Health Services	47.8
Community Services	29.2
Continuing Care	27.6
Funded Nursing Care	3.9
Other Commissioning	26.5
Primary Care Prescribing	49.9
Primary Care	42.0
Running Costs	6.7
0.5% CQUIN	1.0
0.5% Risk Reserve	2.0
Other CCG reserves (Incl. Prior Year)	0.7
Contingency	0.0
Total Expenditure	**477.2**
In-Year Allocation	**454.7**
Surplus / (Deficit)	**(22.5)**
31st March Plan	**(16.0)**
Variance – Gap to deliver £16.0m	**(6.5)**

Note: the variance to the £6.3m deficit plan being monitored by NHS England is £16.2m.

- **QIPP:** (see section 8)

QIPP Summary	£m
QIPP Target	14.4
Delivered at Month 11	(7.1)
Forecast to deliver in remainder of year	(0.3)
QIPP gap (included in overall gap)	**7.0**

- **Cash:** the CCG met its internal Key Financial Measure to have a month-end cash holding within 1.25% of the monthly draw down. The CCG has had its Maximum Cash Drawdown (MCD) amended to reflect the Month 9 outturn and extra allocations and has confirmation it will be able to make supplementary March drawdowns to reflect the position above.

- **Key Actions & Areas for Discussion**:
  - **Level of risk (Acute)** – The reported forecast outturn now includes the agreed year-end position with York Teaching Hospital NHS Foundation Trust. The CCG has begun discussions with all other acute providers to agree similar year-end deals, but a number of these have rejected this preferring to trade out on a PbR basis.
  - **Disputes and Challenges** – The Hull and East Yorkshire Hospitals NHS Trust forecast outturn has deteriorated by £228k this month. The Contracting Team are disputing the increased costs with NHSE on the basis of a lack of timely notification, they cannot identify the underspend they allude to within their letter in which they justify transferring the cost and because the CCG has been unable to identify a corresponding transfer of funding during the Identification Rule reallocation.
  - **Level of risk (Other)** – Significant progress was made towards minimising this with an agreement across the four North Yorkshire CCGs to the principles and process to establish an agreed outturn for CHC, FNC and mental health out of contract. This is reflected in the forecast outturn in Month 11 and has been supported in principle by Mazars.
  - **Prescribing** – Pharmacy costs now include the full anticipated impact from No Cheaper Stock Obtainable (NCSO) items of £1.9m within the forecast outturn.

NHS Vale of York Clinical Commissioning Group Financial Performance Report – ***Detailed Narrative***

Report produced: March 2018

Financial Period: April 2017 to February 2018 (Month 11)

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1. Red / Amber financial statutory duties and measures

- *'In-year total expenditure does not exceed total allocation'* – forecast expenditure is £22.5m higher than the CCG's in-year allocation.
- *'CCG cash drawdown does not exceed maximum cash drawdown'* – the cash drawdown required for the year currently exceeds the Maximum Cash Drawdown (MCD) as advised by NHS England. Although this has reduced following the adjustment to the MCD to reflect the Month 9 forecast expenditure, CCGs are not allowed to exceed this so a further adjusted MCD will be required from NHS England or the CCG must ensure it manages its working capital to stay within the original MCD. The CCG has already started to consider how it could potentially manage its payments in the final months of the year should no further adjustment be made.
- *'Programme spend within plan'* – programme spend is forecast to overspend by £16.8m. This is offset by an under-spend on running costs of £0.6m which results in the overall position being £16.2m worse than plan.
- *'Actual position is within plan (in-year)'* – the in-year position of a £22.5m deficit now reflects the anticipated year end outturn expenditure position including all risks and mitigations that the CCG must now manage to and deliver.
- *'Actual position is within plan (cumulative)'* - the cumulative position has moved in line with the above.
- *'QIPP delivery'* – year to date QIPP delivery is 54.6% of plan which equates to £5.9m under delivery.

2. Month 11 & Year-to-date Supporting Narrative

The plan at Month 11 was for a deficit of £5.8m; however the actual deficit is £17.0m, £11.2m worse than planned.

Following the recent and previously reported reviews of QIPP delivery and the turnaround report to Governing Body in January, the forecast QIPP position has been updated to accurately reflect the current position which is a forecast delivery of £7.4m, £7.0m short of the original plan and fully reflected in the reported year-to-date and outturn position.

		£m
QIPP plan		14.4
Original CEP proposals	9.7	
Underlying position improvement	(1.9)	
Net CEP		7.8
Total savings plan as at June 12th		**22.2**
Removal of net CEP		(7.8)
Year to Date Delivery		(7.1)
Forecast further delivery		(0.3)
Shortfall		**7.0**

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust	(£10.0m)	The bulk of this relates to slippage on QIPP schemes, £4.9m, because the majority of the Health Optimisation proposals are impacting the Independent Sector providers. Further detail on the trading pressure is within the contract trading report.
Out of Contract Placements and SRBI	(£2.1m)	Increased trading costs in both Out of Contract and SRBI placements. This has included the reclassification of several patients to the Vale of York previously reported to the North Yorkshire CCGs as part of the on-going transfer and review of PCU services.
Primary Care Commissioning	£1.8m	Additional allocation for transitional support for sparsity in Primary Care and associated services £2m, and for co-commissioning interim support in 2017/18 £230k.
Reserves	(£1.5m)	This reflects the impact of prior year pressures where estimates were made at year end. It also includes the release of the contingency and the £2.8m CEP adjustment.
Ramsay and Nuffield Health	£1.4m	Ramsay is currently under trading by £1.75m however this is partly offset by an overtrade with Nuffield of £309k.
Other Prescribing	(£1.0m)	Increased costs on ONPOS offset by an under-spend on Primary Care Prescribing.
Other acute contracts	(£0.9m)	Overspends on Mid Yorkshire Hospitals NHS Trust (£226k), Harrogate and District NHS Foundation Trust (£266k), South Tees NHS Foundation Trust (£105k), Leeds Teaching Hospitals NHS Trust (£97k) and Hull and East Yorkshire Hospitals NHS Trust (£227k), offset by an underspend on NLAG FT (£59k).

Running costs	£0.7m	There have been and remain a number of vacancies throughout the year that have been managed to help deliver the YTD underspend.
Other Primary Care	£0.7m	Slippage in the Out of Hospital QIPP means the associated investment has not yet been committed.
York Teaching Hospital NHS Foundation Trust – MSK	£0.6m	Contract is currently under trading due to lower levels of activity and vacancies and has now been agreed as a block amount for 2017/18 that reflects the actual cost of delivery.
Primary Care Prescribing	£0.3m	Underspend on Primary Care Prescribing offset by overspend on Other Prescribing for increased costs in relation to ONPOS and the associated QIPP. Increase in rebate income for 2016/17 not previously accrued.
Continuing Care and Funded Nursing Care	(£0.2m)	Funded Nursing Care is currently underspent by £1.1m, which is more than offset by an over-spend in Continuing Healthcare of £1.3m.
York Teaching Hospital NHS Foundation Trust – Community	£0.1m	Underspend on non-medical prescribing.
Other variances	(£0.4m)	
Total impact on YTD position	**(£10.5m)**	

3. Financial Plan & Forecast Outturn Supporting Narrative

The current financial plan (as submitted 12th June under CEP) is an in-year deficit of £6.3m, resulting in a cumulative deficit of £30.1m. The forecast as at Month 11 is an in-year deficit of £22.5m which is consistent with both the risk-adjusted Month 9 position and the financial plan approved by the Governing Body in April.

All budget lines have been forecast in line with the YTD position and the usual forecasting methodologies. This is reflected in detail in Appendix 1 and summarised in the table below.

Reported forecast outturn key variances

Description	Value	Reason
York Teaching Hospital NHS Foundation Trust	(£10.7m)	This variance now reflects the anticipated outturn as at the time of closing the month-end position. The bulk of this relates to slippage on QIPP schemes, £8.3m, as the majority of the Health Optimisation proposals are impacting the Independent Sector providers and the Out of Hospital programme has not generated nay savings. Further detail on the trading pressure is within the contract trading report.
Reserves	(£6.2m)	This relates largely to the impact of the removal of the CEP schemes £7.8m, but also includes the cost of prior year pressures, £0.8m.
Out of Contract Placements and SRBI	(£2.1m)	Increased trading costs in both Out of Contract and SRBI placements.

Primary Care Commissioning	£2.0m	Additional non-recurrent allocation for support forin Primary Care and associated services £2m, and for co-commissioning interim support 17/18 £230k.
Ramsay and Nuffield Health	£1.6m	Ramsay is forecast to under trade by £1.9m which is offset by an over-trade with Nuffield Health of £337k.
Other acute contracts	(£1.0m)	Overtrading positions including £91k on Leeds Teaching Hospitals NHS Trust, £290k on Harrogate & District NHS FT, £237k on Hull & East Yorkshire Hospitals NHS Trust and £233k on Mid Yorkshire Hospitals NHS Trust.
Prescribing	(£0.8m)	Overtrading position on Other Prescribing (£1.2m) partly in relation to ONPOS, offset by an underspend on Primary Care Prescribing (£325k).
York Teaching Hospital NHS Foundation Trust – MSK	£0.7m	Contract cap agreed with YHFT as part of an aligned incentive style agreement and investment of £500k no longer required.
Running Costs	£0.6m	Achievement of running cost QIPPs
Other Primary Care	£0.5m	Slippage in the Out of Hospital QIPP means the associated investment has not yet been committed, off-set by £223k for PMS premium monies.
CHC and FNC	(£0.4m)	Overtrading position on CHC (£1.5m) and under trading position on FNC (£1.1m).
York Teaching Hospital NHS FT - Community	£0.1m	Forecast under-spend on non-medical prescribing of £141k.
Other variances	(£0.5m)	
Total impact on FOT position	**(£16.2m)**	

4. Allocations

The cumulative allocation at Month 11 is as follows:

Description	Recurrent/ Non-recurrent	Category	Value
Allocation brought forward			£428.5m
Transitional support for sparsity in Primary Care & associated services	Non Recurrent	Programme	£2,000k
Co-commissioning interim support 17/18	Non Recurrent	Programme	£230k
York/Scarborough Programme Development	Non Recurrent	Programme	£70k
CYP Crisis Acceleration Funding	Non Recurrent	Programme	£6k
GPFV Online consultations - North cohort 1	Non Recurrent	Programme	£89k
Total allocation at Month 11			**£430.9m**

5. Gap and key delivery challenges

- **NHS Property Services** – Discussions have progressed with NHS Property Services, with regards to the historic position for 2015/16 and 2016/17 where both parties have agreed a full and final settlement position. Work is on-going for 2017/18, which remains complicated and potentially high value, but agreeing an historic position within previously reported financial positions reduces the previously reported risk in this area.

6. Underlying Position

The underlying position reported at Month 11 based on the forecast deficit is detailed below:

Description	Value
Deficit at Month 11	**(£22.5m)**
Adjust for non-recurrent items -	
Non-recurrent allocation adjustments	(£2.9m)
Non-recurrent allocation expenditure adjustments	£0.9m
Repayment of system support	£0.3m
0.5% headroom	£2.0m
Non recurrent QIPP (BMI & Smoking)	(£2.7m)
Prescribing adjustments (Incl. NCSO and Cat M)	£2.7m
Prior year pressures	£0.9m
Prescribing Indicative Budgets mobilisation payments	£0.3m
Syrian Refugee income	(£0.1m)
Underlying financial position	**(£21.1m)**

7. Balance sheet / other financial considerations

The CCG met its internal Key Financial Measure to have a month-end cash holding within 1.25% of the monthly draw down. The CCG has had its Maximum Cash Drawdown (MCD) amended to reflect the Month 9 outturn and the extra allocations it received in Month 11 and has confirmation from NHS England it will be able to make supplementary March drawdowns if necessary to reflect the position above. Contingency plans have been developed to ensure the year-end Key Financial Statutory Duty with regards to cash is delivered.

The CCG also continued its delivery of the Better Payment Practice Code requirements for NHS and Non-NHS creditors to be paid within 30 days of invoicing in terms of both value and volume of invoices.

8. QIPP programme and Capped Expenditure Process schemes

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
PLANNED CARE							
Anti-Coagulation service	194	Apr-17	236	99	259	(55)	
Cataract Thresholds	161	Apr-17	275	0	300	0	In plan from 2018/19
Faecal Calprotectin	PC4	Oct-16	53	(25)	53	(25)	
Biosimilar high cost drugs gain share	016	Apr-17	298	143	318	163	
Remove SpR block from contract	168	Apr-17	872	872	952	952	
Commissioning for Value (PNRC)	006	Apr-17	138	0	150	0	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	2,750	2,476	3,000	2,718	
RightCare - Circulation (Heart Disease)	008	Oct-17	83	83	100	100	
RightCare - Gastroenterology	009	Apr-18	0	0	0	0	In plan from 2018/19
RightCare - Respiratory (COPD)	010	Apr-18	0	0	0	0	In plan from 2018/19
RightCare - Orthopaedics / MSK	011	Oct-17	625	0	750	0	In plan from 2018/19
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	833	0	1,000	0	In plan from 2018/19
UNPLANNED CARE							
Community Podiatry	IC4	May-17	358	308	393	339	
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	386	323	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	217	187	217	187	
Community Equipment service re-procurement	187	Apr-17	418	0	418	0	New contract in place but costs higher than expected.
Patient Transport - contracting review	190a	Apr-17	11	11	11	11	
Unplanned Care Programme (including urgent care and out of hospital care)	149	Jul-17	733	0	824	0	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	693	185	756	202	Scheme up and running.
Review of community inpatient services - Phase II	019b	Oct-17	167	0	200	0	
RightCare Phase 2 - Trauma & Injuries	017	Apr-18	0	0	0	0	In plan from 2018/19
Patient Transport project - re-procurement	190b	Apr-18	0	0	0	0	In plan from 2018/19

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
PRIMARY CARE							
Dermatology Indicative Budgets	195	Apr-17	36	28	36	28	
GP IT - NYNET	003	May-17	167	167	183	183	
Roll out indicative budgets to other specialities	020	Jul-17	67	0	75	0	
PRESCRIBING							
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	254	254	277	277	
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	117	117	128	128	
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	97	97	106	106	
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	63	63	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	68	68	75	75	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	825	825	900	900	
CCG wide: Continence & Stoma Care	199	Oct-17	44	44	53	53	
COMPLEX CARE							
Continence Supplies	C1	Apr-17	23	5	23	5	
CHC review 1 to 1 care packages	024a	Apr-17	98	0	98	0	
CHC review: Short Breaks	024b	Apr-17	51	0	51	0	
CHC review panel decisions (jointly funded packages of care)	024c	Apr-17	83	0	83	0	
Complex Care - CHC and FNC benchmarking	024d	Oct-17	1,292	0	1,550	0	
Recommission MH out of contract expenditure	025	Apr-17	275	0	300	0	
BACK OFFICE							
Commissioning support (eMBED) contract savings	004	Apr-17	190	190	207	207	
Vacancy control	027	Apr-17	50	546	54	407	
Total identified QIPP			**12,944**	**7,069**	**14,396**	**7,389**	
QIPP shortfall			0	0	0	7,007	
Additional QIPP required as a result of removing CEP			0	0	0	7,840	
Total QIPP requirement			11,493	7,069	14,396	22,236	

QIPP programme delivery updates and risks are provided in the integrated performance and QIPP report; the table above represents a summary financial analysis.

Appendix 1 – Finance dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			Forecast Outturn Previous Month			Forecast Outturn 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	168,680	178,676	(9,996)	153,979	161,994	(8,014)	14,701	16,683	(1,982)	184,446	195,127	(10,681)	184,446	194,237	(9,791)	0	890	(890)
Yorkshire Ambulance Service NHS Trust	11,768	11,768	0	10,698	10,698	0	1,070	1,070	0	12,838	12,838	0	12,838	12,838	0	0	0	0
Leeds Teaching Hospitals NHS Trust	7,555	7,652	(97)	6,888	6,993	(105)	667	659	8	8,276	8,367	(91)	8,276	8,389	(113)	0	(22)	22
Hull and East Yorkshire Hospitals NHS Trust	2,740	2,967	(227)	2,502	2,516	(14)	238	451	(213)	2,994	3,231	(237)	2,994	3,002	(8)	0	228	(228)
Harrogate and District NHS FT	1,684	1,950	(266)	1,535	1,736	(201)	149	214	(65)	1,843	2,133	(290)	1,843	2,083	(240)	0	50	(50)
Mid Yorkshire Hospitals NHS Trust	1,912	2,138	(226)	1,745	1,933	(188)	167	205	(39)	2,087	2,320	(233)	2,087	2,288	(202)	0	32	(32)
South Tees NHS FT	1,150	1,255	(105)	1,053	1,144	(92)	98	111	(13)	1,258	1,372	(114)	1,258	1,367	(109)	0	5	(5)
North Lincolnshire & Goole Hospitals NHS Trust	516	457	59	470	414	56	46	43	3	565	500	64	565	498	67	0	2	(2)
Sheffield Teaching Hospitals NHS FT	197	183	14	179	165	14	18	18	0	215	201	14	215	201	14	0	0	0
Non-Contracted Activity	3,586	3,604	(18)	3,260	3,260	(0)	326	344	(18)	3,912	3,930	(18)	3,912	3,825	87	0	105	(105)
Other Acute Commissioning	846	802	44	769	733	36	77	69	8	923	884	39	923	896	27	0	(12)	12
Ramsay	6,158	4,408	1,750	5,624	4,028	1,597	534	380	154	6,721	4,778	1,943	6,721	4,744	1,977	0	34	(34)
Nuffield Health	2,681	2,990	(309)	2,448	2,668	(220)	233	321	(89)	2,926	3,263	(337)	2,926	3,190	(264)	0	73	(73)
Other Private Providers	953	1,059	(106)	867	937	(71)	87	121	(35)	1,040	1,167	(127)	1,040	1,134	(94)	0	33	(33)
Sub Total	**210,426**	**219,910**	**(9,483)**	**192,018**	**199,220**	**(7,202)**	**18,408**	**20,690**	**(2,282)**	**230,044**	**240,112**	**(10,068)**	**230,044**	**238,695**	**(8,651)**	**0**	**1,418**	**(1,418)**
Mental Health Services																		
Tees Esk and Wear Valleys NHS FT	36,334	36,480	(146)	33,035	33,160	(125)	3,299	3,319	(21)	39,650	39,805	(154)	39,644	39,795	(150)	6	10	(4)
Out of Contract Placements and SRBI	4,791	6,903	(2,111)	4,356	6,657	(2,301)	436	246	190	5,227	7,307	(2,080)	5,227	7,316	(2,090)	0	(10)	10
Non-Contracted Activity - MH	386	359	27	351	364	(12)	35	(5)	40	421	419	2	421	434	(12)	0	(15)	15
Other Mental Health	214	214	0	194	194	0	19	19	0	272	272	0	250	249	0	23	23	0
Sub Total	**41,725**	**43,955**	**(2,230)**	**37,936**	**40,375**	**(2,439)**	**3,789**	**3,580**	**209**	**45,571**	**47,803**	**(2,232)**	**45,542**	**47,794**	**(2,252)**	**29**	**8**	**20**

	YTD Position			YTD previous month			YTD Movement			Forecast Outturn			YTD previous month			YTD 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
Community Services																		
York Teaching Hospital NHS FT - Community	17,980	17,881	98	16,363	16,275	88	1,616	1,606	10	19,596	19,507	89	19,596	19,526	70	0	(19)	19
York Teaching Hospital NHS FT - MSK	2,504	1,867	636	2,231	1,736	495	273	132	141	2,777	2,107	670	2,777	2,107	670	0	0	(0)
Harrogate and District NHS FT - Community	2,425	2,548	(123)	2,207	2,306	(99)	218	242	(24)	2,643	2,753	(109)	2,643	2,745	(101)	0	8	(8)
Humber NHS FT - Community	903	907	(4)	821	822	(1)	82	85	(4)	985	990	(5)	985	987	(2)	0	3	(3)
Hospices	1,143	1,142	1	1,039	1,038	1	104	104	0	1,247	1,246	2	1,247	1,246	1	0	(0)	0
Longer Term Conditions	420	414	7	382	388	(6)	38	26	13	458	454	4	458	467	(8)	0	(12)	12
Other Community	1,979	1,931	48	1,779	1,742	37	200	189	11	2,179	2,106	73	2,179	2,091	87	0	15	(15)
Sub total	**27,354**	**26,690**	**664**	**24,823**	**24,307**	**516**	**2,531**	**2,383**	**148**	**29,885**	**29,162**	**723**	**29,885**	**29,168**	**717**	**0**	**(6)**	**6**
Other Services																		
Continuing Care	23,915	25,197	(1,282)	21,840	24,111	(2,271)	2,075	1,086	989	26,033	27,567	(1,534)	25,990	27,494	(1,504)	43	73	(30)
Funded Nursing Care	4,588	3,541	1,047	4,171	3,656	515	417	(115)	532	5,005	3,863	1,142	5,005	3,863	1,142	0	0	0
Patient Transport - Yorkshire Ambulance Service NHS Trust	1,841	1,886	(45)	1,674	1,708	(34)	167	178	(11)	2,007	2,060	(52)	2,007	2,057	(50)	0	3	(3)
Voluntary Sector / Section 256	490	511	(21)	432	467	(35)	57	43	14	547	554	(7)	547	553	(7)	0	0	(0)
Non-NHS Treatment	529	531	(3)	482	478	4	47	53	(6)	576	578	(3)	576	572	4	0	6	(6)
NHS 111	745	744	1	678	668	9	68	76	(8)	813	810	3	813	801	12	0	10	(10)
Better Care Fund	10,152	10,450	(298)	9,229	9,299	(70)	923	1,151	(228)	11,138	11,283	(144)	11,138	11,297	(159)	0	(14)	14
Other Services	2,018	2,054	(37)	1,832	1,862	(29)	185	193	(8)	2,203	2,245	(43)	2,203	2,244	(41)	0	2	(2)
Sub total	**44,277**	**44,915**	**(638)**	**40,339**	**42,251**	**(1,912)**	**3,938**	**2,664**	**1,274**	**48,321**	**48,960**	**(639)**	**48,278**	**48,880**	**(602)**	**43**	**80**	**(37)**

	YTD Position			YTD previous month			YTD Movement			Forecast Outturn			YTD previous month			YTD 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
Primary Care																		
Primary Care Prescribing	45,912	45,601	311	42,024	41,886	138	3,888	3,715	173	50,196	49,871	325	50,196	50,257	(61)	0	(386)	386
Other Prescribing	617	1,581	(964)	561	1,402	(841)	56	179	(123)	673	1,831	(1,158)	673	1,616	(943)	0	216	(216)
Local Enhanced Services	1,732	1,401	331	1,545	1,268	277	187	133	54	1,918	1,834	84	1,918	1,948	(30)	0	(114)	114
Oxygen	241	275	(34)	219	249	(29)	22	27	(5)	263	300	(37)	263	298	(34)	0	2	(2)
Primary Care IT	914	940	(26)	832	877	(45)	82	63	19	1,146	1,164	(18)	1,146	1,167	(21)	0	(3)	3
Out of Hours	2,903	2,976	(72)	2,639	2,695	(56)	264	280	(17)	3,167	3,219	(52)	3,167	3,223	(55)	0	(4)	4
Other Primary Care	856	186	670	617	110	507	239	77	162	1,095	589	506	856	343	513	239	246	(7)
Sub Total	**53,176**	**52,961**	**215**	**48,439**	**48,487**	**(49)**	**4,737**	**4,473**	**264**	**58,459**	**58,808**	**(350)**	**58,220**	**58,851**	**(631)**	**239**	**(42)**	**281**
Primary Care Commissioning	**40,360**	**38,556**	**1,804**	**34,849**	**35,046**	**(196)**	**5,511**	**3,510**	**2,000**	**44,027**	**42,030**	**1,998**	**41,797**	**41,797**	**0**	**2,230**	**232**	**1,998**
Trading Position	**417,318**	**426,986**	**(9,668)**	**378,404**	**389,685**	**(11,281)**	**38,914**	**37,301**	**1,613**	**456,307**	**466,875**	**(10,568)**	**453,767**	**465,186**	**(11,419)**	**2,541**	**1,690**	**851**
Prior Year Balances	0	846	(846)	0	986	(986)	0	(140)	140	0	846	(846)	0	986	(986)	0	(140)	140
Reserves	(2,733)	0	(2,733)	(2,349)	0	(2,349)	(385)	0	(385)	206	2,839	(2,633)	352	1,999	(1,648)	(146)	840	(986)
Contingency	2,061	0	2,061	1,874	0	1,874	187	0	187	2,248	0	2,248	2,248	0	2,248	0	0	0
Unallocated QIPP	0	0	0	0	0	0	0	0	0	(4,994)	0	(4,994)	(4,994)	0	(4,994)	0	0	0
Reserves	**(672)**	**846**	**(1,518)**	**(475)**	**986**	**(1,461)**	**(197)**	**(140)**	**(57)**	**(2,540)**	**3,685**	**(6,225)**	**(2,394)**	**2,985**	**(5,379)**	**(146)**	**700**	**(845)**
Programme Financial Position	**416,645**	**427,831**	**(11,186)**	**377,929**	**390,671**	**(12,742)**	**38,717**	**37,161**	**1,556**	**453,768**	**470,560**	**(16,793)**	**451,373**	**468,171**	**(16,798)**	**2,395**	**2,390**	**5**
In Year Surplus / (Deficit)	(5,816)	0	(5,816)	(5,287)	0	(5,287)	(529)	0	(529)	(6,345)	0	(6,345)	(6,345)	0	(6,345)	0	0	0
In Year Programme Financial Position	**410,829**	**427,831**	**(17,002)**	**372,642**	**390,671**	**(18,029)**	**38,188**	**37,161**	**1,027**	**447,423**	**470,560**	**(23,137)**	**445,028**	**468,171**	**(23,143)**	**2,395**	**2,390**	**5**
Running Costs	**6,678**	**5,943**	**736**	**6,071**	**5,496**	**575**	**607**	**447**	**161**	**7,287**	**6,673**	**614**	**7,287**	**6,668**	**619**	**0**	**5**	**(5)**
Total In Year Financial Position	**417,508**	**433,774**	**(16,266)**	**378,713**	**396,167**	**(17,454)**	**38,795**	**37,607**	**1,188**	**454,710**	**477,233**	**(22,523)**	**452,315**	**474,838**	**(22,523)**	**2,395**	**2,395**	**(0)**
Brought Forward (Deficit)	(21,779)	0	(21,779)	(19,799)	0	(19,799)	(1,980)	0	(1,980)	(23,759)	0	(23,759)	(23,759)	0	(23,759)	0	0	0
Cumulative Financial Position	**395,729**	**433,774**	**(38,046)**	**358,914**	**396,167**	**(37,253)**	**36,815**	**37,607**	**(792)**	**430,951**	**477,233**	**(46,282)**	**428,556**	**474,838**	**(46,282)**	**2,395**	**2,395**	**(0)**

Appendix 2 – Running costs dashboard

Directorate	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			Forecast Outturn Previous Month			Forecast Outturn 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
Governing Body/ COO/Execs	806	777	29	733	716	18	73	61	11	880	1,017	(137)	880	906	(27)	(0)	111	(110)
System Resource & Performance	1,628	1,265	363	1,479	1,163	316	149	102	47	1,777	1,390	386	1,777	1,414	362	(0)	(24)	24
Planning & Governance	1,096	916	180	996	837	160	100	79	20	1,196	998	198	1,196	997	199	(0)	1	(1)
Joint Commissioning	457	425	31	415	380	35	42	45	(4)	498	471	27	498	471	27	0	(0)	0
Transformation & Delivery	318	268	50	289	244	45	29	24	5	347	294	52	347	294	53	(0)	0	(1)
Medical Directorate	866	807	59	787	740	47	79	67	12	945	881	64	945	899	46	(0)	(18)	18
Finance	902	798	104	816	787	29	86	11	75	988	882	106	988	952	36	(0)	(70)	70
Quality & Nursing	616	489	126	561	438	123	55	51	3	671	521	150	671	521	150	0	0	(0)
Recharges & PCU	230	196	34	213	193	20	17	3	14	247	218	29	247	214	33	0	4	(4)
Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QIPP	(239)	0	(239)	(218)	0	(218)	(21)	0	(21)	(261)	0	(261)	(261)	0	(261)	0	0	0
Overall Position	**6,678**	**5,943**	**736**	**6,071**	**5,498**	**575**	**607**	**445**	**161**	**7,287**	**6,673**	**614**	**7,288**	**6,668**	**618**	**(1)**	**5**	**(4)**

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Item Number: 9

Name of Presenter:Tracey Preece

Meeting of the Governing Body

5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Draft Financial Plan 2018/19

Purpose of Report
For Approval

Reason for Report

The CCG has refreshed the 2018/19 year of the 2017/2019 Financial Plan following publication of national planning guidance. The report outlines key points from this guidance and the impact on Vale of York CCG.

The report then details the Draft Financial Plan 2018/19 as it currently stands, the assumptions on which it is based and the risks currently associated with delivery.

The draft plan has undergone extensive engagement and 'confirm and challenge' through a number of forums including private sessions of the Governing Body, the Executive Committee, Finance and Performance Committee, Primary Care Commissioning Committee and has undergone review and benchmarking by NHS England.

The draft plan meets the 2018/19 control total set by NHS England.

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 It is recommended that the Governing Body consider approval of the Draft Financial Plan 2018/19.	

Responsible Executive Director and Title Tracey Preece, Chief Finance Officer	**Report Author and Title** Tracey Preece, Chief Finance Officer

NHS
Vale of York
Clinical Commissioning Group

Draft Financial Plan 2018-19

Governing Body

5 April 2018

Tracey Preece
Chief Finance Officer

Draft V4 - 05/04/2018

Summary

- Based on Month 10 Forecast Outturn (£22.5m deficit) and revised underlying position following discussions with NHS England and Finance and Performance Committee (£21.1m)
- Updated for 2018/19 financial planning guidance requirements & funding (slides 3-4)
- Modelled using 2017/18 and 2018/19 tariff inflation, efficiency and growth assumptions together with local assessments where relevant, including further adjustment and clarification of demographic and non-demographic growth following initial plan review by NHS England (slide 9)
- Fully reflective of the outcome of Confirm and Challenge sessions with each Executive Director, Clinical and Operational Leads in terms of key expenditure assumptions to inform investments and cost pressures (slides 10-11)
- Reflects revised and most current 2018/19 QIPP plan following Confirm and Challenge sessions and continuing development of this programme (slide 8)
- Updated for 2018/19 contract negotiations and variations signed where agreed following national 23 March deadline (slide 12)
- Includes assessment of risk to delivery of the plan (slide 13)

Planning Guidance 18/19 – Financial Key Points

- Increased funding nationally:
  - £600m nationally on fair shares - £3.2m VoY
  - £370m nationally no 0.5% NR requirement - £2.0m VoY
  - £400m nationally Commissioner Sustainability Fund (CSF) - £14.0m VoY (we get this if we hit our control total of £14.0m)
  - Providers – STF now Provider Sustainability Fund (PSF) and increases by £650m to £2.45bn, A&E performance releases 30% of this for Trusts (comparing relevant qtr 17/18 to same in 18/19)
- Vale of York CCG 18/19 control total £14m deficit
- Running costs – no change
- Quality Premium (QP) – could now plan to access if can meet financial gateways
- No requirement to plan for 0.5% non-recurrent reserve
- Timescales tight:
  - Draft plans 8 March (local submission 2 March)
  - Contract variations 23 March (AIC w/York FT)
  - Further local submission 4 April
  - Final GB approved plans 30 April

Planning Guidance 18/19 – Financial Key Points

The increased funding expected to fund:

- Realistic but constrained levels of non-elective activity (linked to QP)
- Additional elective activity to tackle waiting lists (must *maintain* through 18/19, not deteriorate)
- Winter – no additional funding, must be included fully in plans up front
- Mental Health – mandate all CCGs to meet MHIS (required growth > overall growth) and will be subject to external audit review
- General practice – original 18/19 planning position maintained, extended access funding still flowing, no changes to funding formula
- Prescribing – underlying growth assumed to be offset by efficiencies including reforms to OTC drugs (NCSO assumed not to be recurrent into 18/19)
- Pay inflation up to 1%
- Trust CNST pressures

Allocation growth summary	£m
Original published growth for 18/19 - core	8.0
Additional CCG core allocation published in 18/19 update	3.3
Original Primary Care Delegated Commissioning growth	1.2
Total Allocation Growth 2018/19	**12.5**

Key Metrics

	2018/19 Plan £000s
In year Allocation	463,880
In year Surplus / (Deficit)	**(14,000)**
QIPP Target	14,587
QIPP % (on recurrent in-year allocation)	3.1%
QIPP Identified	15,632
Control Total	**(14,000)**
Control Total Shortfall	0
Mental Health Investment Standard Required %	2.8%
Mental Health Investment Standard (Incl. LD and Dementia) %	2.9%*
Mental Health Investment Standard (Excl. LD and Dementia) %	4.6%*
2017/18 Opening Underlying Position	(22,400)
2017/18 Exit Underlying Position	(21,048)

* The assessment of the MHIS achievement can only be calculated on completion of the NHSE financial planning template. This is due for resubmission on the 4 April and this presentation will be updated to reflect this in time for the Governing Body meeting.

Dashboard Headings: 17/18 to 18/19

	2017/18 Plan £000s	2017/18 Month 10 Forecast Outturn £000s	2017/18 Exit Underlying Position £000s	2018/19 *Draft* Plan £000s
York Teaching Hospital NHS Foundation Trust	184,446	195,100	195,172	191,285
Other Acute	45,583	44,457	49,220	46,833
Mental Health Services	45,411	47,794	46,856	49,887
Community Services	29,885	29,168	29,168	29,416
Continuing Care and Funded Nursing Care	30,995	31,357	31,357	31,684
Other Commissioning	25,244	26,118	24,266	26,822
Prescribing	50,196	50,257	47,727	48,222
Primary Care	41,797	41,797	41,915	43,466
Contingency	2,248	0	0	2,318
Reserves and Unallocated QIPP*	(4,642)	2,122	1,028	118
Running Costs	7,287	6,668	6,637	6,784
Total Expenditure	**458,451**	**474,838**	**472,318**	**477,880**
In-Year Allocation	**452,106**	**452,318**	**451,270**	**463,880**
In-Year Surplus / (Deficit)	**(6,345)**	**(22,520)**	**(21,048)**	**(14,000)**

* £228k Winter Pressures plus £350k CEOV less £460k for TCP additional allocation

Dashboard Headings: Growth & Cost Pressures Summary

	2017/18 Exit Underlying Position £000s	Inflation, Efficiency and Growth £000s	Investment & Pressures £000s	Contract Adj. and Business Rules £000s	QIPP £000s	2018/19 Plan £000s
York Teaching Hospital NHS Foundation Trust	195,172	4,845	(393)	834	(9,173)	191,285
Other Acute	49,220	1,049	(1,321)	(1,115)	(1,000)	46,833
Mental Health Services	46,856	485	2,290	758	(500)	49,887
Community Services	29,168	104	129	135	(120)	29,416
Continuing Care and Funded Nursing Care	31,357	2,827	0	0	(2,500)	31,684
Other Commissioning	24,266	334	3,707	(715)	49	26,822
Prescribing	47,727	2,123	0	0	(1,628)	48,222
Primary Care	41,915	1,188	20	344	0	43,466
Contingency	0	0	0	2,318	0	2,318
Reserves and Unallocated QIPP	1,028	0	118	(1,028)	1,045	118
Running Costs	6,637	0	907	0	(760)	6,784
Total Expenditure	**472,318**	**12,954**	**5,455**	**1,531**	**(14,587)**	**477,880**

QIPP: Savings & Investment

	Gross Saving £000s	Gross Investment £000s	Net QIPP £000s
York Teaching Hospital NHS Foundation Trust	(9,173)	0	(9,173)
Other Acute	(1,000)	0	(1,000)
Mental Health Services	(500)	0	(500)
Community Services	(713)	593	(120)
Continuing Care and Funded Nursing Care	(2,500)	0	(2,500)
Other Commissioning	(276)	325	49
Prescribing	(2,698)	1,070	(1,628)
Primary Care	0	0	0
Contingency	0	0	0
Running Costs	(760)	0	(760)
Total QIPP Identified	**(17,620)**	**1,988**	**(15,632)**
Reserves QIPP	1,045	0	1,045
Total QIPP Target	**(16,575)**	**1,988**	**(14,587)**

Inflation and Growth

	Inflation	Efficiency	Demographic	Non-Demographic
Tariff Uplift (Secondary Care)	2.10%	(2.00%)	1.12%	1.26%*
Mental Health Uplift (Contract and NCA)	2.10%	(2.00%)	0.00%	0.00%
Mental Health Uplift (Out of Contract)	4.00%	0.00%	1.90%	0.00%
Ambulance Service Uplift	2.10%	(2.00%)	0.00%	0.00%
Community Uplift	2.10%	(2.00%)	0.00%	0.00%
Hospices and Voluntary Sector	2.00%	0.00%	0.00%	0.00%
Primary Care Services	1.00%	0.00%	0.60%	0.00%
Prescribing Uplift	2.20%	0.00%	2.20%	0.00%
Continuing Healthcare	4.00%	0.00%	5.50%	0.00%
Funded Nursing Care	4.00%	0.00%	0.00%	0.00%
Other NHS Services	2.10%	0.00%	0.00%	0.00%
Primary Care Co-commissioning - GMS	2.70%	0.00%	0.60%	0.00%
Primary Care Co-commissioning - PMS	2.70%	0.00%	0.60%	0.00%
Primary Care Co-commissioning - Premises	2.00%	0.00%	0.00%	0.00%
Primary Care Co-commissioning - Enhanced Services	1.00%	0.00%	0.60%	0.00%
Primary Care Co-commissioning - QOF	1.00%	0.00%	0.60%	0.00%
Primary Care Co-commissioning - Other services	1.00%	0.00%	0.60%	0.00%
Better Care Fund	1.90%	0.00%	0.00%	0.00%

* Based on 0.8% for two extra working days and 0.46% for actual outturn compared to year-end deal

Investments and Pressures (1)

		Recurrent £000s	Non-Recurrent £000s	Dashboard Heading
Investments	Primary Care £3 per head		1,077	Other Commissioning
	FH business case		33	York Teaching Hospital and Other Acute
	Psychiatric liaison	482		Mental Health Services
	YAS 999 share of £3.5m investment to move towards ARP requirements	236		York Teaching Hospital and Other Acute
	YAS 111 share of £0.9m investment	88		York Teaching Hospital and Other Acute
	Chronic Fatigue	10		Mental Health Services
	Market Rent Adjustment - Admin		31	Running Costs
	Winter Plans		228	Reserves
	Weight Management - Tier 3 service	70		York Teaching Hospital and Other Acute
	Sub-Total Investments	**887**	**1,369**	

Investments and Pressures (2)

		Recurrent £000s	Non-Recurrent £000s	Dashboard Heading
Pressures	Running cost match allocation	863		Running Costs
	Adjustment to expenditure for HRG4+ and IR rules		(2,160)	York Teaching Hospital and Other Acute
	Correction of NHS PS allocation	224		Other Commissioning
	NHS PS market rent adjustment	1,923		Other Commissioning
	Repayment of TEWV system ask		333	Mental Health Services
	Near Patient Testing / Amber Drugs - PMS	23		Other Commissioning
	Near Patient Testing / Amber Drugs - GMS	70		Other Commissioning
	Tadcaster Insurance Premiums	20		Primary Care
	Anti-Coagulation LES re-pricing - PMS	32		Other Commissioning
	Anti-Coagulation LES re-pricing - GMS	156		Other Commissioning
	CEOV	350		Reserves
	Paramedic Re-Banding		106	York Teaching Hospital and Other Acute
	HSCN - GP Funding		106	Other Commissioning
	HSCN - GP Funding - Admin		3	Running Costs
	Procurement support for 111 tender		10	Running Costs
	Community Equipment FYE of Year 2 price increase	62		Community Services
	Wheelchair stock shortfall pressure	67		Community Services
	Bankfields Named Patient Agreement		308	Mental Health Services
	TCP	1,154		Mental Health Services
	TCP additional allocation	(460)		Reserves
	CQUIN uplift to Selby Care Hub	7		Other Commissioning
	Sub-Total Pressures	**4,492**	**(1,293)**	
	GRAND TOTAL INVESTMENTS AND PRESSURES	**5,379**	**76**	
			5,455	

Contract Summary – York FT

- Contract values for York Teaching Hospital NHS Foundation Trust

	Signed Contract Variation 000s	Plan Pre-QIPP £000s	Plan Post-QIPP £000s	Post-QIPP (Incl. Risk) £000s
Acute	193,878	200,458	191,285	196,313
Community	19,667	19,667	18,967	18,967
MSK	2,277	2,277	2,356	2,356
Total Expenditure	**215,822**	**222,402**	**212,608**	**217,636**

Risks and Mitigations

- Key risks to the 2018/19 plan are the contract alignment risk with York Teaching Hospital NHS Foundation Trust (£3.1m) as they have included the reversal of the contract challenges and the high level of QIPP (£3.4m) in particular the Out of Hospital Programme and Continuing Care.
- Key mitigations include the release of the Contingency (£2.3m), the additional QIPP schemes (£1.0m) currently identified and development of the AIC and associated clinical opportunities (£3.2m).

	Contract £000s	QIPP £000s	Total £000s	Contingency £000s	Other £000s	Total £000s	Net £000s
Acute	(3,094)	(1,934)	**(5,028)**	818	4,210	**5,028**	**0**
Mental Health	0	0	**0**	0	0	**0**	**0**
Community Health	0	0	**0**	0	0	**0**	**0**
Continuing Care	0	(1,500)	**(1,500)**	1,500	0	**1,500**	**0**
Primary Care	0	0	**0**	0	0	**0**	**0**
Primary Care Co-Commissioning	0	0	**0**	0	0	**0**	**0**
Other Programme	0	0	**0**	0	0	**0**	**0**
Running Costs	0	0	**0**	0	0	**0**	**0**
Total	**(3,094)**	**(3,434)**	**(6,528)**	**2,318**	**4,210**	**6,528**	**0**

Discussion and Decision

- Credibility and deliverability of QIPP
- Level of risk
- Other clinical savings and cost reduction opportunities
- Contract position
- Commitment to achieving control total
- Partner engagement and system working

The Governing Body is asked to consider approval of the Draft Financial Plan 2018/19.

Item Number: 10

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Meeting Date: 5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Integrated Performance Report Month 10 2017/18

Purpose of Report
For Information

Reason for Report

This document provides a triangulated overview of CCG performance across all NHS Constitutional targets and then by each of the 2017/18 programmes incorporating QIPP, Contracting and Performance information.

The report captures validated data for Month 10 for performance and contracting and Month 11 for finance and QIPP and should be read alongside the Finance Report.

This report was supplemented at the March meeting of the Finance and Performance Committee with a detailed performance review following a full series of confirm and challenge sessions with all Executive and programme leads. The purpose of the reviews has been to ensure:

- all new and refreshed 2018/19 Integrated Assurance Framework [IAF] and national planning guidance indicators and datasets have been reviewed by the core CCG teams
- reflection on whether current recovery plans are effectively supporting performance returning to target
- the development of new or further action plans to support further recovery in 2018/19

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	26 risks as captured in the Risk report for March 2018
Emerging Risks (not yet on Covalent) n/a	
Recommendations n/a	

Responsible Executive Director and Title	Report Author and Title
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Integrated Performance Report

Validated data to January 2018
Month 10 2017/18

NHS
Vale of York
Clinical Commissioning Group

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Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

Cancer 2 Week Wait	Vale of York CCG met the 93% target for the third consecutive month, with performance in January 2018 at 96.1%, up from 93.5% in December. York Trust also returned to above target this month, with performance up from 92.5% in December to 94.4% in January.	Dermatology continues to be challenged but postcards to support general practices using dermatoscopes are being developed. There is a request for CCG funding to support the distribution of these packs. The delayed audit of dermatoscopes will be led by the newly recruited registrar. The third Dermatology deepdive on 20th March will focus on future models of community dermatology under Aligned Incentives Contract (AIC) framework for 2018/19 and how sustainability can be improved through more effective models of triage in primary care. There are on-going discussions to support the pilot of FIT-testing in response to the pressures on colo-rectal capacity in Lower GI.
DTOC	Delayed bed days have reduced in all monitored areas from December to January. There were fewer acute and non-acute delayed bed days for York Trust, CYC and TEWV.	This is a focus for system financial and performance recovery in 2018/19 and the CCG are working to establish and agree the baseline for DTOCs and the recovery trajectory with partners locally.

Performance Headlines

DETERIORATION IN PERFORMANCE :

A&E 4 hr	York Trust's performance for all attendance types fell further to 81.5% in January 2018, with a very slight rise to 81.8% in February. These months represent the lowest performance since February 2017 which stood at 81.4%. The winter and flu pressures reported in December continued throughout January and February, with significant bed closures at both York and Scarborough sites. The Urgent & Emergency Care national NHSI letter highlighting the continued winter pressures on the system is included in the Annex for reference. There were 14 trolley waits > 12 hours in January and 15 in February.	Weekly performance meetings at YFT have been changed to give a site specific focus. At York, work has continued on the review of the acute floor in and trialling different approaches to assessment in-reach within ED. The Acute Medical Model (AMM) continues to be progressed at the Scarborough site. A senior decision maker has been implemented within ambulance assessment to improve handover times at York. Further analysis on the performance impact 8pm to 8am has been completed to inform work on the Hospital at Night Project. The A&E Delivery Board met on 15th March to review the winter period and identify priorities for incorporating into the Winter Plan for 2018/19. An update will be given by the Programme Lead at Committee.
Diagnostics 6 Week Wait	Vale of York CCG's performance against the >99% target continued to deteriorate to 96.6% in January 2018. This is the lowest performance since May 2017 at 96.5%. York Trust's performance in Diagnostics improved slightly, increasing to 98.1% in January from 97.5% in December but down to 97.9% in February. The key issues for York Trust in January continue to be capacity issues in Sleep Studies due to equipment problems, and Endoscopy with 14 colonoscopy breaches in January. There are also on-going pressures with managing MRI long-waiters and children requiring MRI with GA due to capacity issues.	The Trust is working with commissioners to consider purchasing new Sleep Study equipment to improve the timeliness and robustness of the studies and improve performance. Confirmation of the business case should be given by the CCG Executive Committee by 16th March. The FIT testing pilot will support pressures on endoscopy and the YFT new endoscopy unit is currently under construction. There is a weekly diagnostic meeting to review performance and escalate concerns.

Performance Headlines

DETERIORATION IN PERFORMANCE :

Cancer 62 day Treatment	Vale of York CCG met the 62 day target in November and December 2017, however narrowly missed target in January 2018 with performance of 84.9% against 85% target. York Trust's performance also dropped in January, but still met target with 85.1% compared to 87.2% in December 2017. Overall YFT met 6 of the 7 cancer targets in January. The 104 days+ long waiting patients in dermatology are related to head and neck capacity issues and are all being clinically triaged. The next quarterly detailed cancer update to Committee will co-ordinate with quarterly sub CMB cancer focus sessions and is scheduled for May 2018.	The CCG and Trust continue to work with the Cancer Alliance to deliver the programmes of work which support sustainable 62 day performance delivery. Access to Cancer alliance funding for capital investment to support cancer performance improvement has been assessed against current 62 day performance and reduced locally, which is challenging for all partners involved. The CCGs are now represented at the YFT Cancer Board clinically and with Cancer Alliance programme manager attending monthly. This is supporting a more joined-up approach to understanding the key challenges to delivering and the resulting recovery plans. The national Cancer Intensive Support team have now undertaken a review of cancer services at YFT and the Trust are implementing the recommendations supported by capacity from the IST team. There is a Cancer Strategy Day at YFT on 20/3/18.
RTT 18 Week target	RTT performance dropped to 87.5% in January 2018 from 88.1% in December 2017, this is the lowest performance on record against the incomplete standard for Vale of York CCG. York Trust's performance also declined to 85.3% from 85.8% in December. The RTT position has undoubtedly been affected by winter pressures and the planned reduction of routine capacity in line with the national directive. There were 221 cancelled elective patients in January due to bed pressures.	As at 6th February, there were 123 York Trust patients with an RTT clock waiting 40+ weeks. Directorates have been asked to provide plans for each 40+ week patients on a weekly basis with escalation procedures in place should a patient exceed 45 weeks. There were 4 52 week breaches in December – 3 in general surgery and 1 colorectal at Leeds Teaching Hospital due to winter pressures, cancer prioritisation and patient complications.

Performance Headlines

SUGGESTED ISSUES FOR DISCUSSION:

1. For update:
Headines from **Winter review by A&E Delivery Board**: priorities for 2018/19 Winter Plan – verbal update from Becky Case.

2. For discussion:
Performance Recovery Confirm and Challenge for each area of NHS Constitution and CCG IAF undertaken with each Executive Director for their programme areas: presentation on key priorities and refreshed recovery plans for 2018/19 at Committee on 22nd March [Caroline Alexander & Sheena White]

3. For update:
RTT Stocktake with YFT: feedback from review post winter of elective care performance against RTT target to support establishing baseline and trajectory for RTT performance in 2018/19 [verbal update from Caroline Alexander]

4. For confirmation:
Decision to fund **Sleep Studies equipment improvement** to support diagnostics performance improvement [verbal update from Tracey Preece]

5. For escalation:
DTOCs trajectory - to confirm the internal CCG Exec lead(s) and how they will provide oversight and accountability of any actions the CCG is contributing to system recovery for DTOCs and assurance that there is effective joint system working with partners in 2018/19 to support the management of growth in non-elective activity [verbal update from Phil on behalf of Executive Committee]

6. For update:
Mental health, LD and CHC data – progress with validating data locally and verbal update on performance [Denise Nightingale]

Performance Summary:
All Constitutional Targets 2017/18

Validated data to January (Month 10)

NHS
Vale of York
Clinical Commissioning Group

VoY CCG - NHS Constitution - 2017/18

Generated on: 15 March 2018

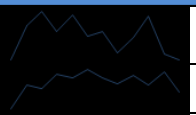
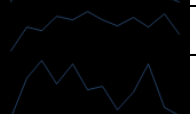
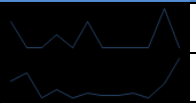
no filter
ALL (Y,R,G)
Green
Red

EMBED HEALTH CONSORTIUM

Planned Care

Indicator	Level of Reporting		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Referral to Treatment																						
Referral to Treatment pathways: incomplete	CCG	Actual	90.5%	90.7%	89.7%	90.2%	90.2%	89.7%	89.3%	88.8%	89.2%	89.2%	88.1%	87.5%	90.0%	89.3%	88.8%	87.5%	89.2%	91.4%		↓
		Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		
Number of >52 week Referral to Treatment in Incomplete Pathways	CCG	Actual	0	2	2	2	0	1	0	0	0	0	3	5	4	1	3	5	13	5		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Diagnostics																						
Diagnostic test waiting times	CCG	Actual	2.00%	2.12%	3.76%	3.49%	2.83%	2.18%	1.63%	1.60%	1.99%	1.85%	2.06%	3.42%	2.83%	1.60%	2.06%	3.42%	3.42%	2.12%		↑
		Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		
Cancer																						
All Cancer 2 week waits	CCG	Actual	97.0%	93.3%	90.5%	89.6%	90.4%	85.9%	85.2%	88.1%	86.8%	96.4%	93.5%	96.1%	90.2%	86.4%	92.1%	96.1%	90.3%	93.6%		↓
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Breast Symptoms (Cancer Not Suspected) 2 week waits	CCG	Actual	95.7%	98.3%	91.9%	95.5%	96.6%	96.8%	96.8%	100.0%	97.6%	91.3%	93.0%	93.2%	95.2%	97.6%	93.4%	93.2%	95.1%	96.3%		↑
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Cancer 31 day waits: first definitive treatment	CCG	Actual	98.2%	96.6%	95.0%	98.9%	97.8%	97.4%	97.4%	96.6%	95.2%	98.2%	98.3%	98.3%	97.5%	97.2%	96.9%	98.3%	97.3%	98.0%		↑
		Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		
Cancer 31 day waits: subsequent cancer treatments-surgery	CCG	Actual	92.1%	100.0%	95.2%	93.8%	96.9%	88.1%	97.7%	95.5%	85.1%	94.2%	97.1%	92.9%	95.3%	93.1%	92.5%	92.9%	93.5%	95.0%		↓
		Target	94.0%	94.0%	94.0%	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
Cancer 31 day waits: subsequent cancer treatments-anti cancer drug regimens	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		-
		Target	98.0%	98.0%	98.0%	96.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%		
Cancer 31 day waits: subsequent cancer treatments-radiotherapy	CCG	Actual	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	99.2%	100.0%	100.0%	98.4%	99.6%	99.6%		↓
		Target	94.0%	94.0%	94.0%	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
% patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer (inc 31 day Rare cancers)	CCG	Actual	74.0%	78.7%	83.6%	74.3%	76.6%	82.0%	87.3%	74.1%	72.5%	87.5%	87.0%	85.1%	77.8%	81.2%	82.1%	85.1%	80.9%	81.8%		↓
		Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	CCG	Actual	93.3%	85.7%	83.3%	100.0%	100.0%	88.2%	100.0%	94.4%	88.9%	90.0%	86.7%	100.0%	94.6%	94.7%	88.4%	100.0%	93.1%	91.9%		↑
		Target	92.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	CCG	Actual	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.5%		
		Target																				
Cancelled Operations																						
Cancelled Operations - York	YFT (Trust Wide)	Actual		7.8%			1.9%			1.1%			0.4%		1.9%	1.1%	0.4%		0.4%	5.1%		↓
		Target		2.0%			11.7%			1.4%			1.0%		11.7%	1.4%	1.0%		5.1%	3.1%		
No urgent operations cancelled for a 2nd time - York	YFT (Trust Wide)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Mixed Sex Accommodation																						
Mixed Sex Accommodation (MSA) Breaches (Rate per 1,000 FCEs)	CCG	Actual	0	0	0	0	0	0	0	0	0	0	0	1.2	0	0	0	1.3	0.1	0		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Number of MSA breaches for the reporting month in question	CCG	Actual	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	15	14	2		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

Unplanned Care

Indicator	Level of Reporting		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
A&E																						
A&E waiting time - total time in the A&E department, SitRep data	% of YFHT activity (CCG weighted)	Actual	81.5%	89.4%	92.9%	88.1%	91.9%	87.1%	88.2%	83.2%	86.7%	91.7%	83.0%	81.5%	90.9%	86.2%	87.0%	81.5%	87.5%	86.4%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	3991	4551	4485	4802	4714	4937	4716	4590	4795	4554	4869	4399	14001	14243	14217	4399	46860	55185		↓
A&E - % Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	68.7%	81.7%	87.5%	79.6%	86.1%	77.6%	79.1%	71.2%	77.1%	86.3%	72.0%	69.4%	84.3%	80.1%	79.5%	69.4%	78.6%	76.6%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 3, SitRep data	% of YFHT activity (CCG weighted)	Actual	1397	1652	1785	1818	1730	1894	1927	1704	1749	1517	1630	1,484	5333	5525	4897	1484	17238	20011		↓
A&E Attendances - Total, SitRep data	% of YFHT activity (CCG weighted)	Actual	6,807	7,881	8,083	8,466	8,201	8,755	8,599	8,024	8,319	7,611	8,157	7,388	24,749	25,377	24,088	7,388	81,602	95,514		↓
A&E Attendances - VoY CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	6,256	7,205	7,069	7,619	7,259	7,661	7,097	7,141	7,822	7,713	8,362	7,444	21,947	21,899	23,897	7,444	75,187	86,952		↓
A&E waiting time -% of patients seen and discharged within 4 hours -CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	79.49%	90.02%	90.38%	83.90%	88.75%	82.14%	84.95%	81.10%	85.23%	87.77%	78.68%	79.19%	87.59%	82.71%	85.19%	79.19%	84.12%	83.55%		↓
	CCG (SUS Data)	Actual	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
Trolley Waits																						
12 hour trolley waits in A&E - Vale of York CCG	CCG	Actual	2	0	0	1	0	2	0	0	0	0	3	0	1	2	3	0	6	19		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12 hour trolley waits in A&E - York	YFT (Trust Wide)	Actual	6	9	0	3	0	2	1	1	2	0	5	14	3	4	7	14	28	85		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Ambulance performance - YAS																						
Category 1 - Response within 8 Minutes	YAS (Region)	Actual	69.8%	75.4%	75.4%	74.1%	68.2%	71.4%	66.8%						69.9%	68.8%			69.5%	67.4%		
		Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%						75.0%	75.0%			75.0%	75.0%		
Achieved 8 Min	YAS (Region)	Actual	215.682	265	269	259	261	281	267						789	809			1337	1171		
Total Calls (C1)	YAS (Region)	Actual	309	352	357	390	382	394	400						1129	1176			1923	1736		
Category 1 - Tail of Performance 75%	YAS (Region)	Actual			00:08:20	00:08:03	00:09:06	00:08:21	00:09:07						00:08:30	00:08:44			00:08:35			
Category 1 - Tail of Performance 100%	YAS (Region)	Actual			00:44:14	00:25:56	00:24:03	00:31:26	00:39:56						00:31:24	00:35:41			00:33:07			
Category 2R (resource) - Response within 19 minutes by a resource	YAS (Region)	Actual	85.3%	83.5%	85.0%	86.9%	86.9%	83.3%	76.5%						86.3%	79.9%			83.4%	83.0%		
Category 2R - Tail of Performance 95%	YAS (Region)	Actual			00:27:25	00:24:04	00:30:40	00:30:54	00:29:53						00:27:23	00:30:24			00:28:35			
Category 2R- Tail of Performance 100%	YAS (Region)	Actual			00:42:35	00:37:19	01:02:20	01:12:04	00:53:05						00:47:25	01:02:35			00:53:29			
Category 2T (transport) - Response within 19 Minutes by DCA unless RRV arrives and DCA not required	YAS (Region)	Actual	69.2%	76.6%	80.0%	77.5%	75.9%	73.0%	75.2%						77.8%	74.0%			76.3%	69.5%		
Category 2T - Tail of Performance 95%	YAS (Region)	Actual			00:34:50	00:31:24	01:01:00	00:38:18	00:40:31						00:42:25	00:39:24			00:41:13			
Category 2T - Tail of Performance 100%	YAS (Region)	Actual			02:22:47	01:20:47	23:24:31	01:53:29	02:59:26						09:02:42	02:26:27			06:24:12			
Category 3R (Resource) - Response within 40 Minutes by a resource	YAS (Region) (	Actual	83.9%	87.3%	91.4%	90.6%	90.6%	88.6%	89.2%						90.9%	88.9%			90.0%	84.8%		
Category 3R - Tail of Performance 95%	YAS (Region)	Actual			01:10:35	00:50:41	00:50:10	00:58:36	00:54:18						00:57:09	00:56:27			00:56:52			
Catergory 3R - Tail of Performance 100%	YAS (Region)	Actual			01:41:40	01:41:01	02:21:42	02:06:15	01:39:51						01:54:48	01:53:03			01:54:06			
Category 3T (Transport) - Response within 40 minutes by DCA unless RRV arrives and DCA is not required	YAS (Region)	Actual	79.2%	87.7%	90.2%	89.7%	83.0%	79.5%	77.9%						87.8%	78.7%			84.3%	80.3%		
Category 3T - Tail of Performance 95%	YAS (Region)	Actual			01:27:56	00:51:25	15:08:40	01:11:36	01:10:23						05:49:20	01:11:00			03:58:00			
Category 3T - Tail of Performance 100%	YAS (Region)	Actual			01:58:55	03:03:13	23:43:28	03:13:24	03:43:33						09:35:12	03:28:28			07:08:31			
Category 4T (Transport) - Response within 90 Minutes of locally determined	YAS (Region)	Actual	94.3%	90.7%	91.8%	91.0%	83.3%	89.2%	76.0%						88.6%	82.6%			86.2%	91.3%		
Category 4H - (Hear and Treat) Hear and Treat within 90 Minutes	YAS (Region)	Actual	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%	98.6%			99.5%	96.4%		

Ambulance Handover Time

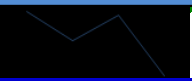
Indicator	Level of Reporting		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Ambulance handover time - % Delays over 30 minutes (Scarborough General Hospital)	Trust Site	Actual	44.20%	21.80%	7.40%	18.30%	14.90%	16.80%	22.30%	31.40%	30.30%	8.30%	32.10%	33.20%	12.90%	23.30%	23.90%	33.20%	21.50%	29.40%		↑
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	533	294	117	182	222	260	357	456	436	112	472	452	521	1073	1020	452	3066	4771		
		Den	1207	1346	1572	994	1487	1552	1601	1450	1440	1352	1470	1360	4053	4603	4262	1360	14278	16224		
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	Trust Site	Actual	23.10%	6.00%	2.60%	6.40%	5.00%	5.00%	6.10%	12.80%	13.70%	1.80%	12.40%	15.50%	4.40%	7.80%	9.50%	15.50%	8.10%	12.90%		↑
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	279	81	41	64	74	77	98	186	197	25	183	211	179	361	405	211	1156	2088		
		Den	1207	1346	1572	994	1487	1552	1601	1450	1440	1352	1470	1360	4053	4603	4262	1360	14278	16224		
Ambulance handover time - % Delays over 30 minutes (York Hospital)	CCG	Actual	20.00%	7.00%	4.10%	10.90%	7.00%	11.00%	10.60%	13.90%	9.80%	7.00%	26.70%	17.70%	7%	11.80%	14.80%	17.70%	12.00%	16.20%		
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		HIDDEN																				
		Num	352	131	78	209	126	200	188	245	192	128	544	356	413	633	864	356	2266	3813		↑
		Den	1760	1869	1906	1921	1794	1820	1767	1765	1954	1841	2039	2016	5621	5352	5834	2016	18823	23476		
Ambulance handover time - % Delays over 60 minutes (York Hospital)	CCG	Actual	7.80%	0.90%	0.90%	3.70%	1.30%	4.10%	2.80%	4.50%	3.20%	1.80%	14.10%	7.70%	2%	3.80%	6.50%	7.70%	4.50%	7.00%		↑
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		HIDDEN																				
		Num	137	16	17	71	23	75	49	79	62	33	287	155	111	203	382	155	851	1655		
		Den	1760	1869	1906	1921	1794	1820	1767	1765	1954	1841	2039	2016	5621	5352	5834	2016	18823	23476		

Mental Health/ IAPT

Indicator	Level of Reporting	Target	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
IAPT																						
% of people who have depression and/or anxiety disorders who receive psychological therapies	CCG	Actual	0.70%	0.62%	0.64%	0.72%	0.94%	0.82%	0.93%	0.86%	0.88%	1.04%			2.30%	2.61%	1.92%		6.83%	13.32%		↑
		Target	1.25%	1.25%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%			2.00%	2.00%	0.7%	0.00%	4.66%	8.57%		
% of people who are moving to recovery	CCG	Actual	50.00%	53.85%	42.50%	54.17%	42.31%	40.91%	37.93%	41.67%	53.85%	46.81%			45.56%	40.00%	50.00%		45.42%	47.04%		↓
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	0.00%	50.00%	50.00%		
% of people who have depression and/or anxiety disorders who receive psychological therapies	CCG	Actual	0.7%	0.6%	0.6%	0.7%	0.9%	0.8%	0.9%	0.9%	0.9%	1.0%			2.3%	2.6%	1.9%	0.0%	6.8%	13.3%		↑
Number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey)	CCG	Actual	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0			31260.0	31260.0	31260.0	0.0	31260.0	31260.0		-
Number of people who receive psychological therapies	CCG	Actual	220	195	200	225	295	255	290	270	275	325			720	815	600		2135	4165		↑
		Target	208	208	208	208	208	208	208	208	208	208			624	624	416		1664	2679		
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	93.33%	93.10%	97.62%	96.15%	92.59%	95.65%	96.77%	96.15%	97.62%	100.00%			95.79%	96.25%	98.91%		97.00%	83.60%		↑
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%			95.00%	95.00%	95.00%		95.00%	95.00%		
The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	100.00%	100.00%	100.00%	100.00%	98.31%	98.04%	98.28%	100.00%	100.00%	100.00%			99.31%	98.77%	100.00%		99.30%	87.15%		-
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%			90.00%	90.00%	90.00%		90.00%	90.00%		
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	80.00%	82.76%	90.48%	80.77%	77.78%	82.61%	80.65%	84.62%	76.19%	70.00%			84.21%	82.50%	72.83%		79.78%	66.24%		↓
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%			75.00%	75.00%	75.00%		75.00%	75.00%		
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	95.45%	92.31%	80.00%	42.22%	49.15%	47.06%	62.07%	75.93%	90.91%	83.08%			55.56%	61.96%	86.67%		66.74%	78.03%		↑
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%		50.00%	50.00%		
Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment enter treatment in the reporting period.	CCG	Actual	46.67%	44.83%	57.14%	84.62%	85.19%	134.78%	109.68%	123.08%	92.86%	88.00%			72.63%	121.25%	90.22%		93.26%	66.56%		↓
		Target	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%			40.00%	40.00%	40.00%		40.00%	40.00%		
Average number of treatment sessions	CCG	Actual	6	7	6	8	7	6	5	5	6	6			7	5	6	0	6	5		↑
% of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	CCG	Actual		99.2%			96.2%			98.8%			94.0%		96.2%	98.8%	94.0%		96.3%	96.9%		↓
		Target		95.0%			95.0%			95.0%			95.0%		95.0%	95.0%	95.0%		95.0%	95.0%		

Dementia																							
Estimated diagnosis rate for people with dementia.	CCG	Actual	55.1%	55.4%	58.4%	58.3%	58.7%	59.1%	59.4%	59.6%	60.2%	61.0%	60.7%	60.9%	58.7%	59.6%	60.7%	60.9%	60.9%	55.4%		↓
		Target	62.8%	66.7%	66.7%	62.8%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%		

HCAI and Quality

Indicator	Level of Reporting		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Hospital Infections																						
Incidence of healthcare associated infection (HCAI): MRSA	CCG ATTRIBUTED	Actual	1	1	1	1	1	2	2	2	0	1	0	0	3	6	1	0	10	9		↓
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile).	CCG ATTRIBUTED	Actual	4	5	4	4	6	5	6	14	12	10	6	9	14	25	28	9	76	61		↓
		Target	6	6	7	6	8	4	7	6	7	5	9	7	21	17	21	7	66	78		
Incidence of healthcare acquired infections (HCAI): MRSA - York FT	YFT TRUST APPORTIONED	Actual	0	0	0	1	0	0	1	1	0	0	0	0	1	2	0	0	3	6		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile) - York FT	YFT TRUST APPORTIONED	Actual	5	5	2	2	5	2	3	5	7	4	3	5	9	10	14	5	38	46		↑
		Target	5	3	3	1	3	3	2	1	3	2	8	10	7	6	13	10	36	45		
Healthcare acquired infection (HCAI) measure (Escherichia Coli infections)	CCG ATTRIBUTED	Actual	27	22	31	21	24	20	23	19	33	25	33	26	76	62	91	26	255	307		↑
		Target	36	23	26	21	24	20	27	25	20	26	27	25	71	72	73	25	241	269		
Serious Incidents/ Never Events																						
Number of Serious Incidents (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	7	5	6	1	9	7	4	3	9	5	5	9	16	14	19	9	58	117		↑
Number of Never Events (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	1	3		-
Smoking at time of Delivery																						
Maternal smoking at delivery.	CCG	Actual		12.3%			10.1%			12.0%			7.5%		10.1%	12.0%	7.5%		9.9%	11.0%		↓
		Target		12.1%			12.1%			12.1%			12.1%		12.1%	12.1%	12.1%		12.1%	12.1%		

Programme Overview - Planned Care

Validated data to January (Month 10)

This dashboard provides an integrated overview of performance against Contracting, QIPP, and key Performance Measures related to the Planned Care Programme.

Executive & Clinical Lead:
Shaun O'Connell, Medical Director, CCG

Programme Leads:
Andrew Bucklee, Head of Commissioning and Delivery
Laura Angus, Lead Pharmacist

NHS
Vale of York
Clinical Commissioning Group

YORK TEACHING HOSPITAL REFERRALS*

- Overall, referrals into York Teaching Hospital for the year to date have decreased by 0.1% (93) in comparison to the same period in 2016/17 (working day adjusted). Referrals via a GP have reduced by 3.2% (1690), whilst consultant to consultant referrals have increased by 5.1% (602) and other referrals have increased by 2.8% (995).

Speciality	Total Referrals (Year on Year comparison)			Change Apr-Feb 2017 v's Apr-Feb 2018 by Referral Type				% Change (Apr-Feb 2017 v's Apr-Feb 2018)			
	Apr-Feb 2016	Apr-Feb 2017	Apr-Feb 2018	GP	Cons:cons	Other	Total Change	GP	Cons:cons	other	Total change
320: Cardiology	13,484	13,753	15,067	256	24	1034	1,314	6.6%	2.9%	11.4%	9.6%
100: General Surgery	11,060	11,380	11,410	7	-93	116	30	0.1%	-5.2%	10.8%	0.3%
130: Ophthalmology	10,150	10,898	10,879	-269	114	136	-19	-4.6%	12.7%	3.2%	-0.2%
110: Trauma And Orthopaedic Surgery	10,062	10,583	9,561	175	-132	-1065	-1,022	11.3%	-14.1%	-13.2%	-9.7%
120: Ear, Nose And Throat	6,716	6,770	6,449	-381	7	53	-321	-7.7%	2.6%	3.4%	-4.7%
502: Gynaecology	5,781	5,742	5,893	-147	63	235	151	-2.9%	20.2%	76.8%	2.6%
501: Obstetrics	5,082	4,926	4,936	-9	43	-24	10	-10.1%	860.0%	-0.5%	0.2%
330: Dermatology	5,069	5,001	4,797	-299	67	28	-204	-6.6%	17.9%	26.2%	-4.1%
420: Paediatrics	3,685	4,164	4,297	-43	-70	246	133	-2.0%	-6.1%	29.0%	3.2%
101: Urology	4,126	4,054	4,103	-265	129	185	49	-8.7%	18.0%	65.8%	1.2%
301: Gastroenterology	4,449	4,054	3,986	-290	105	117	-68	-9.7%	17.2%	26.5%	-1.7%
340: Respiratory Medicine -Thoracic	2,118	2,215	2,215	-119	59	60	0	-7.4%	14.9%	27.9%	0.0%
430: Geriatric Medicine	2,705	2,869	2,045	-283	352	-893	-824	-22.6%	91.9%	-72.4%	-28.7%
302: Endocrinology	1,898	1,862	1,989	90	9	28	127	9.5%	4.9%	3.9%	6.8%
400: Neurology	1,938	1,990	1,884	114	-259	39	-106	8.4%	-43.5%	118.2%	-5.3%
190: Anaesthetics	1,476	1,490	1,603	-6	34	85	113	-0.6%	17.0%	25.0%	7.6%
315: Palliative Medicine	1,449	1,532	1,600	-40	7	101	68	-9.2%	26.9%	9.4%	4.4%
410: Rheumatology	1,534	1,572	1,580	-34	21	21	8	-2.6%	15.2%	18.4%	0.5%
370: Medical Oncology	1,304	1,462	1,506	-9	30	23	44	-22.5%	3.4%	4.3%	3.0%
300: General Medicine	1,285	1,381	1,440	24	39	-4	59	1.9%	557.1%	-3.4%	4.3%
401: Clinical Neuro-Physiology	787	909	931	27	13	-18	22	57.4%	3.1%	-4.0%	2.4%
303: Haematology (Clinical)	1,337	904	734	-175	-18	23	-170	-28.5%	-6.5%	153.3%	-18.8%
160: Plastic Surgery	469	619	642	23	8	-8	23	13.7%	2.2%	-9.9%	3.7%
430: Mental Health Assessment And Liaison Service	0	0	494	0	0	494	494	-	-	-	-
361: Nephrology	520	467	427	-46	9	-3	-40	-17.6%	12.5%	-2.3%	-8.6%
510: Ante-Natal Clinic	396	407	399	6	2	-16	-8	1.9%	-	-16.5%	-2.0%
822: Clinical Biochemistry	89	97	145	17	30	1	48	23.6%	136.4%	33.3%	49.5%
823: Haematology	63	80	77	-8	0	5	-3	-80.0%	-	7.1%	-3.8%
Other (< than 50 referrals)	176	62	61	-6	9	-4	-1	-46.2%	0.3	-0.2	0.0
Grand Total	**99,208**	**101,243**	**101,150**	**-1,690**	**602**	**995**	**-93**	**-3.2%**	**5.1%**	**2.8%**	**-0.1%**

*Note : Referrals have been working day standardised to allow comparison across years.

QIPP: PLANNED CARE AND PRESCRIBING - MONTH 11

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PLANNED CARE									
Anti-Coagulation service	194	Apr-17	236	236	99	259	259	-55	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Cataract Thresholds	161	Apr-17	275	275	0	300	300	0	
Faecal Calprotectin	PC4	Oct-16	53	53	-25	53	53	-25	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Biosimilar high cost drugs gain share	016	Apr-17	298	298	143	318	318	163	Etanercept in place from 2016/17, YTD based on forecast until validated acute data available. Rituximab now in forecast from Oct (was in plan from Apr) due to second biosimilar coming to market later but with lower expected price
Remove SpR block from contract	168	Apr-17	872	872	872	952	952	952	In contract, delivery on track
Commissioning for Value (PNRC)	006	Apr-17	138	138	0	150	150	0	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	2,750	2,750	2,476	3,000	3,000	2,718	Scheme up and running, YTD saving based on forecast profile until validated acute data available
RightCare - Circulation (Heart Disease)	008	Oct-17	83	83	83	100	100	100	
RightCare - Gastroenterology	009	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
RightCare - Respiratory (COPD)	010	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
RightCare - Orthopaedics / MSK	011	Oct-17	625	625	0	750	750	0	
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	833	833	0	1,000	1,000	0	

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PRESCRIBING									
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	254	254	254	277	277	277	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	117	117	117	128	128	128	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	97	97	97	106	106	106	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	63	63	63	75	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	68	68	68	75	75	75	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	825	825	825	900	900	900	YTD based on forecast profile until schemes confirmed and prescribing data available
CCG wide: Continence & Stoma Care	199	Oct-17	44	44	44	53	53	53	

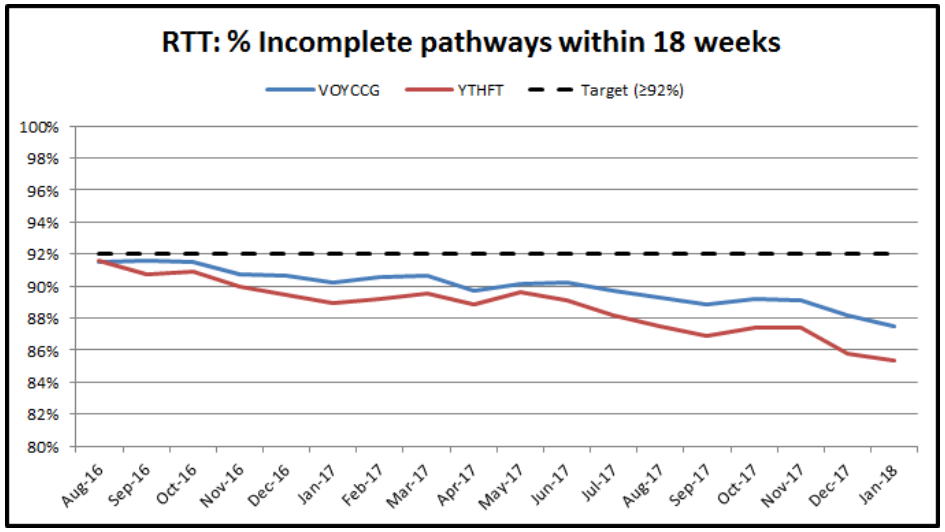
QIPP: PLANNED CARE AND PRESCRIBING – MONTH 11

KEY QUESTIONS: UNPLANNED CARE QIPP

Are QIPP targets being met and are you assured this is sustainable?	What mitigating actions are underway?	Is further escalation required?
See highlights from financial recovery incorporated in Finance report		

PERFORMANCE PLANNED CARE: REFERRAL TO TREATMENT (RTT)

RTT: % Incomplete pathways within 18 weeks (Target ≥92%)					
Vale of York CCG			York Trust		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
88.1%	87.5%	⇩	85.8%	85.3%	⇩



Treatment Function	Total VOYCCG Incomplete Pathways	No. of 18 week breaches	% VOYCCG pathways within 18 weeks	52 week breaches
Oral Surgery	3	-	100.0%	0
Geriatric Medicine	94	1	98.9%	0
General Medicine	184	4	97.8%	0
Neurology	447	26	94.2%	0
Other	1,560	95	93.9%	1
Rheumatology	436	30	93.1%	0
Trauma & Orthopaedics	1,664	130	92.2%	1
Gastroenterology	880	72	91.8%	0
Cardiology	899	78	91.3%	0
Gynaecology	888	86	90.3%	0
Neurosurgery	19	2	89.5%	0
ENT	1,455	189	87.0%	0
Dermatology	1,027	137	86.7%	0
General Surgery	1,844	266	85.6%	1
Plastic Surgery	162	29	82.1%	1
Ophthalmology	2,592	480	81.5%	1
Urology	954	185	80.6%	0
Thoracic Medicine	687	159	76.9%	0
Cardiothoracic Surgery	8	2	75.0%	0
Grand Total	**15,803**	**1,971**	**87.5%**	**5**

Vale of York CCG's performance deteriorated marginally in January 2018 from 88.1% to 87.5%. This equates to 1,971 breaches of the 18 week target, from a cohort of 15,809 patients.

York Trust's RTT performance in January 2018 was 85.3% and dropped further below the STF trajectory of 92%. Un-validated data for February 2018 shows a further decline in performance to 84.1% with the backlog increasing to approximately 4,100 patients.

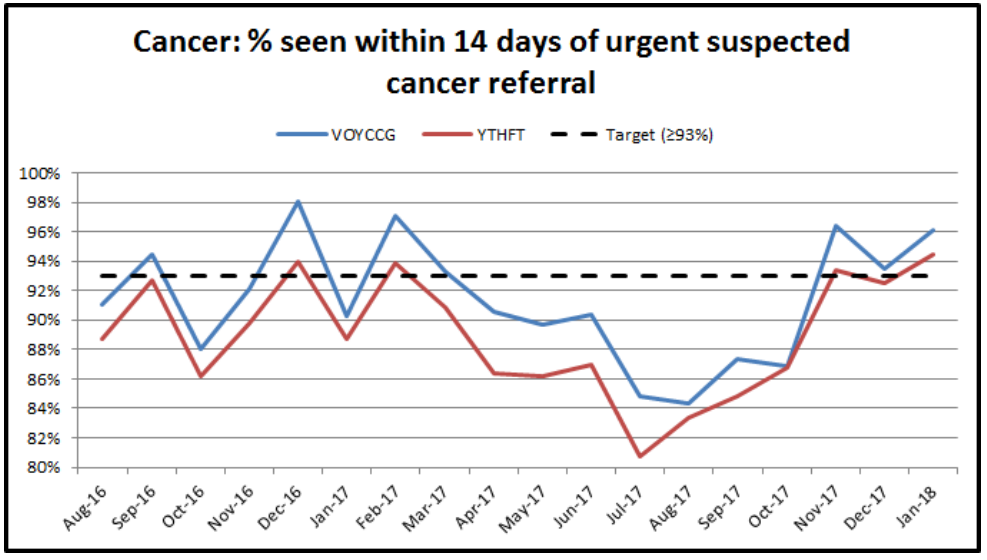
The Trust experienced sustained pressure linked to influenza strains and respiratory viruses within the local community during both December 2017 and January 2018. Ward 23 has been utilised as a flu ward for the past 2 months and Ward 39 is currently closed with Norovirus. The knock-on affect of the winter pressures impacted on bed capacity at York Hospital and RTT performance, as priority was given to urgent electives with the majority of routine electives being cancelled. 307 operations were cancelled due to bed shortages and non-clinical reasons in January 2018.

Long waits continue to be a significant concern in particular for Sleep Services, Urology, Ophthalmology, Max Fax, General Surgery and Dermatology. YHFT has submitted a bid to NHSE for additional funding to support Elective care post Winter but to date no response has been received. Long wait patients are reviewed weekly and prioritised through theatre planning and bed meetings.

The Trust is currently engaged with the NHSI productivity team to support effective theatre utilisation and productive working.

PERFORMANCE PLANNED CARE: CANCER TWO WEEK WAITS

Cancer: % 2WW referrals seen within 14 days (Target ≥93%)					
Vale of York CCG			York Trust		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
93.5%	96.1%	↑	92.5%	94.4%	↑



Tumour Type	VOYCCG: Total Referrals	Number of 2WW breaches	VOYCCG: % within 14 days
Lung	19	0	100.0%
Testicular	1	0	100.0%
Childrens	2	0	100.0%
Haematological Malignancies	3	0	100.0%
Breast	190	3	98.4%
Head and Neck	83	2	97.6%
Skin	136	5	96.3%
Lower Gastrointestinal	181	7	96.1%
Urological Malignancies	121	7	94.2%
Upper Gastrointestinal	70	5	92.9%
Gynaecological	65	5	92.3%
Sarcoma	0	0	N/A
Other Cancer	0	0	N/A
Brain/Central Nervous System	0	0	N/A
Grand Total	**871**	**34**	**96.1%**

Vale of York CCG achieved the 2WW Cancer Standard in January 2018 with a performance of 96.1% against the 93% target. York Hospital also achieved the 2WW target in January with 94.4% performance. Un-validated data for February also indicates that the Trust achieved 6 out of 7 Cancer Standards, including the 2WW target, in February 2018 but a concern was raised with the Trust, re the lengthy waits for the patients who breached.

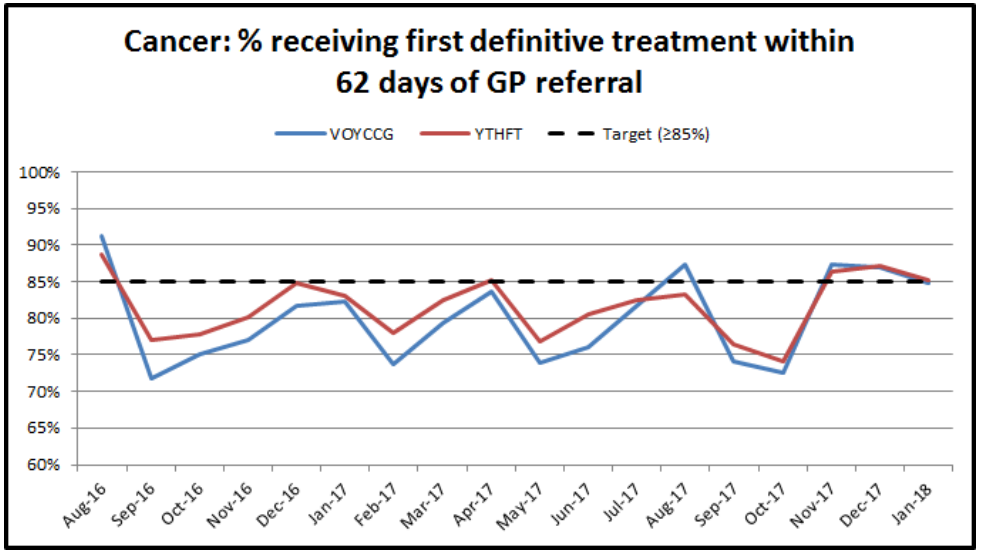
In total there were 34 breaches of the two week wait target for Vale of York CCG patients in January 2018:-
7 Urological, 7 Lower Gastro, 5 Skin, 5 Upper Gastro, 3 Breast , 5 Gynae and 2 Head & Neck.

The reasons for these delays were:-
12 Outpatient capacity inadequate
12 Patient cancellation
4 Patient declined dates offered within 2 weeks
4 Other
2 Admin delay

There is on-going colorectal two week wait improvement work focused on piloting FIT testing with SHIELD practices in 2018 which should capture 70,000 patients over 6 months

PERFORMANCE PLANNED CARE: CANCER 62 DAYS

Cancer: % treated within 62 days of urgent GP referral (Target ≥85%)					
Vale of York CCG			York Trust		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
87.0%	84.9%	↓	87.2%	85.1%	↓



Tumour Type	VOYCCG: Total Treated	VOYCCG: 62 day breaches	VOYCCG: % within 62 days
Other	1	0	100.0%
Haematological (Excluding Acute Leukaemia)	4	0	100.0%
Gynaecological	4	0	100.0%
Breast	19	1	94.7%
Lower Gastrointestinal	11	1	90.9%
Skin	14	2	85.7%
Urological (Excluding Testicular)	25	4	84.0%
Lung	6	2	66.7%
Upper Gastrointestinal	5	2	60.0%
Head & Neck	4	2	50.0%
Grand Total	**93**	**14**	**84.9%**

Vale of York CCG marginally failed to achieve the 62 Day target of 85% in January 2018 with performance of 84.9%, equating to 14 breaches out of a total 93 patients.

York Trust achieved the target with performance at 85.1% in January 2018 and un-validated for February shows they met the target for the third consecutive month.

The main reasons for the delays being:- access to diagnostics, late referrals and patient availability/needing time to think. The longest waiting times range from 63 – 201 days. The longest wait is by a Lung patient at 201 days, and Upper Gastro patients waiting 142 and 108 days due to cross site referrals. There are also long waiters within Skin cancer.

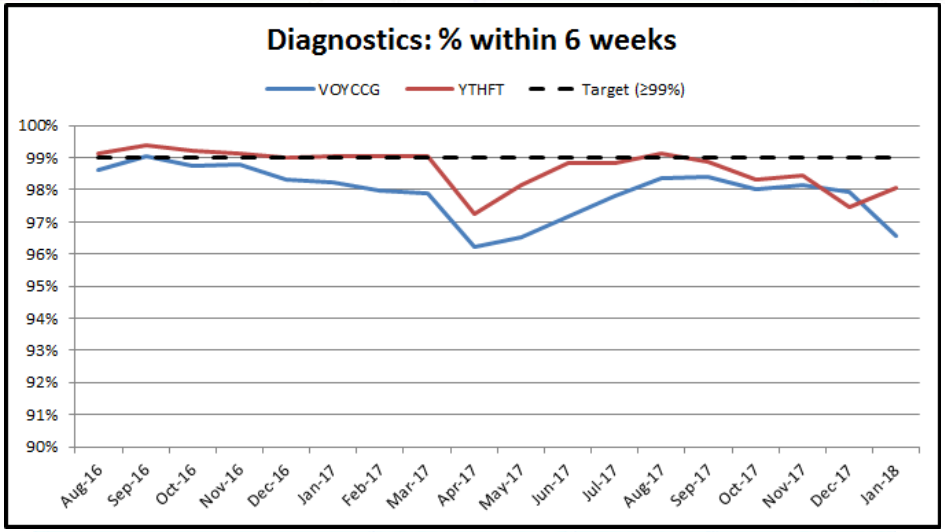
Clinical Harm Reviews are completed on all patients waiting over 104 days. A review is also underway to provide assurance that all possible options for diagnostics have been considered to reduce waiting times for patients.

The NHSI Elective Intensive Support Team visited York Trust in January to review 62 day processes and two clinical pathways – Lung and Haematology. It was a positive day and feedback is expected in February 2018.

YTHFT's Cancer Board has been reviewed and new arrangements will be implemented in January 2018, bringing closer alignment with the STP Cancer Alliance Priorities and the development of the local Trust Cancer Strategy.

PERFORMANCE PLANNED CARE: DIAGNOSTICS

Diagnostics: % within 6 weeks (Target ≥99%)					
Vale of York CCG			York Trust		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
97.9%	96.6%	↓	97.5%	98.1%	↑



Diagnostic Type	Total VOYCCG Waiting List	Total >6 weeks	within 6 weeks
BARIUM_ENEMA	23	0	100.00%
DEXA_SCAN	124	0	100.00%
AUDIOLOGY_ASSESSMENTS	288	1	99.65%
NON_OBSTETRIC_ULTRASOUND	825	8	99.03%
MRI	830	21	97.47%
FLEXI_SIGMOIDOSCOPY	72	2	97.22%
GASTROSCOPY	236	7	97.03%
URODYNAMICS	30	1	96.67%
CT	488	23	95.29%
CYSTOSCOPY	71	4	94.37%
PERIPHERAL_NEUROPHYS	53	4	92.45%
ECHOCARDIOGRAPHY	246	21	91.46%
COLONOSCOPY	176	16	90.91%
SLEEP_STUDIES	44	12	72.73%
ELECTROPHYSIOLOGY	0	0	
Grand Total	**3506**	**120**	**96.58%**

Vale of York CCG achieved 96.6% against the 99% target for patients waiting less than 6 weeks for a Diagnostic Test in January 2018. There were a total of 120 breaches out of 3,506 on the waiting list.

CT breaches at Hull and East Yorkshire Hospitals NHS Trust (HEY) increased with 20 breaches for Vale of York CCG patients and a further 19 breaches for Scarborough and Ryedale CCG patients. The new CT Scanner at HEY is not operational and CT scans are also being subcontracted out to Spire until the end of March 2018 to provide extra capacity and clear the current backlog.

There were 17 MRI breaches at York Hospital in January 2018. The Trust has submitted a bid to NHSE to provide additional funding to increase MRI capacity to accommodate the 'winter backlog' and the MRI patients waiting for GA clinics.
There were 11 Sleep Studies breaches, the business case for new equipment is awaiting CCG approval from Vale of York and Scarborough & Ryedale but is in discussion this month. January also showed an increase in the number of colonoscopy (14) and Echocardiography (11) breaches.

York Teaching Hospitals Foundation Trust's overall performance was 98.1% in January 2018 and did not meet the diagnostic target of 99%.

Un-validated data for February shows YHFT's performance at 97.9%.

KEY QUESTIONS: PERFORMANCE PLANNED CARE

Are targets being meet and are you assured this is sustainable?	What mitigating actions are underway?
Diagnostics – No **Cancer 2 week waits – Yes** **Cancer 62 day standard – Yes** **RTT – No**	**Diagnostics:** • York Trust has submitted a bid to NHSE for additional funding to increase diagnostic capacity and reduce the 'winter backlog'. This includes funding for additional:- • Endoscopy waiting list initiatives at both York and Scarborough, • Radiology - additional scanning and reporting • Cardiology ECHO ECP activity • Cytology Screening – to support 14 day turnaround times for cervical screening • Histopathology – to reduce 14 day and 62 day backlogs improving diagnostic turnaround times. **Cancer:** • NHSI Intensive Support Team are working with York Trust to improve 62 Day process and clinical pathways for Lung and Haematology. • YTHFT's Cancer Board has been reconfigured with 4 work groups focused on: timed pathways, diagnostics, quality surveillance and patient outcomes, living with and beyond cancer. • A clear understanding of the best approach to the management of patients with vague symptoms and design of a pathway to be piloted at York. • Clear understanding of the key issues within diagnostics and agreed actions required to reduce pressures • 3 additional radiographers trained to report plain film by June 2018, reporting 3000 plain film per annum and releasing consultant radiologist time to report an additional 6,000 complex radiographs. 2 WTE radiographers in post to support additional workload
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
YHFT Return to Operational Standards High Level Recovery Plan documents the actions and timescales for recovery.	

Programme Overview - Unplanned Care

Validated data to January (Month 10)

This dashboard provides an integrated overview of performance against QIPP, Contracting and key performance measures of the Unplanned Care Programme.

Executive Lead:
THIS NEEDS TO BE CONFIRMED BY EXEC COMMITTEE
Programme Leads :
Fiona Bell, Assistant Director of Transformation & Delivery
Becky Case, Head of Transformation and Delivery
Clinical Lead:
Andrew Phillips, Medical Director

NHS
Vale of York
Clinical Commissioning Group

QIPP: UNPLANNED CARE MONTH 11

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
UNPLANNED CARE									
Community Podiatry	IC4	May-17	358	358	308	393	393	339	New contract in place from 1st May 2017. YTD saving based on forecast profile until validated activity information available
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	386	386	323	421	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	217	217	187	217	217	187	New contract in place but costs higher than expected. YTD saving based on forecast until expenditure data available
Community Equipment service re-procurement	187	Apr-17	418	418	0	418	418	0	New contract in place but costs higher than expected. YTD saving based on forecast until expenditure data available
Patient Transport - contracting review	190a	Apr-17	11	11	11	11	11	11	Scheme in place since May 2016, FYE in April. YTD saving based on plan until expenditure data available
Unplanned Care Programme (including urgent care and out of hospital care)	149	Jul-17	733	733	0	824	824	0	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	693	693	185	756	756	202	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Review of community inpatient services - Phase II	019b	Oct-17	167	167	0	200	200	0	
RightCare Phase 2 - Trauma & Injuries	017	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
Patient Transport project - re-procurement	190b	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*

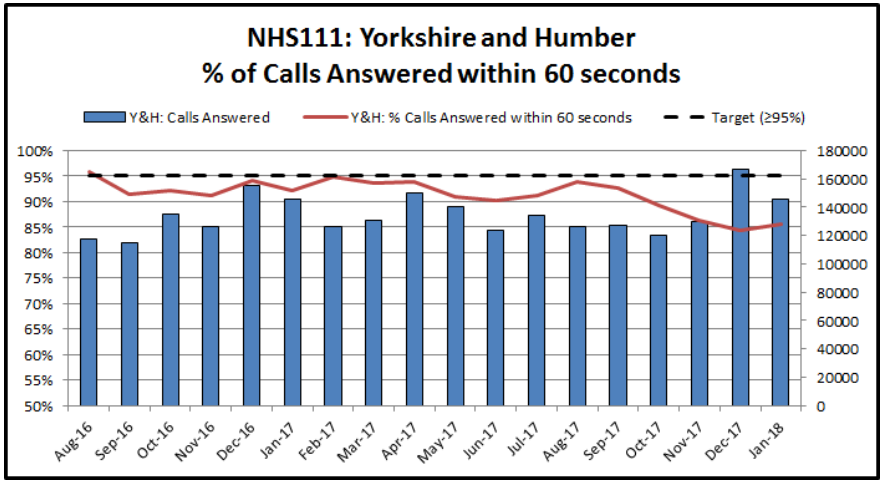
QIPP: UNPLANNED CARE MONTH 11

KEY QUESTIONS: UNPLANNED CARE QIPP

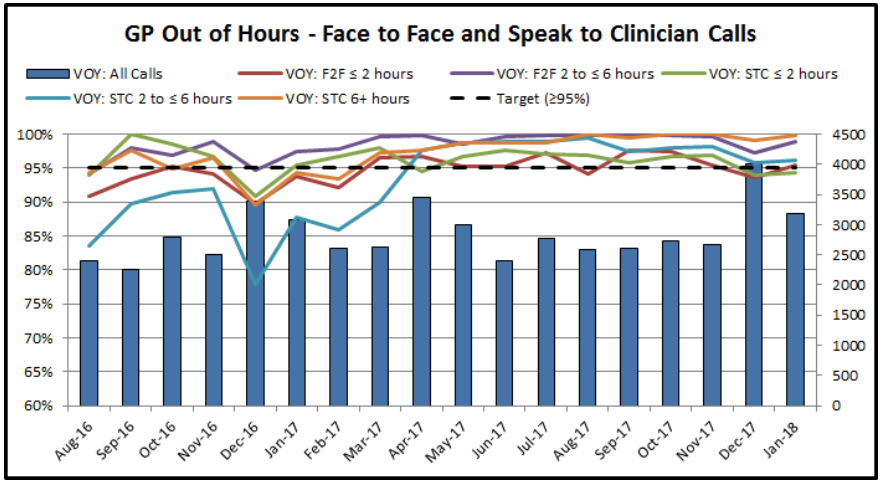
Are QIPP targets being met and are you assured this is sustainable?	What mitigating actions are underway?	Is further escalation required?
See highlights from financial recovery incorporated in Finance report		

PERFORMANCE UNPLANNED CARE: NHS111, GP OOH, YAS and ED

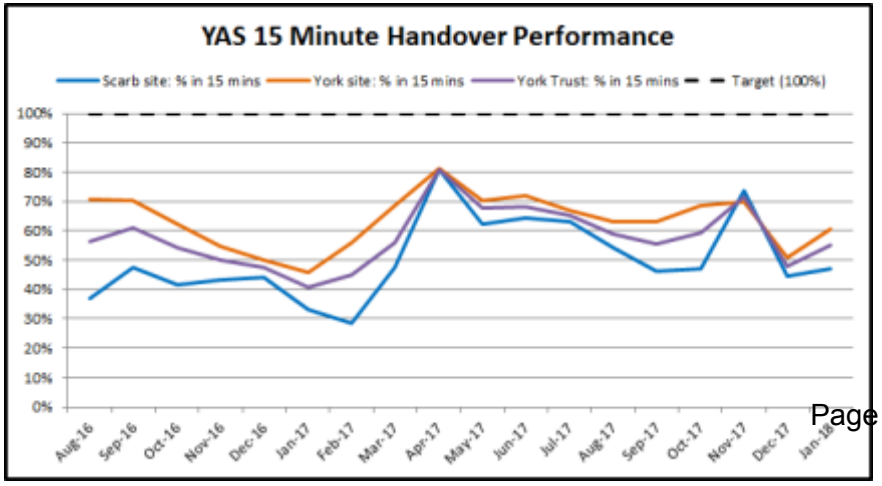
NHS111: Yorkshire and Humber					
Calls Offered			% Answered within 60 seconds		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
170,251	148,703	↓	84.4%	85.6%	↑



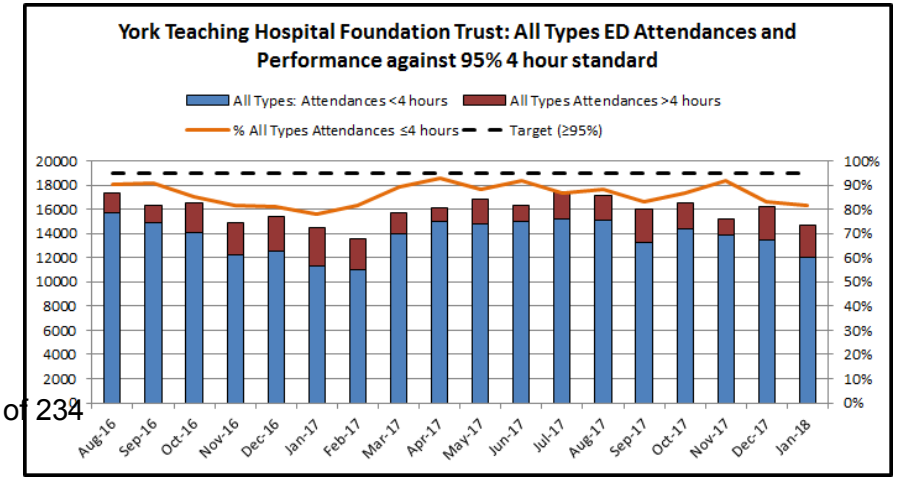
GP Out of Hours - Face to Face and Speak to Clinician Calls					
F2F calls within ≤2 hours (Target 95%)			STC calls within ≤2 hours (Target 95%)		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
93.6%	95.4%	↑	94.0%	94.4%	↑



YAS 15 Minute Handover Performance					
Scarborough site (Target 100%)			York site (Target 100%)		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
44.6%	47.2%	↑	50.7%	60.4%	↑

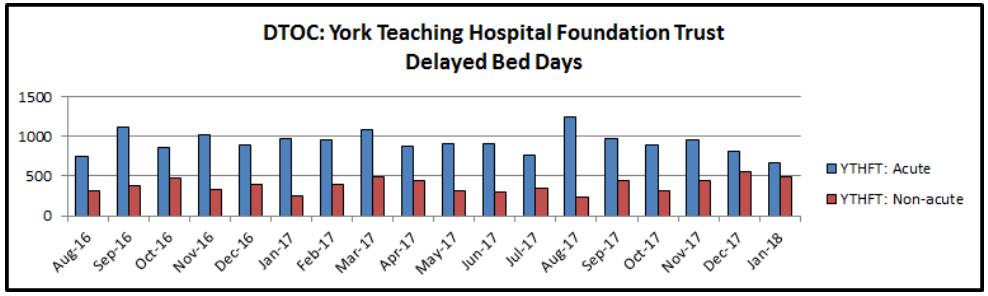


York Teaching Hospital Foundation Trust: ED 4 hour standard					
All Types Attendances			All Types % within 4 hours		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
16,236	14,712	↓	83.0%	81.5%	↓

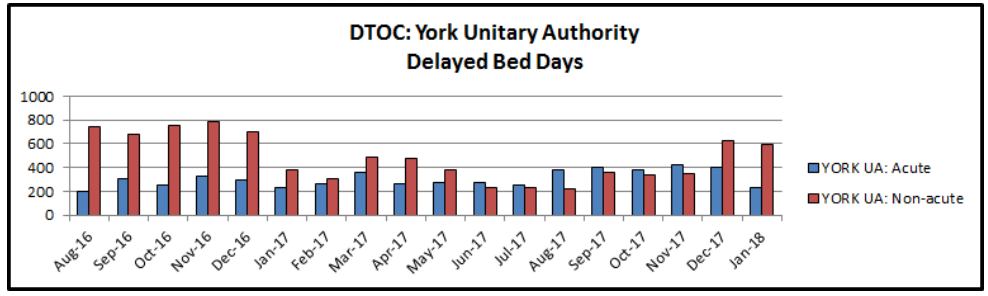


PERFORMANCE UNPLANNED CARE: DELAYED TRANSFERS OF CARE

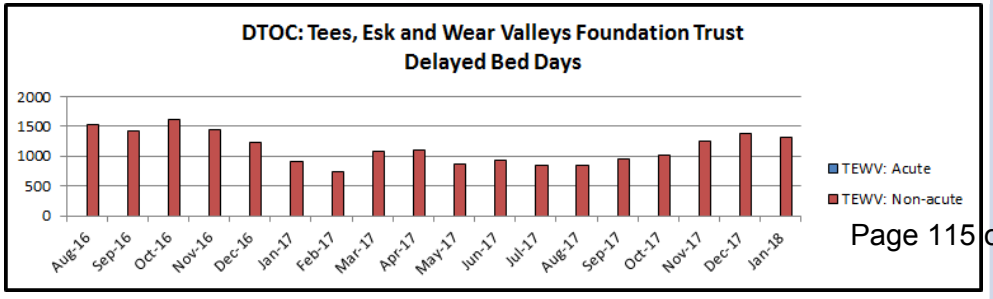
DTOC: YTHFT Delayed Bed Days					
Acute			Non-acute		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
802	660	⇩	556	483	⇩



DTOC: York UA Delayed Bed Days					
Acute			Non-acute		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
399	227	⇩	626	599	⇩



DTOC: TEWV Delayed Bed Days					
Acute			Non-acute		
Dec-17	Jan-18	DoT	Dec-17	Jan-18	DoT
N/A	N/A	N/A	1376	1314	⇩



The number of bed days for acute DTOCs reduced to 660 in January 2018 from 802 in December 2017. There was also a reduction in the bed days for non-acute DTOCs from 556 in December to 483 in January 2018.

York Hospital experienced sustained pressure linked to the influenza strains and respiratory viruses within the local community in December and January 2018. Flu patients have been cohorted on Ward 23 for the past 2 months and wards have also been affected by Norovirus. Symptomatic patients on these wards are unable to be discharged and whilst this impacts on bed capacity, they do not count as delayed transfers of care.

<u>Actions to address the poor performance include:</u>

1. With effect from Saturday 2 December 2017 Social Workers and Care Staff are working 7 days per week to facilitate discharges from York Hospital.
2. Discharge Liaison Team at York Hospital are operating 7 days per week with effect from February 2018.
3. CYC increased the number of hours for packages of home care from providers in January 2018 to assist with discharges.
4. Continuing health care – CHC nurses now co-located at Archways with hospital discharge team and social workers.
5. Discharge to Assess beds at South Park are being utilised as step down beds when vacant.

KEY QUESTIONS : PERFORMANCE UNPLANNED CARE

Are targets being meet and are you assured this is sustainable?

- **4-hour standard:** Performance targets continued to be challenging during January, easing slightly at the start of February, prior to very poor weather bringing new challenges towards the end of February/start of March.
- **Ambulance Handovers**: Again there have been a number of difficulties in January and February, but resilience has been good. There has been a boundary divert for West York patients to Harrogate since January.
- **YAS response times:** These are now being reported against the new ARP targets. We also now have access to specific information for care homes. Targets are not currently being met across Yorkshire.
- **OOH GP**: performance has been good, including during the poor weather.
- **EDFD:** Contracting continues to challenge the financial model. A paper will go to Exec on 21/03 to describe potential process for new operational model.
- **NHS111:** performance has been mostly good, despite difficulties with staff access to their operational hub during the poor weather.
- **DTOC**: Acute DTOCs continue to improve. Non-acute and MH DTOCs have fallen from December, but this was from a high comparator. Ongoing work is sustainable although there will be review of bed spend post winter funding.
- **Utilisation review**: YTHFT have commissioned Ernst & Young to support an internal flow review and MADE/stranded patient audit work continues.

What mitigating actions are underway?

- **4-hour standard:** performance standards continue to be not met. E&Y review may impact on the internal issues affecting bed usage and flow.
- **Ambulance Handovers:** the ongoing divert is moving up to 12 patients are week from ED, and ad-hoc diverts between York and Scarborough have been well utilised and flexible over winter.
- **YAS response times:** We have asked for a CCG breakdown as at present it is impossible to tell where the targets are not being met and hence why. There has been discussion about rural/urban centres.
- **OOH GP:** No mitigating actions required at present; monitoring continues.
- **EDFD:** Work to be progressed on the Exec paper, and clear understanding of resource requirement to be outlined.
- **NHS111:** No mitigating actions required at present; monitoring continues.
- **DTOC:** Complex discharge group met at start of February, actions progressing, One Team work ongoing, Integrated Discharge Hub meeting daily. Spot purchase taking place and CHC beds ring-fenced. Weekend social care becoming embedded.
- **Utilisation review:** Will be reviewed once complete.

Is there a trajectory and a date for recovery/improvement?

- **4-hour standard:** currently we are not meeting the joint trajectory, although NHSE have been supporting system calls and understand that all system actions are being undertaken to manage performance. Winter review 12/03.
- **Ambulance Handovers:** current performance matches that seen regionally; monitoring to continue. YTHFT are reviewing staff/data input process.
- **YAS response times:** CCG performance review to take place when possible.
- **OOH GP:** not applicable at present.
- **EDFD**: not applicable at present.
- **NHS111**: not applicable at present.
- **DTOC**: trajectory now agreed, actions underway, winter funding to support. Escalation of issues to senior teams took place, weekend support continues.

Is further escalation required?

- **4-hour standard:** Performance recovered in February but dipped again to the end of the month. There are signs of system recovery from the first week of March but this does not feel robust at present.
- **Ambulance Handovers**: YTHFT to inform us of data review outcome.
- **YAS response times**: No
- **OOH GP**: No
- **EDFD**: Not at present
- **NHS111**: No
- **DTOC**: Continued focus from Complex Discharge Group and associated programmes. AEDB aware of issues.

Programme Overview - Mental Health, Learning Disability, Complex Care and Children's

Validated data to January (Month 10)

This dashboard provides an integrated overview of performance against QIPP, Contracting and key performance measures of the MH LD CC & Children's Programme.

Executive Lead:
Denise Nightingale, Executive Director of Transformation & Delivery
Programme Leads :
Paul Howatson, Head of Joint Programmes
Bev Hunter, Head of Mental Health Commissioning
Clinical Lead:
Louise Barker, GP

NHS
Vale of York
Clinical Commissioning Group

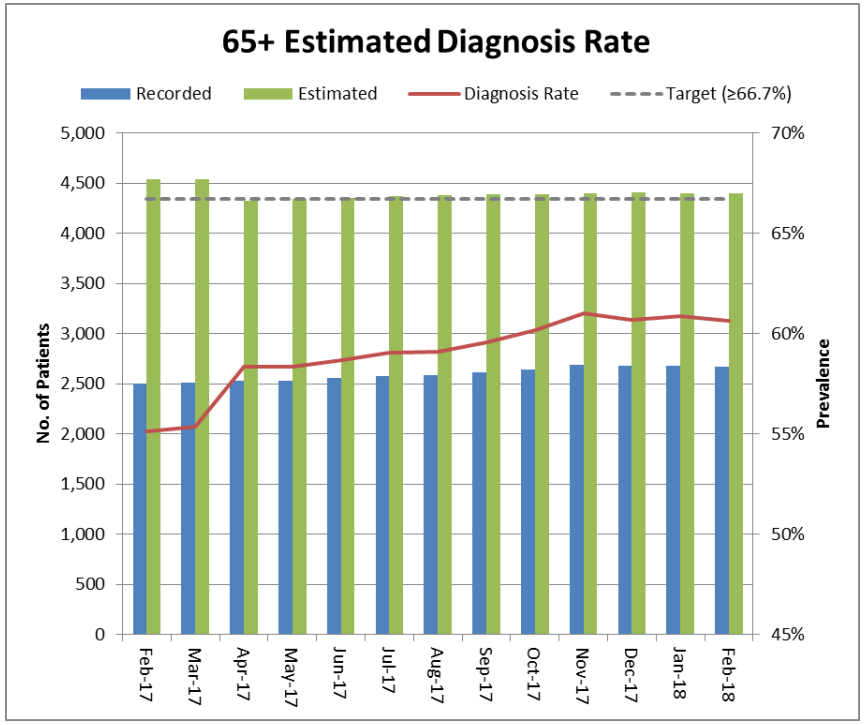
MENTAL HEALTH, LEARNING DISABILITY SERVICES, COMPLEX CARE & CHILDREN: CONTRACT MONTH 11

	Cumulative To Date			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Mental Health Services						
Tees Esk and Wear Valleys NHS Foundation Trust	36,334	36,480	(146)	39,650	39,805	(154)
Out of Contract Placements and SRBI	4,791	6,903	(2,111)	5,227	7,307	(2,080)
Non-Contracted Activity - MH	386	359	27	421	419	2
Other Mental Health	214	214	0	272	272	0
Total	**41,725**	**43,955**	**(2,230)**	**45,571**	**47,803**	**(2,232)**
Continung Healthcare						
Continuing Care	23,915	25,197	(1,282)	26,033	27,567	(1,534)
Funded Nursing Care	4,588	3,541	1,047	5,005	3,863	1,142
Total	**28,503**	**28,738**	**(235)**	**31,038**	**31,430**	**(392)**

PERFORMANCE : MENTAL HEALTH – DEMENTIA

Dementia				
65+ Estimated Diagnosis Rate				
Nov-17	Dec-17	Jan-18	Feb-18	DoT
61.0%	60.7%	60.9%	60.6%	↓

Practice data to follow



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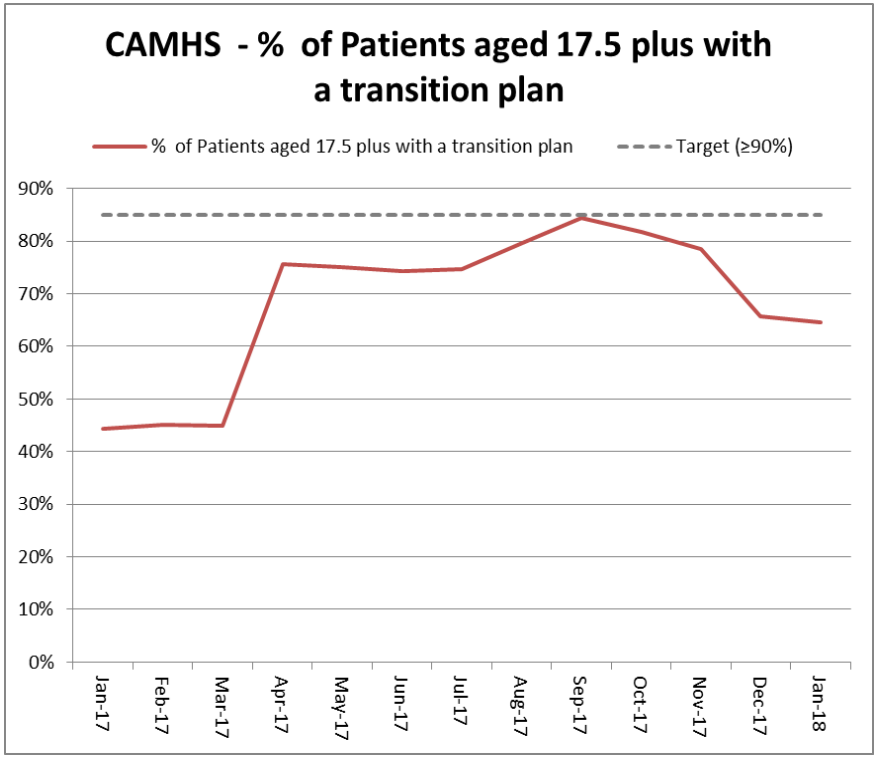
65+ Dementia Diagnosis rate decreased from 60.9% in January 2018 to 60.6% in February 2018.

Note: Rise in April 2017 relates to the recalculation of Estimate Prevalence

PERFORMANCE : MENTAL HEALTH

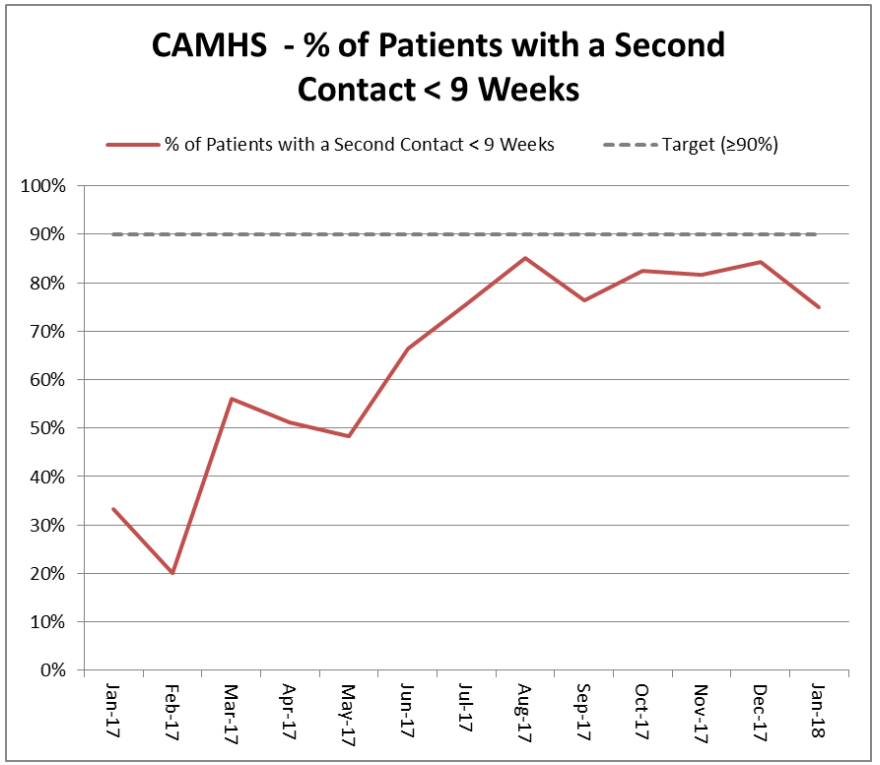
CAMHS				
% of Patients aged 17.5 plus with a transition plan				
Oct-17	Nov-17	Dec-17	Jan-18	DoT
81.7%	78.5%	65.8%	64.5%	↓



The position for January is 64.47%, which is attributable to 27 breaches out of 76 patients.

Reason	Count
New to Service	15
No Transition Plan - Clinicians Contacted	3
Discharged	8
No Recent Engagement	1
	27

CAMHS				
% of Patients with a Second Contact < 9 Weeks				
Oct-17	Nov-17	Dec-17	Jan-18	DoT
82.5%	81.7%	84.3%	75.0%	↓

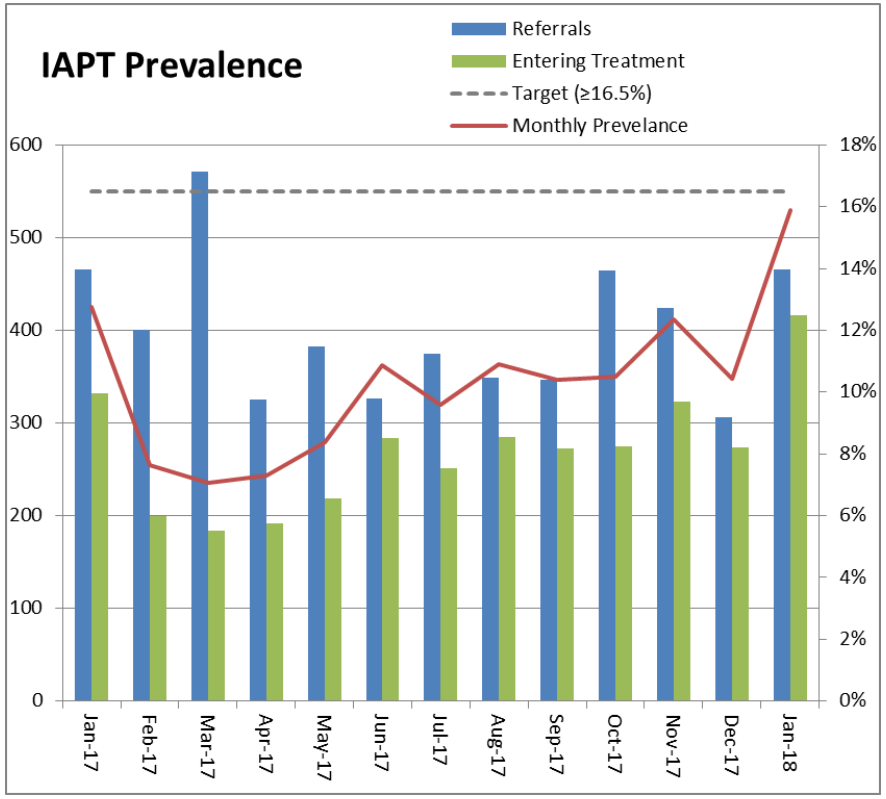


The position for January is 75.00%, which is attributable to 19 breaches out of 76 patients.

Reason	Count
Staff Capacity	14
Availability of Specialist Workers	1
Other (2 Data Quality, 1 Patient Choice, 1 Process Issues)	4
	19

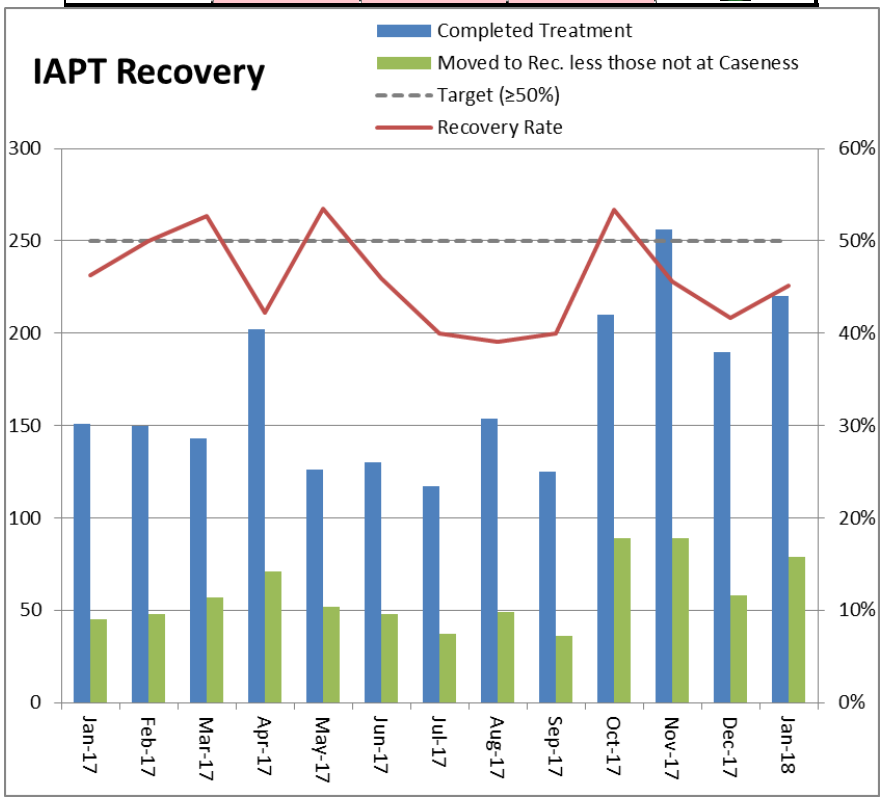
PERFORMANCE : MENTAL HEALTH

IAPT Prevalence				
Org.	Nov-17	Dec-17	Jan-18	DOT
TEWV	11.6%	10.3%	16.1%	↑
Humber	29.6%	13.9%	13.0%	↓
Combined	**12.3%**	**10.4%**	**15.9%**	↑



The position for January is 15.9% across TEWV and Humber. This is a increase from 10.4% in December. There has been an increase in activity in January with 416 patients entering treatment compared to 273 in December.

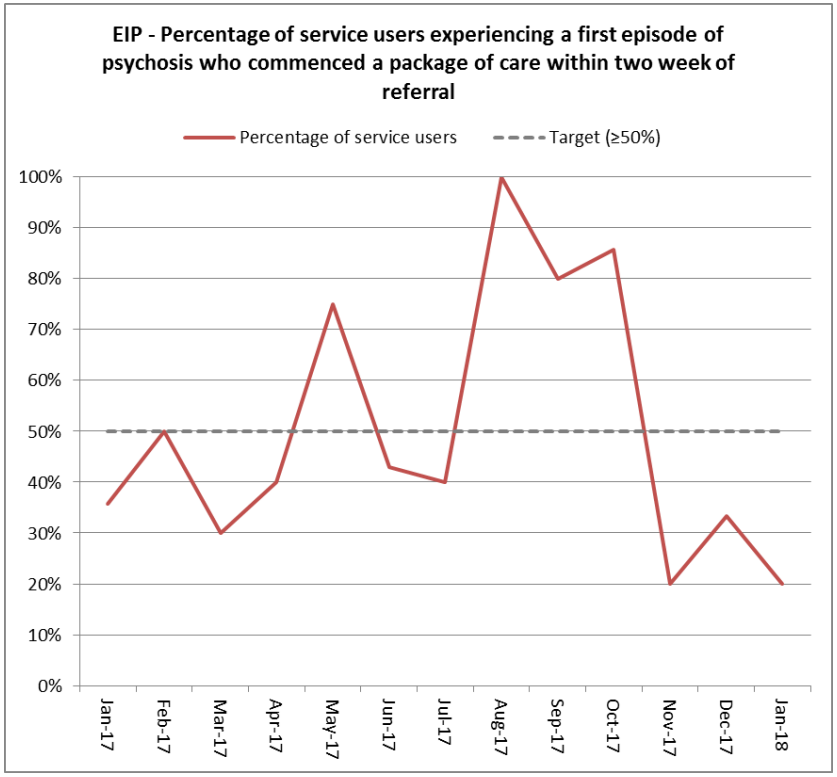
IAPT Recovery				
Org.	Nov-17	Dec-17	Jan-18	DOT
TEWV	44.0%	39.6%	43.9%	↑
Humber	56.7%	62.5%	53.8%	↓
Combined	**45.6%**	**41.7%**	**45.1%**	↑



The position for January is 45.1% across TEWW and Humber. This is an increase from 41.7% in December.

PERFORMANCE : MENTAL HEALTH / CONTINUING HEALTHCARE

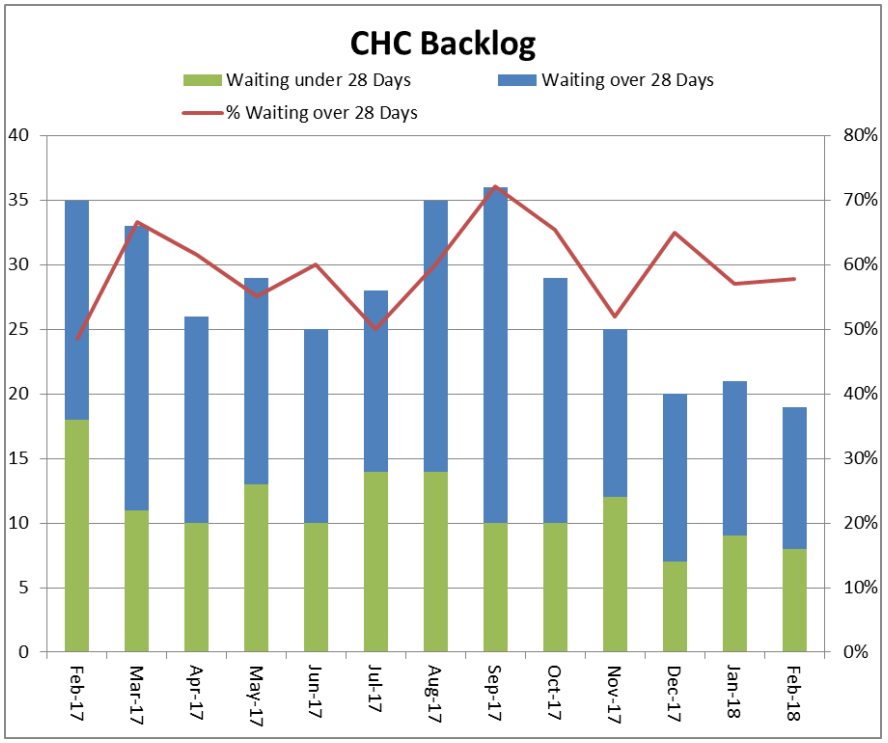
EIP				
Percentage of service users experiencing a first episode of psychosis who commenced a package of care within two week of referral				
Oct-17	Nov-17	Dec-17	Jan-18	DoT
85.7%	20.0%	33.3%	20.0%	



The adverse movement in the position is attributable to 4 breaches out of 5 patients.

- 2 breaches were attributed to staff capacity although 1 of the breaches was subsequently seen within 20 days of referral.
- 2 breaches were attributed to patients not attending. Both patients did commence treatment thereafter.

Continuing Healthcare			
Backlog			
Dec-17	Jan-18	Feb-18	DoT
65.0%	57.1%	57.9%	

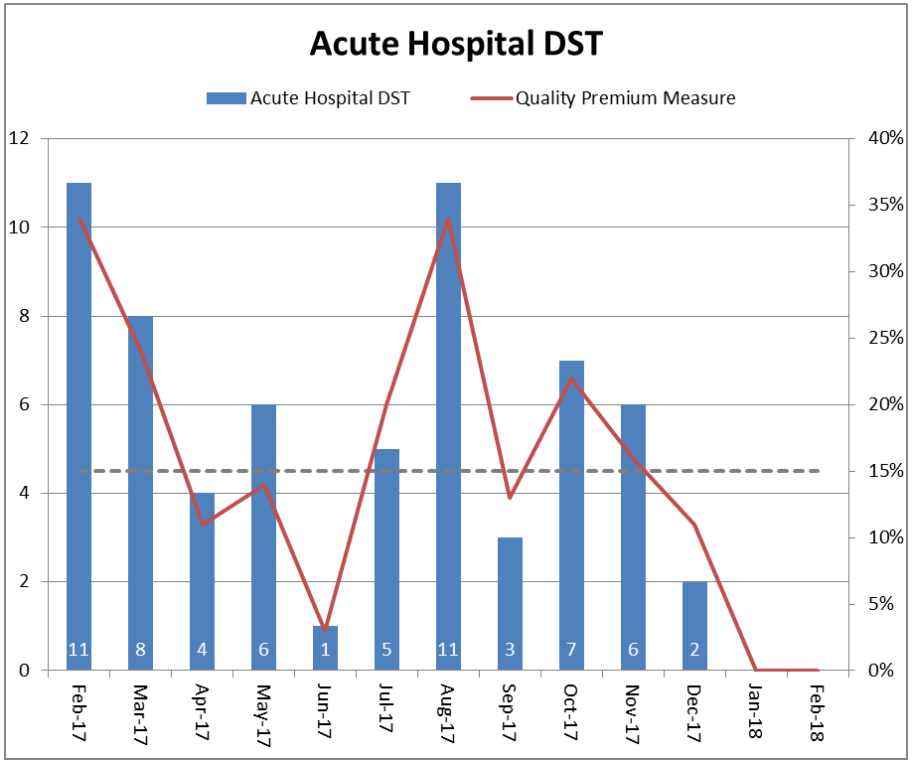


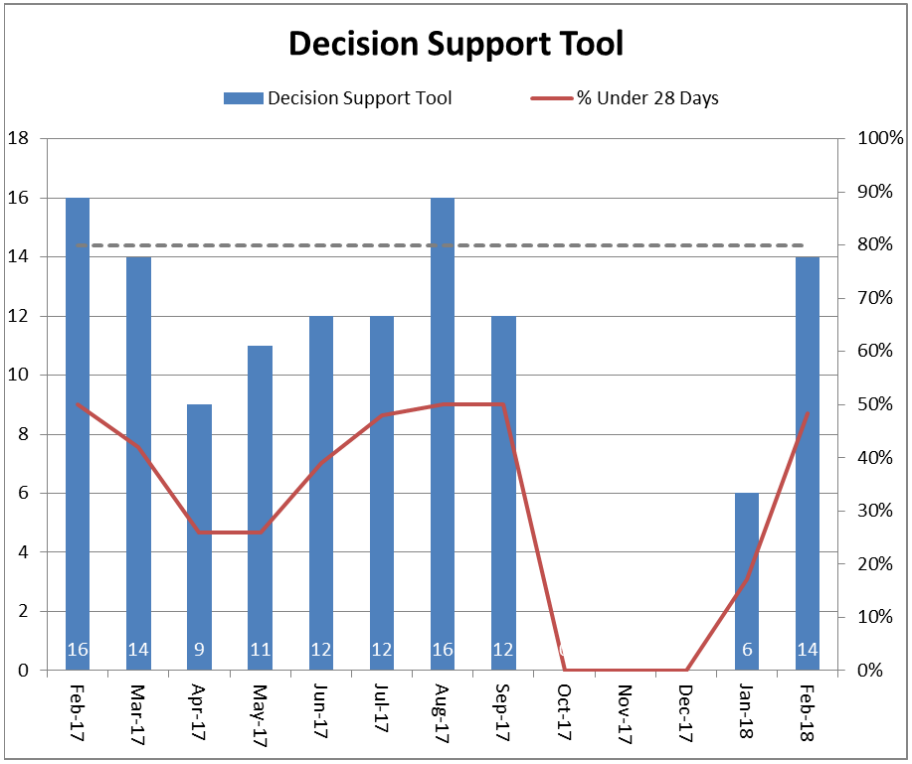
Months Waiting					
1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	Total
3	2	6	0	0	11

An overall reduction over time is noted and some long waiters require specialist CHC nurse skills relating to children's transition which is currently a workforce gap.

Note: Data is unvalidated.

PERFORMANCE : MENTAL HEALTH / CONTINUING HEALTHCARE





No DST's were undertaken in an Acute Hospital in February 2018.

Note that 2 DST undertaken in Oct-17 and Dec-17 had their outcomes reported in Jan-18.

80% of DSTs undertaken from referral to decision within 28 days not achieved although delivery for February in line with NHSE VOYCCG recovery plan.

KEY QUESTIONS: MENTAL HEALTH, LEARNING DISABILITY SERVICES, COMPLEX CARE & CHILDREN

Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
Mental Health: **IAPT :** No **Dementia :** No **CAMHS :** No **EIP:** No **Psych Liaison**: No **CHC :** **Monthly Acute Hospital DST Activity :** Yes **Decision Support Tool :** No	**IAPT** :The CCG has met with NHSE and TEWV for an assurance visit monitoring progress. CMB is expecting a business case ,which will outline TEWV's long term plans for achieving targets up until 2021. Validated data for January is reported at 15.9% **Dementia** : The CCG has met with NHSE and TEWV for an assurance meeting to monitor progress against the IST action plan. Significant progress has been made to date. Work is on-going with Primary Care to increase the dementia diagnosis rates. The CCG executive team approved a resource to further support GPs to increase the diagnosis rates to the end of March. **CAMHS** Draft CAMHS improvement plan being finalised through CMB. **EIP** : A deep dive conducted by NHS England/TEWV/CCG identifies a gap in resources and additional referrals to the service due to unprecedented levels of activity. **Psychiatric Liaison :** The CCG is evaluating the current level of activity and will continue to monitor the shortfall in performance at the monthly CMB. **CHC:**. NECs not currently started the work. **PHB**: targets for increasing the numbers are not being met-review of opportunity and process underway. **DST**s done out of hospital now meeting target due to discharge to assess pathway & performance management.
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
IAPT : Yes – Action plan in place to achieve 15% access, which has been exceeded, and 50% recovery sustainably during Qtr4 2017/18. This is lower than the current national target of 16.8%. Work is underway to develop plans for increasing targets beyond 2018 and depends on future investment. **Dementia :** The tasks in the action plan support progress towards delivery of the national target of 66.7% and this will be reviewed regularly. Additional remedial actions have been put in place for further improvements. **CAMHS :** Further plans are being developed with TEWV to meet required performance targets. **EIP** : Continues to be monitored at CMB and identified as a priority area for investment. **Psychiatric Liaison :** Performance is being monitored	**IAPT recovery:** Verbal update to F & P Committee. **Dementia :** Verbal update to F & P Committee. **CAMHS :** Verbal update to F & P Committee **EIP** : Verbal update to F & P Committee **Psychiatric Liaison :** No escalation required at this stage. ***CHC :*** *No further escalation at present*

Programme Overview - Primary care

Month 11

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PRIMARY CARE									
Dermatology Indicative Budgets	195	Apr-17	36	36	28	36	36	28	Scheme in place since 2016/17, saving in 2017/18 is FYE. YTD saving based on forecast until validated acute data available
GP IT - NYNET	003	May-17	167	167	167	183	183	183	Scheme up and running?
Roll out indicative budgets to other specialities	020	Jul-17	67	67	0	75	75	0	

Acronyms

2WW	Two week wait: Urgent Cancer Referrals Target
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactive Disorder
AEDB	A and E Delivery Board
AIC	Aligned Incentives Contract (A non-payment by results contracting approach)
AMM	Acute Medical Model (Emergency care service)
CAMHS	Child and Adolescent Mental Health Services
CC	Continuing Care
CEP	Capped Expenditure Process
CGA	Comprehensive Geriatric Assessment
CHC	Continuing Healthcare
CMB	Contract Management Board
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (framework)
CRUK	Cancer Research UK
CT	Computerised Tomography Scan
CYC	City of York Council
DNA	Did not attend
DTOC	Delayed Transfer of Care
DEXA	Dual energy X-ray absorptiometry scan
DQIP	Data Quality Improvement Plan (in standard acute contract)
ED	Emergency Department

Acronyms continued

EDFD	Emergency Department Front Door
EMI	Elderly Mentally Infirm
ENT	Ears Nose & Throat
F&P/ F&PC	Finance & Performance Committee (CCG)
FIT	Faecal Immunochemical Test
FNC	Funded Nursing Care
GA	General Anaesthetic
GI	Gastro-intestinal
GPFV	GP Forward View
H&N	Head and Neck
HCV	Humber, Coast & Vale (Sustainable Transformation Plan or STP)
HR&W	NHS Hambleton, Richmondshire and Whitby CCG
HaRD	NHS Harrogate and Rural District CCG
IAF	Integrated Assurance Framework (NHS England)
IAPT	Improving Access to Psychological Therapies
IFR	Individual Funding Review (complex care)
IPT	Inter-provider transfer (Cancer)
IST	Intensive Support Team
LA	Local Authority
LD	Learning Disabilities
LDR	Local Digital Roadmap
MCP	Multi-Care Practitioner
MDT	Multi Disciplinary Team

Acronyms continued

MH	Mental health
MMT	Medicines Management Team
MNET	Medical Non Emergency Transport
MSK	Musculo-skeletal Service
MIU	Minor Injuries Unit
NHSE	NHS England
NHSI	NHS Improvement
NYCC	North Yorkshire County Council
NYNET and	NYNET Limited (created by North Yorkshire County Council, provides WAN connectivity broadband services to private and public sector sites)
ONPOS	Online Non Prescription Ordering Service
OOH	Out of hours
PCH	Primary Care Home
PCU	Partnership Commissioning Unit
PIB	Permanent Injury Benefit
PID	Project Initiation Document
POD	Point of Delivery
PM	Practice Manager
PMO	Programme Management Office
PNRC	Procedures Not Routinely Commissioned
QIPP	Quality, Innovation, Productivity and Prevention
RRV	Rapid Response Vehicle
RSS	Referral Support Service
RTT	Referral to treatment

Acronyms continued

S&R/ SCRCCG	NHS Scarborough and Ryedale CCG
SRBI	Special Rehabilitation Brain Injury
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Plan
STT	Straight to Triage
SUS	Secondary Uses Service (data)
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
T&I	Trauma and Injury
TIA	Transient Ischaemic Attack
ToR	Terms of Reference
UCC	Urgent Care Centre
UCP	Urgent Care Practitioner
VoY	Vale of York
VoY CCG	NHS Vale of York CCG
VCN	Vale of York Clinical Network
YAS	Yorkshire Ambulance Service
YDUC	Yorkshire Doctors Urgent Care
Y&H	Yorkshire & Humber (region)
YTH/YTFT/YTHFT/York FT	York Teaching Hospital NHS Foundation Trust
YDH	York District Hospital
YHEC	York Health Economics Consortium

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Item Number: 11

Name of Presenter:Tracey Preece

Meeting of the Governing Body

5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Consideration of Director Declarations including 'Going Concern Status' for the 2017-18 Accounts

Purpose of Report
For Decision

Reason for Report

For the financial year ended 31 March 2018, the CCG's external auditors, Mazars, are required to ask management and those charged with governance (including the CCG Governing Body) about the arrangements the entity has put in place to prevent and detect fraud and comply with applicable law and regulations.

The purpose of this report is to propose a response to the questions and request agreement on a collective response from the Governing Body.

This report also includes the final version of the going concern paper which has previously been received and reviewed by the Audit Committee in draft at their meeting in March 2018.

Finally, this report requests that the Governing Body formally give formal delegated approval to the Audit Committee to approve the Annual Report and Accounts on its behalf prior to national submission at the end of May. This is planned for the Committee meeting on 23 May 2018.

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

It is recommended that Governing Body agree a collective response to the proposed questions posed by the CCG's external auditors, Mazars.

It is recommended that the Governing Body delegate approval to the Audit Committee to approve the Annual Report and Accounts on its behalf prior to national submission at the end of May.

Responsible Executive Director and Title	**Report Author and Title**
Tracey Preece, Chief Finance Officer	Tracey Preece

Annexes

Annexe 1 – Mazars Request for Declarations 2017-18
Annexe 2 – Consideration of 'Going Concern Status' 2017-18

Director's Declarations

For the financial year ended 31 March 2018, the CCG's external auditors, Mazars, are required to ask management and those charged with governance (including the CCG Governing Body) about the arrangements the entity has put in place to prevent and detect fraud and comply with applicable law and regulations. This is set out in the Request for Declarations 2017-18 (see Annexe 1). The purpose of this report is to propose a response to the questions and request agreement on a collective response from the Governing Body.

Questions about arrangements for preventing and detecting fraud

How does the Governing Body assess the risk that the financial statements may be materially misstated due to fraud?

The Governing Body and Finance and Performance Committee receive detailed finance reports throughout the year, monthly, which outline the current position, forecast outturn and all risks. The reports also highlight reasons for any variances and all movements from one month to another. This gives a high degree of assurance that the financial position reported in the financial statements is consistent with that reported throughout the year and is not subject to material misstatement due to fraud.

Internal Audit conduct audits during the year on all key financial control systems and no material issues regarding potential fraud have been raised.

All finance and contracting staff are trained and qualified to an appropriate level and work to detailed financial reporting guidelines. All CCG staff can also access the Healthcare Financial Management Association e-learning package as an introduction to NHS finance.

The CCG are required to report monthly to the NHS England Area Team who has full access to the CCG general ledger.

Throughout 2017/18 the CCG has been operating under legal Directions and has been agreeing monthly financial reporting and planning information alongside the NHS England finance team.

Is the Governing Body aware of the management's process for identifying and responding to the risks of fraud generally and specific risks of misstatement in the financial statements?

The process for identifying and responding to such risks is managed through the Audit Committee which is clear in the terms of reference of the committee, the CCG policy and the governance arrangements for the CCG which all Governing Body members are aware of.

Is the Governing Body aware of the arrangements in place for management to report about fraud to the Governing Body?

All fraud reporting is done through the Audit Committee which is clear in the terms of reference of the committee, the CCG policy and the governance arrangements for the CCG which all Governing Body members are aware of. The Audit Committee receive regular reports from the Head of Anti-Crime Services and the Governing Body receives the minutes and a Chair's report from the Audit Committee.

Is the Governing Body aware of the arrangements management have in place, if any, for communicating with employees, lay members, partners and stakeholders regarding ethical governance and standards of conduct and behaviour?

The CCG has a 'Policy on Business Conduct' policy which is available to all staff, partners and stakeholders on the website. The subject is also covered in the induction process and any relevant issues communicated to staff through the weekly team brief. Governing Body and committee members regularly discuss relevant issues, in particular in relation to conflict of interests, and these are recorded in the relevant minutes.

Does the Governing Body have knowledge of actual or suspected fraud, and if so is it aware of what actions management is taking to address it?

It is outlined in the Annual Counter Fraud Plan 2017/18 that the Local Counter Fraud Specialist (LCFS) will provide updates for the Audit Committee on counter fraud work, including updates on current and concluded fraud investigations and proactive counter fraud work undertaken. The update reports identify the outcomes from fraud investigations, what - if any - sanctions were obtained and details of any system weaknesses exploited by fraudsters and the action taken by management to address them. Audit Committee minutes and a summary report are provided to Governing Body.

What arrangements are in place for the Governing Body to oversee management arrangements for identifying and responding to the risks of fraud and the establishment of internal control?

The arrangements for identifying and responding to the risks of fraud are enshrined in the Local Anti-Fraud, Bribery and Corruption Policy and the Audit Committee has oversight of the processes from the update reports and Annual Counter Fraud Report provided by the LCFS. The Audit Committee provides assurance to the Governing Body that the business of the CCG is being conducted in line with the policy.

Questions about arrangements for complying with law and regulations responsibilities

Has management provided a clear statement which confirms its consideration of relevant laws and regulations and its compliance with them?

The principal legal requirements were embodied in the Health and Social Care Act 2012 which significantly amended the NHS Act 2006. The CCG adopted the model constitution which itself contained the legal requirements and was published by the NHS Commissioning Board (NHS England). Where appropriate and necessary, specific advice is sought on any given matter that arises.

The CCG has complied with the requirements of the legal Directions in place from NHS England effective 1st September 2016 and has provided the Governing Body with regular updates.

How does the Governing Body satisfy itself that all relevant laws and regulations are being complied with?

The Audit Committee and Governing Body receive and approve an Annual Governance Statement in addition to regular reports on any non-compliance. The CCG also complies with the various reporting requirements as directed by NHS England.

Is the Governing Body aware of any instances of non-compliance with laws or regulations?

Other than the breach of the statutory duty of the CCG to remain within resources, the CCG management are not aware of any instances of non-compliance with laws or regulations.

Has management provided a list of litigation and claims?

No new claims have been made since the CCG was established.

Has as assessment been made of the outcome of the litigation or claim and its estimate of the financial implications, including costs involved?

Not applicable.

Has the reasonableness of management's assessments been considered and additional information provided to the auditor where necessary?

Not applicable.

Questions about the appropriateness of the going concern assumption

Has a report been received from management forming a view on going concern?

A draft going concern paper was presented to and considered by the Audit Committee in March 2018. The paper has been updated to reflect the latest position and is attached in Annexe 2 for Governing Body consideration and approval.

Are the financial assumptions in that report (e.g. future levels of income and expenditure) consistent with the strategic business plan and the financial information provided to the Governing Body throughout the year?

The financial assumptions within the report are in line with the CCG's Medium Term Financial Strategy approved by the Governing Body in March 2017 and the Draft Financial Plan information presented to the Governing Body at the April 2018. The assumptions are also in line with developing versions of the plan that have been scrutinised by Executive Committee, Finance & Performance Committee and Governing Body over recent months.

If not, does the report contain a clear explanation, with supporting evidence, for the assumptions used, and are those assumptions appropriate? This should include written evidence of agreed income and expenditure for major funding streams.

Not applicable.

Are the implications of statutory or policy changes appropriately reflected in the business plan, financial forecasts and report on going concern?

The going concern paper is prepared on the basis of the CCG complying with all statutory and policy changes. The NHS planning guidance for deficit organisations are also met as part of the proposed Draft Financial Plan.

Have there been any significant issues raised with the Governing Body during the year (e.g. adverse comments raised by internal and external audit regarding financial performance or significant weaknesses in systems of financial control, or significant variances to activity levels compared to those planned), which could cast doubts on the assumptions made?

There have been no significant issues, adverse or otherwise, raised by internal or external audit with regards to financial control.

However, a letter was sent from the CCG's auditors, Mazars, on 31 January 2018, to the Secretary of State for Health which was a report under Section 30 of the Local Audit & Accountability Act 2014 for the anticipated or actual breach of financial duties. This is noted in 'Note 1.1 Going Concern' of the CCG's Accounting Policies but does not affect the CCG preparing the accounts on a going concern basis. This position has been further reinforced by NHS England who has confirmed that the CCG's deficit outturn does not affect its ability to operate as a going concern.

Has an analysis been undertaken of the CCG's projected or actual performance against its financial plan? If so, is it robust and does it identify any areas of potential concern?

The Governing Body and Finance and Performance Committee receive detailed finance reports monthly throughout the year which outline the current position, forecast outturn and all risks. The reports also highlight reasons for any variances and all movements from one month to another.

With regard to the Draft Financial Plan, the principle risk identified is the degree of advancement of QIPP and system cost reduction savings also associated with the development of an alternate contract payment mechanism that moves away from PbR.

Where there are potential concerns what action is being taken to address those areas of potential weakness?

This is outlined in Annex 2. Main areas of action to mitigate the risk of non-delivery of savings are around targeting QIPP schemes above the level of the QIPP target required in the plan, identifying and pursuing savings opportunities released through the move to an aligned incentives type contract and use of the 0.5% contingency.

Does the organisation have sufficient staff in post, with the appropriate skills and experience, particularly at senior management level, to ensure the delivery of the organisation's objectives? If not, what action is being taken to obtain those skills?

Significant organisational change has happened over the last year with a re-focusing of capacity to commissioning intentions priorities and a re-set of the Governing Body to ensure a clinical focus.

The acute system transformation agenda has also been resourced with a dedicated Chief Officer (full time from April 2018) and a programme structure to support.

Regular discussions take place in Executive Committee around the deployment of resource to priority areas and interim arrangements, secondments and additional resource sourced if required.

Request for Directors' Declarations

NHS Vale of York CCG

March 2018

MAZARS

CONTENTS

1. PURPOSE OF THIS DOCUMENT

International Auditing Standards require auditors to ask management and those charged with governance about arrangements the body has put in place:

- to prevent and detect fraud; and
- to comply with applicable law and regulations.

This requirement applies each year subject to audit.

For NHS Vale of York CCG, we consider the Governing Body, supported by the Audit Committee, to be those charged with governance, in line with the scheme of delegation in the Constitution. We request your responses to the questions detailed below and would be grateful for a response prior to the start of our final accounts audit on 24 April 2018.

Our request also covers the appropriateness of the going concern assumption.

2. QUESTIONS ABOUT ARRANGEMENTS FOR PREVENTING AND DETECTING FRAUD

- How does the Governing Body assess the risk that the financial statements may be materially misstated due to fraud?
- Is the Governing Body aware of the management's process for identifying and responding to the risks of fraud generally and specific risks of misstatement in the financial statements?
- Is the Governing Body aware of the arrangements in place for management to report about fraud to the Governing Body?
- Is the Governing Body aware of the arrangements management have in place, if any, for communicating with employees, lay members, partners and stakeholders regarding ethical governance and standards of conduct and behaviour?
- Does the Governing Body have knowledge of actual or suspected fraud, and if so is it aware of what actions management is taking to address it?
- What arrangements are in place for the Governing Body to oversee management arrangements for identifying and responding to the risks of fraud and the establishment of internal control?

3. QUESTIONS ABOUT ARRANGEMENTS FOR COMPLYING WITH LAW AND REGULATIONS RESPONSIBILITIES

- Has management provided a clear statement which confirms its consideration of relevant laws and regulations and its compliance with them?
- How does the Governing Body satisfy itself that all relevant laws and regulations are being complied with?
- Is the Governing Body aware of any instances of non-compliance with laws or regulations?
- Has management provided a list of litigation and claims?
- Has as assessment been made of the outcome of the litigation or claim and its estimate of the financial implications, including costs involved?
- Has the reasonableness of management's assessments been considered and additional information provided to the auditor where necessary?

3. QUESTIONS ABOUT THE APPROPRIATENESS OF THE GOING CONCERN ASSUMPTION

- Has a report been received from management forming a view on going concern?

- Are the financial assumptions in that report (e.g. future levels of income and expenditure) consistent with the strategic business plan and the financial information provided to the Governing Body throughout the year?

- If not, does the report contain a clear explanation, with supporting evidence, for the assumptions used, and are those assumptions appropriate? This should include written evidence of agreed income and expenditure for major funding streams.

- Are the implications of statutory or policy changes appropriately reflected in the business plan, financial forecasts and report on going concern?

- Have there been any significant issues raised with the Governing Body during the year (e.g. adverse comments raised by internal and external audit regarding financial performance or significant weaknesses in systems of financial control, or significant variances to activity levels compared to those planned), which could cast doubts on the assumptions made?

- Has an analysis been undertaken of the CCG's projected or actual performance against its financial plan? If so, is it robust and does it identify any areas of potential concern?

- Where there are potential concerns what action is being taken to address those areas of potential weakness?

- Does the organisation have sufficient staff in post, with the appropriate skills and experience, particularly at senior management level, to ensure the delivery of the organisation's objectives? If not, what action is being taken to obtain those skills?

3. CONTACT DETAILS

Please let us know if you would like further information on any items in this report.
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Annex 2 - Draft Consideration of 'Going Concern' Status 2017/18

1. Introduction

The annual accounts of the CCG are prepared on the basis that the organisation is a 'going concern' and that there is no reason why it should not continue in operation on the same basis for the foreseeable future. Within the accounts, the CCG is required to make a clear disclosure that the management and those charged with governance have considered the position, and that preparation of the accounts on this basis is, in their opinion and given the facts at their disposal, correct. Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the CCG, these should be disclosed.

The Department of Health Group Accounting Manual 2017/18 includes the following with regards to going concern.

- *The FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.*

- *For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DH group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DH sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.*

- *Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.*

- *Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.*

- *Where a DH group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.*

- *Should a DH group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible.*

2. Criteria

IAS 1 requires management to make an assessment of the entity's ability to continue as a going concern when preparing the financial statements. The standard stipulates that in assessing if the going concern assumption is appropriate management should take into account all available information about the future.

The period of review covered should be at least 12 months from the date of approval of the financial statements, but it should not be limited to the same. The assessment of the validity of the going concern assumption involves judgement about the outcome of events and conditions which are uncertain. The uncertainty increases significantly the further into the future a judgment is being made about the outcome of an event or condition. Therefore, usually the 12 month period from the balance sheet date is considered appropriate.

Financial statements should not be prepared on a going concern basis if management determines after the end of the reporting period either that it intends to liquidate the entity or to cease trading or that it has no realistic alternative to do so. In these circumstances the entity may, if appropriate, prepare its financial statements on a basis other than that of a going concern.

The Financial Reporting Council, in their publication 'Guidance on the Going Concern Basis of Accounting and Reporting on Solvency and Liquidity Risks 2016,' sets out a number of areas Boards, or in CCGs, Governing Bodies, may wish to consider. Those relevant to CCGs in the NHS are as follows:

- Forecast and budgets;
- Timing of cash flows;
- Contingent liabilities;
- Products, services and markets;
- Financial and operational risk management.

Where there are particular points to report or risks, these areas are reported to the Finance and Performance Committee, as part of the monthly reporting and Governing Body, at the public meetings through the year, but some further assumptions for the future are described below.

3. Financial Assumptions for 2017/18

3.1 Outturn

The forecast financial outturn for 2017/18 is a deficit of £22.5m of expenditure over allocation. There are a number of reasons for this revised position which include activity being above contract at the CCG's main acute Trust, York Teaching Hospital NHS Foundation Trust. The CCG has also continued to experience a higher than planned spend on Mental Health Out of Contract placements and Continuing Healthcare as a result of increased activity and complexity of packages, as well as an increase in prescribing costs following the impact of the national 'No Cheaper Stock Obtainable' issue.

The CCG remains under Legal Directions from 1st September 2016 as a result of its financial position and a letter was sent on 31st January from the CCG's auditors, Mazars, to the Secretary of State for Health under Section 30 of the Local Audit & Accountability Act 2014 reporting the

anticipated or actual breach of financial duties. However, this does not affect the CCG preparing the accounts on a going concern basis.

3.2 Proposal to de-escalate from Legal Directions

The CCG is proposing to exit from Legal Directions by October 2018. This proposal is founded on the core criteria included in the Northern regional de-escalation guidance around the extent to which Directions are no longer seen as being needed to achieve the desired financial outcome and has obtained initial support from the NHS England Yorkshire & Humber Area Senior Management Team. It is also based on the following progress that has been made throughout 2017/18:

- The CCG has delivered in full the Improvement Plan agreed with NHSE under legal Directions from October 2016 and confirmation of this delivery was captured in the letter of July 2017 following the Q4/ Annual review of the CCG.
- The CCG has continued to deliver all its duties in relation to finance, delivery and governance in 2017/18 without any external intervention from NHSE and the established CCG Leadership team has achieved financial stability with a forecast £22.5m deficit.
- The CCG has improved its underlying deficit having opened 2017/18 with an underlying deficit of £22.4m the CCG is expecting to exit the year with a £21.1m deficit.
- There has been external validation from both NHS England and audit of the significant assurance around contracting, performance, quality assurance and financial governance, and financial recovery in 2017/18 has achieved a 52% (£7.4m) delivery of planned QIPP targets with strong demand management programmes resulting in the elimination of all referrals growth in one year.
- Additionally, the CCG Leadership team has developed a Vale-Scarborough five year financial recovery and acute transformation plan with fellow commissioners and provider partners while delivering a 10% reduction in running costs and establishing a joint system team to lead delivery of this medium term plan.
- This will be supported by an Aligned Incentive Contract for 2018/19, which will enable partners from the CCG, NHS Scarborough and Ryedale CCG, NHS East Riding CCG and York Teaching Hospital NHS Foundation Trust to manage risk and focus on a joint programme of work to take costs out of the system.
- There have been significant improvements in performance during 2017/18 and the local delivery of cancer and RTT for the CCG is the highest in the STP and higher than other CCGs who are not in Special Measures and are rated Outstanding in some cases.
- This provides a strong foundation for the CCG to refresh its financial and operational plans for 2018/19 working with system partners to deliver both Local CCG place plans and the approved System Medium Term Financial Recovery Plan.

The CCG has now met and provided evidence of improving and stabilising for every improvement criteria incorporated in legal Directions except for the elimination of the CCG financial deficit. The CCG would propose to continue the strong delivery in 2018/19 within a Special Measures Framework that is tailored to the accelerated programme of financial and performance recovery which will be captured within the refreshed Financial and Operational Plans for the CCG.

3.3 Financial Plan 2018/19

Last year CCGs were required to prepare plans to cover the 2017/19 period and as such the 2018/19 plan is a refresh of the plan already prepared.

The CCG submitted the first draft financial plan for 2018/19 on 8 March 2018 in line with guidance. The plan includes a number of assumptions that should be taken into account:

3.3.1 Business Rules

The 2018/19 planning guidance update includes a number of updates that must be built into the refreshed financial plan as follows:

- The 2018/19 control total for the CCG set by reference to the in-year allocation is a deficit before Commissioner Sustainability Funding of £14.0m. The CCG is also eligible for the Commissioner Sustainability Fund and has been allotted an indicative allocation of £14.0m from the Fund, sufficient to offset the deficit for the year as long as the conditions of the Fund are met;
- Continued provision of 0.5% Contingency within both Core and Primary Care allocations;
- There is no longer a requirement to hold 1% Non-Recurrent spend (0.5% previously uncommitted for the national risk, 0.5% previously required to support transformation and change implied by STPs).

3.3.2 Revenue Resource Limit

The CCG based its plan on the following notified allocations.

Allocation	**2018/19** **£'m**
Core	412.5
Primary Medical	43.9
Sub-total	**456.1**
Running Cost allowance	7.5
Total Notified Allocation	**463.9**

3.2.3 Planning Assumptions

The following requirements for 2018/19 have been built into the financial plan based on a combination of the planning guidance and local decisions:

	Assumption for uplift 2018/19		
	Growth %	Pay and Prices %	Efficiency %
Acute	2.4	2.1	(2.0)
Mental Health – Contract	0.0	2.1	(2.0)
Mental Health – Out of Contract	1.9	4.0	0.0
Mental Health – NCA	1.9	2.1	(2.0)
Ambulance Service	0.0	2.1	(2.0)
Community	0.0	2.1	(2.0)
Hospices and Voluntary Sector	0.0	2.0	0.0
Primary Care Services	0.6	1.0	0.0
Prescribing	2.2	2.2	0.0
Continuing Healthcare	5.5	4.0	0.0
Funded Nursing Care	0.0	4.0	0.0
Other NHS Services	0.0	2.1	(2.0)
Primary Care Commissioning – PMS and GMS	0.6	2.7	0.0
Primary Care Commissioning – Premises	0.0	2.0	0.0
Primary Care Commissioning – Enhanced Services, QOF and Other Services	0.7	1.0	0.0
Better Care Fund	0.0	1.9	0.0
All other services	0.0	0.0	0.0

3.2.4 Investments and Cost Pressures

There are a number of investments and cost pressures included in the financial plan, the most notable of which are as follows:

Investments	**£'m**
YAS 999 and 111 requirements	0.3
Primary Care £3 per head (non-recurrent)	1.1
Psychiatric Liaison	0.5
Other	0.1
Winter Plans (non-recurrent)	0.2
Total Investments	**2.2**

Cost Pressures	£'m
Running costs to match expenditure	0.9
Adjustment for HRG4+ and IR rules (non-recurrent)	(2.1)
Market rent adjustment	2.1
Repayment of TEWV system ask (non-recurrent)	0.3
Charge Exempt Overseas Visitor adjustment	0.3
Bankfields Named Patient Agreement (non-recurrent)	0.3
Transforming Care Partnerships (net of expected funding)	0.7
Primary Care (LES & property pressures)	0.3
Other	0.4
Total Cost Pressures	**3.2**

4. Cash Flows and Liquidity

The cash position is reported to the Finance and Performance Committee monthly and Governing Body at each public meeting. In addition, detailed cash flow monitoring and forecasting is in place with NHS England on a monthly basis. The CCG will require a Maximum Cash Draw Down adjustment to reflect the £22.5m deficit and supplementary drawdowns in March in order to access this and meet its cash requirements for the year. However, this has been discussed with NHS England all of this is expected to flow as expected.

There are no anticipated risks with regards to cash or the overall liquidity position of the CCG as a result of the pressures outlined earlier in this report.

5. Contingent Liabilities

There have been no known contingent liabilities in 2017/18 and this is expected to be the case for the remainder of the year.

6. Services

The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is important evidence of going concern.

The CCG is not aware of any plans that would fundamentally affect the services provided to an extent that the CCG would not continue to be a going concern.

7. Risks and Adaptability

The CCG is now reporting risk within the financial position and therefore there are minimal risks attached to the delivery of the financial programme in the Financial Plan. The detailed financial risks are captured and monitored in the Covalent system and are regularly reviewed and updated.

Area of Plan	Risk	Mitigation
QIPP	QIPP under delivery Although plans have been identified and developed a number of these remain at a high level and there is currently £6.5m gross risk identified.	QIPP plans are currently identified above the required target (£1m). Agreement of the Aligned Incentive Contract and the associated joint programme of work for system cost reduction. The CCG could use the 0.5% contingency (£2.3m) if required.

These are not significant enough to impact on the CCG's ability to trade for the foreseeable future as a going concern. Adaptability is the organisation's ability to alter its plans to enable it to take effective action to respond to unexpected needs or opportunities. The CCG has robust policies and procedures in place, alongside a very high proportion of its expenditure covered by contractual arrangements. This gives the CCG considerable protection against unexpected events.

8. Documentation

The Finance and Performance Committee and Governing Body receive regular reports on the financial performance of the CCG which gives considerable assurance and documentary evidence of performance. Other documentation includes risk register reviews, Draft Financial Plan, Final Financial Plan, monthly QIPP reports and ad-hoc reports and information as required. The CCG also submits monthly information to NHS England as part of the CCG assurance process.

9. Recommendation

Having considered the position as set out above, it is recommended that management prepare the annual accounts for 2017/18 on a going concern basis.

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Item Number: 12

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 5 April 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – COR02 Health and Safety Policy

Purpose of Report
For Approval

Reason for Report

The NHS Vale of York The Clinical Commissioning Group (CCG) is committed to ensuring the health, safety and welfare of its employees, clients, patients, students, contractors, visitors and members of the general public as a matter of prime importance and will, so far as is reasonably practicable, establish procedures and systems necessary to implement this commitment and to comply with their statutory obligations under Section 2 of the Health and Safety at Work Act 1974.

The CCG will provide and maintain a healthy and safe working environment with the objective of minimising the number of instances of occupational accidents and illnesses. The CCG will pay particular attention to ensuring that:

- Safe systems of work are set and followed;
- A safe working environment without risks to health is maintained;
- There is provision of adequate welfare facilities;
- There is provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control risks;
- Plant and equipment are safe;
- There are safe arrangements for the use, handling and storage and transport of articles, materials and substances;

There is safe access and egress. Whilst the CCG will take all reasonable steps to ensure the health, safety and welfare of its employees, health and safety at work is also the responsibility of the employees themselves. It is the duty of each employee to take reasonable care of their own and other people's health, safety and welfare, and to report any situation which may pose a serious or imminent threat to the wellbeing of themselves or any other person.

The Governing body would endorse the need for managers and staff to work together positively to achieve a situation compatible with the provision of high quality services to patients and clients where the risk of personal injury and hazards to the health of staff and others can be reduced to a minimum. Thus risk must be assessed and significant findings recorded.

The policy sets out the arrangements for health and safety management; it determines the levels of responsibility at all levels and the channels of communication for health and safety matters.

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)

There is the potential risk that if an adequate and robust Health and Safety Policy that reflects current legislation and regulations is not in place, the CCG is exposed to challenge which could result in damage to the CCG reputation and also financial consequences.

Recommendations

The Governing Body are requested to approve the policy.

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington Executive Director of Quality and Nursing	Mary Hughes Business Support Manager

NHS
Vale of York
Clinical Commissioning Group

HEALTH AND SAFETY POLICY

March 2018

Authorship:	Business Support Manager, NHS Vale of York CCG
Reviewing Committee:	Executive Committee
Date:	March 2018
Approval Body	Governing Body
Approved date:	XX
Review Date:	XX
Equality Impact Assessment	Completed-Draft
Sustainability Impact Assessment	Completed-Draft
Related Policies	COR03 Risk Management COR11 Serious Incident & Concerns Policy HR13 Induction Policy HR25 Managing Stress in the Workplace
Target Audience:	All NHS Vale of York CCG employees and persons working for the CCG; all members attending CCG committees and members of the governing body. All contractors providing services to the CCG.
Policy Reference No:	COR02
Version Number:	0.1

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
0.1	Business Support Manager	Draft		

To request this document in a different language or in a different format, please contact:
Communications Manager
Telephone: 01904 555870
Voyccg.communications@nhs.net

CONTENTS

1. INTRODUCTION

1.1 The NHS Vale of York The Clinical Commissioning Group (CCG) is committed to ensuring the health, safety and welfare of its employees, clients, patients, students, contractors, visitors and members of the general public as a matter of prime importance and will, so far as is reasonably practicable, establish procedures and systems necessary to implement this commitment and to comply with their statutory obligations under Section 2 of the Health and Safety at Work etc Act 1974.

1.2 The CCG will provide and maintain a healthy and safe working environment with the objective of minimising the number of instances of occupational accidents and illnesses. The CCG will pay particular attention to ensuring that:

- Safe systems of work are set and followed;
- A safe working environment without risks to health is maintained;
- There is provision of adequate welfare facilities;
- There is provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control risks;
- Plant and equipment are safe;
- There are safe arrangements for the use, handling and storage and transport of articles, materials and substances;

1.3 There is safe access and egress. Whilst the CCG will take all reasonable steps to ensure the health, safety and welfare of its employees, health and safety at work is also the responsibility of the employees themselves. It is the duty of each employee to take reasonable care of their own and other people's health, safety and welfare, and to report any situation which may pose a serious or imminent threat to the wellbeing of themselves or any other person.

1.4 The Governing body endorses the need for managers and staff to work together positively to achieve a situation compatible with the provision of high quality services to patients and clients where the risk of personal injury and hazards to the health of staff and others can be reduced to a minimum. Thus risk must be assessed and significant findings recorded.

1.5 This policy is supplemented by other policies on specific areas of law. This documents sets out the arrangements for health and safety management; it determines the levels of responsibility at all levels and the channels of communication for health and safety matters.

1.6 It is the responsibility of employees at all levels to familiarise themselves and comply with the CCG's procedures and systems on health and safety.

Definitions

1.7 **Manager** – the Corporate Manslaughter and Corporate Homicide Act 2007 defines senior managers as those who play a significant role in making decisions about the management of the whole or a substantial part of their organisation's activities and those who actually manage or organise those activities.

1.8 **Competent Persons** – the Management of Health and Safety at Work Regulations 1999, Regulation 7 requires every employer to appoint one or more competent

persons to assist with putting measures in place to ensure legal compliance. The Competent Person can be either an individual or a company providing these services. The person is regarded as competent if they have 'sufficient training and experience or knowledge and other qualities to properly assist the employer to meet their safety obligations.'

1.9 **Risks –** A risk is the chance, high or low, that any hazard will actually cause somebody harm. Risk = likelihood x consequence.

1.10 **Hazards** - A hazard is something that can cause harm, e.g. electricity, chemicals, working up a ladder, noise, a keyboard, a bully at work, stress, etc.

2. POLICY STATEMENT

2.1. The Vale of York Clinical Commissioning Group policy statement, e.g. The Vale of York Clinical Commissioning Group aspires to the highest standards of corporate behaviour and responsibility. All Vale of York Clinical Commissioning Group staff are required to comply with this policy.

3. IMPACT ANALYSES

Equality

3.1. As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached at Appendix 1.

Sustainability

3.2. A sustainability assessment has been completed and is attached at Appendix 2. The assessment does not identify and benefits or negative effects of implementing this document.

4. SCOPE

4.1. This Policy covers all staff that are employed by the CCG while they are at work either within CCG premises or at any other location in pursuance of their normal work activities.

4.2. Staff working in CCG premises who are not CCG employees must follow the policy of their employer, however the results of risk assessments carried out in CCG premises that they work in must be shared with them and their risk assessments shared with CCG staff.

4.3. This Policy should be read in conjunction with other CCG Policies and procedures such as the Serious Incidents Policy and the Risk Management Strategy and other relevant policies.

4.4. The CCG will work with independent contractors to ensure that an appropriate level of support is provided in relation to Health & Safety.

5. POLICY PURPOSE/AIMS & FAILURE TO COMPLY

5.1. NHS Vale of York Clinical Commissioning Group (the CCG) is committed to ensuring the health, safety and welfare of its employees, and it will, so far as is reasonably practicable, establish procedures and systems necessary to implement this commitment and to comply with its statutory obligations on health and safety.

Organisation and Arrangements for Health and Safety

5.2. The CCG has ultimate responsibility for managing Health and Safety.

5.3. A Health & Safety Service Level Agreement exists with eMBED outlined within this document where they provide a specialist which the CCG can use if necessary. It also highlights areas which the CCG can use to gain additional training if required, offer guidance and ensure the CCG complies with the latest legislation.

5.4. It is a disciplinary offence, which could lead to dismissal, to work or permit others to work in a way which is contrary to the requirements of health and safety legislation and the CCG's Health and Safety Policy.

Health and Safety Policies

5.5. Policy documents and Standard Operating Procedures on particular aspects of health and safety will be developed in consultation with stakeholders and will be approved at the appropriate committee on behalf of the CGG Governing body.

Health and Safety Training

5.6. Health and Safety training should be included in the Personal Development Plan, and agreed between employee and line manager. In addition to mandatory training requirements, additional training necessary for the job should be determined as a result of the risk assessment process.

Health and Safety Communication

5.7. The CCG will ensure that suitable and relevant information relating to health, safety and welfare in the workplace is communicated to staff and users. Statutory notices will be displayed throughout the workplace. Consultation and communication over health and safety issues will be encouraged at all levels within the CCG.

Specialist Advice

5.8. While the Health and Safety team should be considered as the primary source for expert legal advice on complying with health and safety legislation and CCG policy, where necessary the Accountable Officer will ensure staff have access to other Competent Persons (as defined in the Management of Health and Safety at work Regulations 1999) either through separate appointments or robust and appropriately monitored Service Level Agreements with third party providers. The CCG in based with the City of York Council.

5.9. These will include as a minimum;

- Occupational Health Service (including physiotherapy)
- Advice relating to infection prevention and control
- Estates/ facilities services
- Electricity testing (PAT Testing)
- Human Resources
- Fire
- Security

6. PRINCIPLE LEGISLATION AND COMPLIANCE WITH STANDARDS

Health & Safety at Work etc. Act 1974

6.1. The relevant legislation includes the following:

- It is the duty of every employer; so far as is reasonably practicable, to ensure the health, safety and welfare at work of all his employees.
- Every employer must conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment are not exposed to risks to health or safety.
- Employees are to take reasonable care for the health and safety of themselves and of others who may be affected by his acts or omissions at work.

Corporate Manslaughter & Homicide Act 2007

6.2. An organisation is guilty of the offence of corporate manslaughter if the way in which any of the organisation's activities are managed or organised by its senior managers – a) causes a person's death; and b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

Health & Safety Offences Act 2008

6.3. The new maximum penalties under this Act are:

- £20,000 fines in lower courts for nearly all summary offences, unlimited fines in higher courts;
- Imprisonment for nearly all offences – up to six months in Magistrates Courts and two years in the Crown Court

Bribery Act 2010

6.4. The provisions of the Bribery Act 2010 apply. Further information on the Bribery Act can be found at www.opsi.gov.uk/acts.

7. ROLES / RESPONSIBILITIES / DUTIES

7.1. The **Governing Body** is responsible for setting the CCG's Health & Safety Policy, monitoring compliance and ensuring that appropriate action is taken to eliminate or mitigate against significant risks.

7.2. The **Accountable Officer** is responsible for ensuring that;

- The CCG complies with all statutory obligations in relation to health and safety.
- Appropriate Policy proposals are made to the Board and, when adopted, fully implemented.
- The CCG's performance regarding health & safety is monitored on behalf of the Governing Body.
  The CCG provides workplace facilities which protect the safety and health of everyone in the workplace, including people with disabilities.
- The CCG has made arrangements for first aid, accidents and ill health.
- Arrangements are made for effective consultation with staff, normally at departmental level, but also through the CCG team brief meetings.
- The Governing Body is informed and advised on any relevant health & safety issues brought to the Chief Operating Officer's attention.
- The establishment and maintenance of an effective health and safety advisory service to all levels of management.
- Adequate health and safety training programmes are provided and maintained for all levels of management and staff.
- Annual objectives for all managers include those to improve health and safety at work, and that their performance against those objectives is regularly reviewed.
- Prompt action is taken to eliminate any reported safety weakness in practice, procedure, environment or equipment.
- Ensuring that the CCG has adequate employers' liability insurance

7.3. The **Head of Legal and Governance** is responsible for;

- Ensuring that the CCG's Policy is implemented by agreeing a programme of action for health and safety, setting objectives at CCG level and monitoring their effectiveness and achievements.
- Keeping the Accountable Officer informed on progress in the implementation of the CCG's policy on Health & Safety and the attainment of objectives.
- Providing the means for effective consultation with staff on health and safety matters through the CCG team brief meetings.
- Communicating this Policy and supporting health and safety policies and procedures to all CCG managers and staff, and confirming through inspections and audits that they are effectively implemented.
- Ensuring that those to whom health and safety responsibilities are delegated fully understand and meet those responsibilities.
- Ensuring that adequate health and safety training is provided for all levels of management and staff they are responsible for.
- Ensuring that the CCG has adequate health and safety advice provided by one or more competent persons in order to comply with requirements under relevant statutory provisions.

7.4. **All Managers** are responsible for the implementation of the CCG's Health and Safety Policy. In particular they will;

- Ensure their staff are familiar with the health and safety policy and implement it, calling on specialist advice as necessary.
- Establish and maintain safe and healthy working conditions and systems of work.
- Ensure that the health and safety responsibilities of managers etc are specifically included in their job descriptions and that these are reflected in appraisal objectives for regular review.
- Ensure, through risk assessment, that risks to health and safety are evaluated and any appropriate steps taken to ensure that suitable control measures are provided where the risks cannot be eliminated.
- Ensure that all training needs are assessed and that training programmes are provided for all levels of the workforce regarding health and safety.
- Ensure that specified health and safety training of all employees is carried out, including induction training, refresher training, training when employees are exposed to new or increased risks and instruction in local operating procedures to ensure high levels of competency.
- Ensure when allocating work to employees that the demands of the job do not exceed the employee's capability to carry out the work without risk to themselves or others.
- Ensure compliance with all legal requirements in regard to health and safety in their Service / Department.
- Ensure that all accidents are properly investigated and that the appropriate report form is promptly completed and any recommendations to prevent a reoccurrence are implemented.
- Ensure that there are adequate arrangements in place that are to be followed in the event of serious and imminent danger and that these procedures are brought to the attention of the relevant employees, contractors and others.
- Providing the means for effective consultation with staff on health and safety matters within their Service/Department, including having health and safety as a standing agenda item for meetings with staff.
- Fully involve and utilise staff, particularly Safety Representatives, as a resource to further departmental safety objectives.
- Enable Safety Representatives to effectively carry out their role by providing them with appropriate time and resources.
- Obtain information from suppliers on hazards associated with the use of articles or substances and ensure that adequate assessments are made of the risks.
- Provide to employees relevant and comprehensible information on risks to which they are exposed and the precautionary measures that must be taken.
- Ensure that, where it is within their sphere of responsibility, adequate resources are provided to adequately maintain plant, equipment and buildings under the control of the CCG.

7.5. **All staff,** regardless of their position have a duty to themselves, to their colleagues, and to any person who might be affected by their actions or omissions, to work in a safe manner. These include to:

- Take reasonable care for the health and safety of themselves and any other people who may be affected by their acts or omissions.

- Report to their manager all faults, hazards, errors, accidents/incidents, near misses, dangerous occurrences or damage, regardless of whether persons are injured.
- Co-operate with management to ensure that all relevant statutory regulations, policies and arrangements and procedures are adhered to, and ensure that the CCG, as their employer, can carry out their legal responsibilities.
- Participate in training designed to improve their knowledge and understanding about health and safety,
- Take appropriate action within their powers of authority, to ensure that potential risks are prevented or minimised,
- To work in accordance with safety instructions and training.
- Not misuse or interfere with anything provided in the interests of health and safety.

Fire Wardens

7.6. Fire Wardens are identified and trained by the City of York Council Security Team. A list of the fire wardens for the ground floor where the CCG is situated can be found in the Minster Hub Kitchen. The main duties of the Fire Warden are to:

- Act as a focal point on fire safety issues for their local area of the building.
- Organise and assist in the implementation of fire safety procedures within local areas.
- Raise issues regarding fire safety with the Health and Safety Manager.
- Assist with coordination of the response to an incident within the immediate vicinity.
- Be responsible, within an allocated area, for ensuring evacuation of personnel during an incident or fire drill.
- Be trained to tackle a fire with fire-fighting apparatus where appropriate.

First Aiders

7.7. First Aiders are identified and trained by the City of York Council Security Team. A list of the fire wardens for the ground floor where the CCG is situated can be found in the Minster Hub Kitchen. First Aiders must only provide first aid within the limits of their training (First aiders will be required to gain a First Aid certification after attending a 3 day FAA Level 3 Award in First Aid at Work training course).

7.8. Their key responsibilities are:

- Provide first aid in cases where a person will need assistance from a doctor or nurse; treatment for the preserving of life and minimising the consequences of injuries and ill health until such help is required.
- Treatment of minor injuries which would otherwise receive no treatment, or which do not need treatment from a doctor or nurse.
- Ensure adequate first aid facilities are provided and maintained.
- Take charge of instances where first aid is required. • Provide casualties with early and effective help.
- Arrange for casualties to be taken to hospital where required.
- Remain with casualty until help arrives.
- Ensure that casualties' personal belongings are safe and secure.

Appointed Persons (First Aid)

7.9. Appointed persons will only provide first aid within the limits of their training (Appointed persons will attend a 1 day basic HSE First Aid at Work training course).

7.10. Their key roles are:

- To take charge of a situation where first aid is required.
- Call an ambulance if there is a serious illness or injury
- Arrange for casualties to be taken to hospital where required.
- Remain with casualty until help arrives.
- Ensure that casualties' personal belongings are safe and secure.

8. THE MANAGEMENT OF HEALTH AND SAFETY

8.1. The CCG has a legal duty to put in place suitable arrangements to manage for health and safety. It should be part of the everyday process of running a business and an integral part of workplace behaviours and attitudes. It doesn't matter what the size, industry or nature of the organisation, key to effectively managing for health and safety is:

- Leadership and management (including sound business processes)
- A trained/skilled workforce operating in an environment where people are trusted and involved.

8.2. The CCG leases premises from

- City of York Council; and
- NHS Scarborough and Ryedale CCG

And works closely with premises landlords to create a safe working environment.

8.3. In line with the Health and Safety at Work etc Act 1974, there is meeting which is chaired by Head of Legal and Governance and held bimonthly where there is a standing agenda item for health and safety. These offers staff the opportunity to raise health and safety concerns working in partnership with management in initiating, developing and implementing improvements ensuring effective employee health and safety. This forum also allows for management and staff consultation on new health and safety policy directives and issues before the introduction or change of legislation, new equipment or new technology. Health and safety issues that arise in this forum are reported to the Executive Team and where appropriate escalated to the Landlord of the building.

9. RISK ASSESSMENTS

9.1. The CCG's Health and Safety arrangements comply with the CCG's Risk Management Policy and are integrated into every day practices.

9.2. The CCG has assessed what might cause harm to people in order to take reasonable steps to prevent harm. This is known as risk assessment and it is something the CCG is required by law to carry out.

9.3. The Health and Safety risk assessment identifies sensible measures to control the risks in the workplace. The risk assessment will help the CCG decide whether they have covered all they need to. For some risks, other regulations require particular control measures. The Risk Assessment can help identify where the CCG may need to look at certain risks and particular control measures in more detail. These control measures do not have to be assessed separately but can be considered as part of, or an extension of, the overall organisation risk assessment:

- STEP 1: Identify
- STEP 2: Estimate
- STEP 3: Evaluate
- STEP 4: Record
- STEP 5: Review

STEP 1: Identify

- What are the hazards?
- Know who might to be harmed (especially at risk people)?
- How might they be harmed?

STEP 2: Estimate

- Who is at risk?
- How likely is it that something would go wrong?
- How serious would the outcome be?

STEP 3: Evaluate

- Likelihood
- Impact
- Mitigations

9.4. The CCG's risk management matrix is located in the corporate Risk management Policy (COR03) which is located on the CCG's website: http://www.valeofyorkccg.nhs.uk/publications-plans-and-policies-1/policies/

STEP 4: Record

- Location, activity and equipment being assessed
- Hazards and risks levels
- Risk controls
- Assessor Details
- Date and Time
- Review dates

9.5. The CCG's Health and Safety Risk Assessment is held in electronic format: Y:\VOYCCG\Governance\Health and Safety\Health and Safety Risk Assessments Findings are shared with staff so that they are fully aware of the hazards and risks relating to tasks so that they can take appropriate action (control steps) to ensure they keep themselves and others safe.

9.6. Mitigating actions are detailed in the Governance Team Action Plan held on the CCG the CCG's Pentana Integrated Governance

System: https://valeofyorkccg.covalentcpm.com/actions/show/3099836/gtwp-14a-health-and-safety-annual-assessment-and-implementation-of-recommendations-health-and-safety-training-module-all-staff-qualifications-bsm#tab_subactions

STEP 5: Review

9.7. The CCG's Risk Assessment is reviewed on an annual basis, or when changes occur (personnel, equipment or activities) the risk assessment will need to be reviewed.

10. CONTROLLING HEALTH AND SAFETY RISK

10.1. Risk control involves making adaptations in order to minimise risk. The CCG needs to consider:

- Reducing the likelihood of the hazardous event happening
- Reducing the consequence of the hazardous event
- Reducing both factors.

10.2. The approach that the CCG decides to take may involve:

- Eliminating the hazard
- Reducing the risk
- Preventing people from coming into contact with the hazard
- Safe systems at work
- Personal Protective Equipment
- All the methods have weaknesses but some are less prone to failure than others. Usually, risk controls that rely on people to do something or behave in a certain manner are weaker than those that don't. For example, even though you have given a member of staff personal protective equipment and they have been trained on how to use it, you are relying on them to wear it and wear it correctly.

10.3. Factors that impact decisions are:

- How many people need to be protected?
- How reliant is the effectiveness of the risk control on human behaviour?
- How often will the risk control needs to be tested, maintained and replaced?
- How much does the risk control cost?
- How much is it going to reduce the risk by?

10.4. The final decision is a compromise between all these points.

10.5. Generally the CCG's approach is to reduce risks 'so far as is reasonably practicable' in line with the CCG's risk apetite. This means that in terms of time, cost, effort or inconvenience – associated with risk controls outweighs the benefits of the risk reduction, it's not reasonably practicable to use that risk control.

11. UNDERSTANDING HAZARDS

11.1. Common hazards exist in every workplace. The organisation needs to be able to recognise them and know what to do about them. Hazards normally fall into 6 board groups:

- **Mechanical** – created by the powered operation of apparatus or tools. The applied power may be machine generated or human.
- **Physical** – are those substances or conditions that may harm a person's physical safety.
- **Chemical** - considered as a hazard due to their intrinsic properties to cause harm to humans, property and the environment.
- **Biological** – there are organic substances or microorganisms that pose a threat to the health of humans and other living organisms.
- **Environmental** - are conditions or states of events that have the potential to affect the environment and adversely impacting people's health.
- **Organisational** - associated to behaviour, workload, time constraints and deadlines.

HSE Office Risk Assessment

11.2. The CCG uses the HSE Office risk assessment to identify hazards that could take place with the CCG office environment, the hazards identified are:

- Physical Hazards such as slipping, tripping and fire.
- Environmental Hazards such as noise, lighting and temperature
- Organisational Hazards such as stress due to behaviour, workload, time constraints and deadlines.
- Other Hazards such as disabled or pregnant workers and telephones/meeting members of the public which could lead to aggression or violence

11.3. The Business Support Manager completes the HSE Office Risk Assessment on a yearly basis however as it is recommended above, the assessment is reviewed and amended when necessary.

12. POLICY IMPLEMENTATION

12.1. This Policy will be available to all staff via the CCG Intranet and will be communicated through team briefings and CCG newsletter.

12.2. Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the CCG's disciplinary procedure.

12.3. The CCG has a duty to consult with its employees on health and safety. Consultation is a two-way process, allowing staff to raise concerns and influence decisions on the management of health and safety. Our employees are often the best people to understand risks in the workplace and they are encouraged to raise any concerns they may have. Staff consultation will be included at the regular team meetings and topics may include:

- Health and safety and the work we do;

- How risks are controlled;
- The best ways of providing information and training.
- The Chairs of the Governing Body, the Council of Members and all other committees and sub committees for dissemination to members and attendees.
- The Practice Managers of all member practices for information, (if appropriate).

13. TRAINING & AWARENESS

13.1. The CCG recognises the importance of training, which will be provided as is necessary to ensure the health and safety at work of employees at all levels. The provision of information, instruction and training to employees is seen as a fundamental part of providing a safe working environment.

13.2. Training needs to be provided at the start of employment (induction) and then on a regular basis throughout employment. This continual training programme is to ensure high standards of safety are being maintained for the benefit of staff and the general public.

13.3. Departmental managers will have the overall responsibility for safety training within each department and must ensure, or make arrangements for adequate training to be supplied to all employees.

Training Arrangements

13.4. Training is organised at two levels:

- At a CCG-wide level for all staff to access then;
- At a local, more job specific level. Health and safety training locally will include, for example, use of work equipment, emergency procedures, COSHH and use of personal protective equipment.

13.5. Training should where possible involve practical instruction where the trainer demonstrates or explains how to carry out a particular procedure.

13.6. To support training employees should be provided with written information to be used as reference at future date.

13.7. All training provided to staff must be recorded and evidence kept that training was locally provided. Certificates of attendance are issued to all staff participating in CCG centrally organised training. Safety related information will be provided on the CCG Intranet (when available).

13.8. Induction training for new employees will be required in all circumstances as they are more likely to have accidents than existing employees, due to the unfamiliarity of the work environment and the work systems or equipment.

13.9. The prime objective of induction training is to orientate new employees into the existing health and safety climate and culture.

13.10. The CCG requires two forms of Induction training to take place;

13.11. “First Day” Induction”; This requires all new employees to be informed and instructed of such things as:

- Fire drills and procedures.
- First Aid and hygiene facilities.
- Adverse Incident Reporting procedures and the Serious Incident Policy.
- Major hazards and risks within that Department including all hazardous substances.
- Safety procedure and equipment.

13.12. This should be carried out within 5 to 10 working days of starting work and recorded by the department manager.

Corporate Induction Course

13.13. On commencing employment at the CCG, All staff must attend the Corporate induction with the City of York Council Building Induction (see APPENDIX 5) which involves:

- Fire including Fire Assembly Point, First Marshals, Fire Alarm testing and Fire Evacuation protocol for employees with disability
- Security arrangements including ID issuing
- Access to the building
- DSE Assessments
- PPE Storage
- Housekeeping Standards

Refresher Training

13.14. Refresher training will be required at appropriate intervals, a need that is frequently overlooked. These intervals will be identified, as part of the training needs analysis. In general terms this will be determined through observation of employees and will relate to the complexity of the task and information required to perform it safely, the degree of risk associated with it and the frequency with which it is performed.

Health and safety Training

13.15. Specific training needs will be required in some circumstances, particularly if there is a specific legislative requirement, this will be indicated in the Mandatory Training Policy. For example**,** first-aid training, Back Care training, training in fire evacuation procedures or fire fighting.

13.16. The Management of Health and Safety at Work Regulations 1999 specify the training needs to be applicable to the CCG. These have long been recognised as being critical in maintaining the health and safety of all employees. Regulations specify that employers must provide adequate health and safety training when:

- New employees join the CCG
- Employees are required to take on new responsibilities
- Employees are required to use new work equipment or when existing equipment is changed
- New technology is introduced into the workplace affecting employee activities
- New or changed systems of work are introduced.

13.17. Other elements of health and safety training are considered to be essential and vary from one service to another depending on the risks to staff. These are included within the following sections.

Risk Assessor Training

13.18. The CCG must determine the number of risk assessors required to assess all the risks and hazards that staff are exposed to.

13.19. Risk Assessments are a statutory requirement for the following:

- Control of Substances Hazardous to Health
- Display Screen Equipment
- Manual Handling Operations
- Workplace Risk Assessment (this will include general workplace and where applicable task related assessments)

10.7 Task-specific training will be required for most jobs and will require appropriate skills training, it should include the following:

- Discussion of any legal requirements and duties,
- Discussion of the significant risks associated with the task,
- Details of the necessary preventive measures and any use of personal protective equipment, and
- Discussion of the special procedures to be followed in the event of an emergency, imminent danger or the use of permits to work.

10.8 Training for managers will be required at all levels to ensure that responsibilities and objectives are fully understood. It is important for managers to appreciate the health and safety legal framework, the importance of specific rules, the business consequences of accidents, accident causation models, and likely sources of risk, preventive techniques and disciplinary procedures. This will help them enforce health and safety procedures, develop a greater awareness of health and safety issues and inform and motivate their staff positively in the safety effort. This will be provided through an appropriate training course such as the **IOSH 'Managing Safety'** course. The Business Support Manager or appropriate individual will receive the training necessary to ensure this policy is properly implemented and practises monitored.

14. MONITORING & AUDIT

14.1. The operation of health and safety policies and procedures will be monitored by the following means: -

- Regular assessment of accident and untoward incident reports
- Regular assessment of risks / hazards through systematic audit
- Regular assessment of fire incident reports
- Regular reports on health and safety training and staff attendances
- Consideration of formal Improvement Notices;
- Consideration of any reports or minutes from safety groups.

Procedural and HSE work place Risk Assessment audit is to be undertaken in line with the CCG internal audit schedule this should be completed by the designated person within the workplace on a yearly basis when the policy is due for renewal.

15. POLICY REVIEW

15.1. This policy will be reviewed in one year. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/ guidance, as instructed by the senior manager responsible for this policy.

16. REFERENCES

- The Health & Safety at Work etc Act 1974
- The Management of Health & Safety at Work Regulations 1999
- The Health and Safety Information for Employees Regulations 1989
- The Safety Representatives and Safety Committees Regulations 1977
- The Health and Safety (Consultation with Employees) Regulations 1996
- http://www.nhsemployers.org/~/media/Employers/Publications/workplace-health-safety-standards.pdf
- HSE - Controlling the risks in the workplace http://www.hse.gov.uk/risk/controlling-risks.htm
- HSE - Plan, Do, Check, Act: An introduction to managing for health and safety http://www.hse.gov.uk/pubns/indg275.htm

17. ASSOCIATED POLICIES

- COR03 Risk Management
- COR11 Serious Incident & Concerns Policy
- HR13 Induction Policy
- HR25 Managing Stress in the Workplace

18. CONTACT DETAILS

Business Support Manager
01904 555870
Address: NHS Vale of York Clinical Commissioning Group, West Offices, Station Rise,York. Y01 6GA

19. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM

1.	**Title of policy/ programme/ service being analysed**
	Health and safety Policy
2.	**Please state the aims and objectives of this work.**
	The CCG will provide and maintain a healthy and safe working environment with the objective of minimising the number of instances of occupational accidents and illnesses
3.	**Who is likely to be affected? (e.g. staff, patients, service users)**
	Staff directly employed on the business of the organisation, (both on and off premises, during working hours); all visitors to CCG offices, (public, business partners and service support staff); temporary staff employed by the organisation.
4.	**What sources of equality information have you used to inform your piece of work?**
5.	**What steps have been taken ensure that the organisation has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics**
	The analysis of equalities is embedded within the CCG's Committee Terms of Reference and project management framework.
6.	**Who have you involved in the development of this piece of work?**
	Internal involvement: Senior Management team **Stakeholder involvement**: Consultation with Senior Managers **Patient / carer / public involvement**: This is an Internal policy aimed at staff employed by the CCG and contractors working for the CCG. The focus is on compliance with statutory duties and NHS mandated principals and practice. There are no particular equality implications.

7.	**What evidence do you have of any potential adverse or positive impact on groups with protected characteristics?** **Do you have any gaps in information?** **Include any supporting evidence e.g. research, data or feedback from engagement activities** **(Refer to** Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)	
Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc	
N/a		
Sex Men and Women	Consider gender preference in key worker, single sex accommodation etc	
N/a		
Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc.	
N/a		
Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.	
N/a		

Trans People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
N/a	
Sexual orientation This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
N/a	
Religion or belief Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.
N/a	
Marriage and Civil Partnership Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
N/a	
Pregnancy and maternity Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/a	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
N/a	

Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc
N/a	
8.	**Action planning for improvement** Please outline what mitigating actions have been considered to eliminate any adverse impact? Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people? An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

Sign off
Name and signature of person / team who carried out this analysis *Mary Hughes, Business Support Manager*
Date analysis completed *01 November 2017*
Name and signature of responsible Director
Date analysis was approved by responsible Director

21. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Health and Safety Policy
What is the main purpose of the document	The CCG will provide and maintain a healthy and safe working environment with the objective of minimising the number of instances of occupational accidents and illnesses
Date completed	01 November 2017
Completed by	*Mary Hughes, Business Support Manager*

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		
	Will it promote ethical purchasing of goods or services?	0		
	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	1	Clear principles and references to operating procedures that promote safety.	
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/a		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		
	Will it increase safety and security in new buildings and developments?	1	Security will be considered under risk assessments and appropriate mitigations undertaken as appropriate	
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

22. APPENDIX 3: CITY OF YORK COUNCIL HEALTH AND SAFETY POLICY

	HEALTH & SAFETY POLICY	
CITY OF YORK COUNCIL	CYC HEALTH & SAFETY POLICY STATEMENT	
	Version: 4	Issue: August 2016
	Issued by: H&S Team	Section 2 Page: 1 of 1

CYC HEALTH & SAFETY POLICY STATEMENT

As a leader of the community that it serves, City of York Council recognises and accepts the financial and legal responsibilities and duties that it has for the health, safety and wellbeing of its employees and others affected by the Council's activities.

The Council's commitments are:

- To prevent injury and ill health associated with the Council's activities
- That the health, safety and wellbeing of all its employees (and of any others who may be affected by its work) will be considered of equal importance to all of its other commitments.
- To provice a healthy and safe working environment
- To promote a positive health and safety culture throughout the organisation
- To satisfy applicable legal and other requirements
- To continually improve the Council's safety management systems eg by simplifying these where practicable through the use of technological solutions
- To engage employees in developing and implementing a joint approach to the management of health, safety and wellbeing
- To set health and safety objectives and monitor their achievement

As Chief Executive, I am committed to integrating health and safety into decision making and risk management processes within the Council. The Corporate Directors will support me in this role and, together with the Corporate Leadership Group and Directorate Management Teams, will ensure the effective leadership of health and safety for the Council and others affected by the Council's activities.

Employees with management responsibilities will ensure that all significant risks are properly assessed, controlled and any measures implemented to mitigate risk are appropriately monitored. They will also regularly review these assessments, to ensure that the Council complies with legal requirements and strives to achieve best practice.

The Council will maintain arrangements to consult trade union representatives, employees, and others who may be affected by Council activities, to encourage a joint approach to the management of health, safety and wellbeing.

The Council expects all employees and those undertaking work on behalf of, or in partnership with, the Council to take reasonable care of their own health and safety, for the health & safety of others and to co-operate with the Council in the performance of its moral and statutory duties.

Mary Weastell, Chief Executive Date 31th August 2016

(The signed copy is held by the CYC Health & Safety Manager)

Vale of York
Clinical Commissioning Group

Item 13

Chair's Report: Executive Committee

Date of Meeting	3 and 17 January 2018 7 and 21 February 218
Chair	Phil Mettam

Areas of note from the Committee Discussion

1. The Executive finalised the projected CCG financial position for 2017/18.
2. The Executive discussed the process and timetable for the 2018/19 financial plans and QIPP refresh.
3. A number of delivery issues and risks were discussed and mitigations agreed where appropriate.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

NHS
Vale of York
Clinical Commissioning Group

EXECUTIVE COMMITTEE

3 January 2018, 9.00am to 12.00pm

Rowntree room, West Offices, Station Rise, York, YO1 6GA

Attendees: Dr Andrew Phillips, Dr Shaun O'Connell, Denise Nightingale, Phil Mettam, Michelle Carrington,Tracey Preece, Dr Kevin Smith, Caroline Alexander, Dharminder Khosa, Simon Cox, Fiona Bell, Pippa Corner

		Action
1.	**Apologies**	
2.	**Declaration of Members' Interests in the Business of the Meeting**	
3.	**Minutes from previous meetings** To be carried over to 17/1	
4.	**Acute System Review York and Scarborough System** Verbal update was provided by SC on the establishment so far of the team across VoYCCG and SRCCG to deliver the ask. Clarification of the structure and exact roles and responsibilities would take place at a meeting held later that day. There would need to be some pragmatism regarding the necessary support CCGs will need to give to winter and the current focus on resolving issues at Malton Hospital following the MCP award by SRCCG. It was noted that the team may not have the capacity to manage the workload at this moment in time.	
5. 5.1 5.2	**Finance, QiPP and contracts** Turnaround Headlines Meeting is in the diary for final prep work, managing engagement documentation and external audit. On top of monitoring, confirming and challenging QiPP. AIC workshop in diary for all staff to attend. Latest Financial Position • TP working on month 9 at the moment but no information to share yet as month 9 account submission to do. Also working on 18/19 QiPP Refresh Process & Timetable. **Malton beds issue:** • MC – letter went out to Malton asking for confirmation that Community Services would not be affected by the changes. FB had advised that	

	the Trust response was that everything would be continuity of service, but that we have requested further detailed information and have requested a meeting asap. • Humber FT are in discussion with ryedale GPs to cover the Malton beds. • Post MCP meeting regarding the in-patient beds needed every 2 weeks to take stock, assess risks and further develop the service going forward. **Action: FB to discuss risks with Abby Combes to ensure risks have been captured and mitigated as far as possible** • Selby Hospital Beds – FB is going to pick up with Mel Liley re the use of the beds in context of the trust serving notice for the GP support to those beds **System Transformation Board agenda for the following week was discussed, no actions for exec.**	FB FB
6. 6.1 6.2	**Performance & Delivery** Dermatology Consultant Capacity at YHFT remains an issue. Winter Planning Mobilisation Advice to CCGs was to not instigate financial penalties for mixed sex accommodation breaches in light of winter and influenza pressures. NHS 111 over Christmas period **Action: AP to provide report for A&E Delivery Board**	AP
7 7.1 7.2	**Service, Quality and Safety** CQC report York System Review Pippa Corner brought a report highlighting progress so far since the CQC system review and publication of the report in December 2017. CQC is expected to receive the York action plan by the end of January 2018. It was agreed that an Improvement Board would be established to oversee the action plan chaired by CYC. The executive was asked to comment on the action plan thus far**.** **Agreed: it was agreed to setup a working group to support the finalising of the joint action plan. Working group to include Andrew Phillips, Laura Angus, Paul Howatson, Shaun Macey to work directly with Pippa** **Process for Commissioning Statements** SOC brought a paper detailing the proposed way forward to manage the development and sign off of VOYCCG commissioning statements in light of issues following the STP approach. The approach was approved and the executive asked that clarification was sought regarding those statements that	

	did not require sign off by Governing Body and then have the process approved at the next Governing Body meeting.	SOC
8. 8.1 8.2	**Strategy** Malton Hospital Briefing – covered earlier in the agenda York Health Economic Consortium activity model and report – enclosure noted by the executive	
9	**Commissioning Primary Care – no items on the agenda**	
10	**Local Issues – no items on the agenda**	
11.	**National and Regional Issues – no items on the agenda**	
12. 12.1	**People, Support and Development** Temperature Check Results – CCG local staff survey MC updated the committee on the results from the local staff survey. There were many positives to note and a shift from previous staff feedback. It was noted that CHC staff who had TUPE across to the CCG from the PCU were not included but would be from this point on. MC to write to the Staff Engagement Group to note the results and ask for an action plan to be developed on the back of the feedback. Repeat the survey again as planned. MC informed the executive that the national staff survey results were now available and high level results shared with PM and MC only at this point. The plan is for the detailed results to come through from HR department with a comparison to other CCGs and for this to be presented to the executive in March. . **Action: staff engagement group to develop a plan following the local staff survey results** **Agreed: the committee agreed that Staff Briefing would continue to be held every 6 weeks and PM will continue with the Friday notes**.	MC
13.	**Corporate** The Committee discussed the progress of the commissioning statements and the concerns around capacity for the Executive Committee and Governing Body – see item in section 7.2.	
14.	**Engagement & Communications – no items on the agenda**	
15.	**Issues from other Committees – no items on the agenda**	
16.	**Key Messages to Council of Representatives – no items on the agenda**	
17. 17.1	**Any Other Business** **Disclosure UK letter** The Committee discussed the Association of British Pharmaceutical Industry	

	(ABPI) disclosure log that was in June 2016. There are concerns that GPs are not disclosing costs earned. The committee agreed that further investigation is required, governance and ensure conflicts of interest are dealt with in the correct manner. **Action: LA and SOC to discuss with providers and produce report after discussion with AC (legal and governance).** **Paper Referral Switch Off (PRSO) Governance Proposal** The paper has been authored by YTHFT and has received input from SRCCG, ERCCG and VOYCCG. An earlier draft has also been sent to the LMC chair so they are aware of the proposed governance process. This governance process is to aid implementation of the national target for 100% of e-referrals for consultant led first outpatient appointments by October 2018 (YTHFT have been set a local target by NHS digital of March 2018). The governance proposal is going to be discussed at the Paper Referral Switch Off Board on 10th January and will hopefully be formally signed off by all parties there following receipt of approval through our own individual governance processes. SRCCG have already approved this through their own governance process. **The approach for PRSO was approved by the executive.**	LA/SOC
18.	**Issues of Assurance Framework and/or risk register – no items on the agenda**	
19.	**Next meeting:** 17th January 2018 Meeting closed 12:25hrs	

Minutes of the Executive Committee, meeting held on

17 January 2018 at West Offices, York

Present

Michelle Carrington (MC)	Executive Director of Quality and Nursing
Dr Shaun O'Connell (SOC)	Medical Director
Tracey Preece (TP)	Chief Finance Officer
Dr Kev Smith (KS)	Executive Director of Primary Care and Population Health

In Attendance

Paul Howatson (PH) for DN	Head of Joint Programmes
Simon Cox (SC) to item 4	Chief Officer, Scarborough & Ryedale CCG
Fiona Bell (FB) to Item 4	Assistant Director of Transformation & Delivery
Laura Angus (LA) to Items 5.6 & 5.7	Lead Pharmacist and NICE Medicines and Prescribing Associate
Rachael Murray (Minutes)	

Apologies

Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Andrew Phillips (AP)	Medical Director
Dharminder Khosa (DK)	Director of Turnaround and Delivery

1. **Apologies**
   As noted above.

2. **Declaration of Interests**
   S'OC advised he may have a potential Declaration of Interest on the Anticoagulation paper.

3. **Minutes from the previous meeting**
   The minutes of the Executive Committee held on 20 December were approved.

   The minutes of the Executive Committee held on 03 January were deferred to the next meeting.

4. **Acute System Review York System**
   - Update on Malton & Selby

   SC explained that the Scarborough Executive board had met yesterday around realignment of CCG team to support the acute transformation plan.

Malton Update: positive discussions with Humber FT progressing re provision of beds at Malton hospital. Formal confirmation re bed cover expected later this week. FB progressing with a comparison of the current York provided community service and the specification for the Humber model to understand any potential variances in provision in the Ryedale locality. Planned date of 1st May for transfer of community services for Scarborough Ryedale CCG patients from York trust to Humber.

Selby Hospital GP Cover update: York FT has progressed with advertising the tender for community hospital bed cover in Selby. Initial request is for a 12 month contract with potential to extend to 2 years maximum and to cover all Vale of York patients admitted to Selby hospital under the agreed criteria, regardless of registered practice. Contract start date is advertised as 1st April 2018. FB has met with the Head of Community Services in York to explore opportunities for joint working in the south locality and potentially align system opportunities such as improving access to primary care, community hospital cover, urgent treatment centres etc.

Posterngate have given notice to the trust on providing GP support for their own patients from end March – the CCG has agreed temporary cover by Beech Tree surgery with additional funding up to a maximum of 12 patients to the end of January to ensure optimisation of the bed base at Selby. Heather Marsh progressing discussions to extend this cover to end of March with handover to successful bidder from York tender from 1st April.

MC has spoken with Carrie Wollerton to see if Karen Mazingham could potentially pick up quality. Discussions are progressing, with it been over York & Scarborough she would need Band 6 support.

Action: *SC to provide an update on Malton after S&R and VoY CCG Planned care Delivery meeting on Friday.*

Action: *SC to circulate ToR for Joint Committee by the end of this week*

5. Finance, QIPP and Contracts

5.2 Latest Financial Position

TP reported that the month 9 financial position remains at a risk adjusted forecast outturn of £22.5m. There remain a number of risks to this, including mitigations still to be delivered and outstanding challenges with the York FT acute contract. Efforts continue to resolve these to avoid dispute resolution.

The finance team is working closely with NHS England colleagues to ensure transparency of the financial position, the underlying position and outstanding disputes.

The CCG has obtained agreement from the Trust around ensuring Q4 waiting times are the most efficient within the 18 weeks requirement; SC will draft a letter to go out regarding this. TP reported that her and PM are attending a meeting with Ramsay next week and will discuss this on the agenda.

5.4 Anti-coag Update

SO advised this service is being moved out to the 26 practices. To date practices have taken on 50% of the patients in the trust at the rate £151 per year per patient. In Tollerton, Kirbymoorside, Pocklington & Pickering practices take up is around 100%. Two practices are not taking patients on – Sherburn in Elmet and East Parade. During the transition patients have been given the impression they had the choice as to where they went, and those who chose to stay in hospital are apparently reluctant to move to a practice.

The hospital has reported that they are finding it difficult to retain nurses who work in the anti-coag clinic.

A suggestion was made that a default service is procured in the future from one or more providers across the patch with the aim that where practices don't take up the service patients could go to the default provider and through this all patients should be able to move out to primary care

SO highlighted the risk to the project's smooth continuation given Stacey Marriott is due to leave the team at the end of next week.

The decision was made to extend Emma Olandj's contract a further 3 months.

Action: *SC to speak to Chris O'Neil re support with the service model*
Action: *MC to inform HR re Emma's contract extension*
Action: *SO to inform Emma re her contract extension.*
Action: *Anticoagulation project team to meet later today to discuss way forward and bring proposals back to Exec.*
Action: *Meeting with hospital colleagues next week*
Action: *SO to provide summary for PM of project history*

5.5 Month Governance Statement Return

TP reported that the finance team is currently working through month 9 accounts which is a substantial exercise and ensures information is all in place for year-end accounts. The submission also requries the CCG to make a draft governance statement return highlighting key issues of risk and governance. Propose same areas as last year with the addition of changing governance structures and updating of PCU areas to reflect current position.

A community equipment paper is currently being prepared and TP highlighted the considerable contracting resource that is being utilised to manage the contract.

5.6 Prescribing Indicative Budgets

Laura Angus advised there have been no further updates from NHSE on the NCSO situation, however alliances are anxious as to what is going on regarding PIB.

LA asked CCG Exec if to continue with PIB and if the model needed reviewing.

Risk is the CCG and the alliances will not make savings due to impact of NCSO.

MC advised a discussion had already taken place at PCCC and it was agreed to carry on with PIB.

Agreed to continue with PIB and work with the alliances to ensure the financial model was suitable for both the CCG and the alliances.

Finance to review the financial model.

LA to liaise with the alliances.

***Action**: LA to provide an update*

***Action**: MAM is to provide a financial update*

TP left the meeting

The decision was made to rebase PIB – this was the actual language used in the meeting.

Community Dietitian currently employed by the Trust, funded by CCG, on a FTC, due to expire end of March 2018. Trust would like to know if we are wanting to give notice or continue post.

Post linked to PIB because sip feeds included in PIB.The dietitian has been working with alliances to review prescribing.

There is no vacancy money in Meds Management budget to continue to pay for a dietitian.

Exec committee reviewed savings made since Community Dietician has been in post. CCG Exec determined that the savings do not justify the continuation on the post in the current financial climate.

The decision was made not to extend the dieticians contract.

FB left the meeting.

5.7 MCC Recommendations

TA491: Counter Drug
Promazine – antipsychotic: No longer use can be taken off
Meibopatch: RAG status should be black not N/A

SO'C explained the flash glucose monitoring system to be used on patients 4 years and above for a 6 month period, after this time it would only continue if they met the criteria of the bullet points on the Flash Glucose Monitoring system paper, we do not pay for the device only the sensors. Through the MMT review we have established this would consist of 50 people; 20 adults, 20 pregnant women and 10 children. 8 test strips would need to be used per day and they cost £9 for a pack of 50.

MC advised this is a very political issue and MP letters have been received.

As this has no clinical benefit, if we reject this and the patient appeals then it would go to IFR panel.

The general feel was to go ahead with the full service but would need to review activity as numbers may get bigger, and we would need providers to tell us how they are going to do a cost effective assessment. LA advised MM will monitor this carefully. The concerns are to do this on a cost effectiveness basis, £50k would be spent on this based on 50 patients, and we would need a commissioning statement in place.

S'OC advised we would need to add a in for patients to give us their consent/ permission to see their patient records for audit and also to check they are testing and to ensure they meet the criteria.

MC advised we need a process in place on numbers and cost as the whole thing is based on being cost neutral. If a patient does not meet the criteria then it would go to IFR panel.

We need to review triggers in place

Action: LA to make amendments to policy

6.1 Joint Commissioning Strategy

MC advised there is a meeting with CYC this afternoon which is the newly re-established integrated commissioning meeting between execs of CYC and CCG which will result at a later date in an agreed joint commissioning plan as one had been approved at HWBB although the CCG executive had not seen it.

MC advised Pippa Corners contract is due to end at the end of March, this is currently a Band 8b post however there is a wish to replace this with an assistant director post Band 8d which CYC are going to go ahead and recruit to. The CCG have an opportunity to 'buy into' this post at a later date if we so wish.

Phil Mettam agreed in principle with Martin Farran to a joint post but this will not be decided until the externally commissioned review has reported.

6.2 Commissioning Intentions

Items for discussion were:

- Process for Prioritisation
- National Planning Requirements and Timetable
- Prioritise Long List

Deferred to the next meeting due to not many attendees.

7. Service, Quality and Safety

7.1 Mental Health Housing & Support

PH advised this was on the agenda for exec to note and inform of future requirements for Mental Health Supported Housing across York. Further reports will be brought to exec committee periodically.

7.2 Dementia IST report & Action Plan

PH highlighted pressures with dementia support services and that there would be a need for exec committee to consider potential additional funding.

Exec committee requested a business case to support additional investment for consideration at a future meeting.

7.3 Extension of retrospective Team contracts

MC asked to extend contracts for CHC retrospective work for 6 weeks of a band 3.

The committee Agreed

8. Strategy

8.1 Gluten Free Foods Provision

SO referred to a previous discussion re an options paper to means testing benefits.

Scarborough/ Ryedale CCG only provide gluten free food to children (under 18). SO reported that following discussions with Abby Combes it was felt that adequate governance could be established for the continued use of the Sodexo cards. The maximum cash build-up on any card would be £48 would have to equate the equivalent of 3 months.

Discussion ensued as to whether the consultation process had asked the right question to enable the CCG to establish this policy. It was noted that during the consultation some adults asserted they should still be entitled to NHS support due to rural, affordability etc. It was felt that in prioritising the use of NHS resources there was clinical justification for supporting children's development and growth and reducing the likelihood of the development of other auto-immune conditions. It was felt that adults have the responsibility to look after themselves and have choice over food and what risks they put themselves at.

Action: MC advised there should be a discussion with Abby Combes as to whether there was sufficient justification from the processes undertaken to reach the proposed position. Public communications would need to be drafted to support this. - SO

Action: It was noted that impact assessments were also needed. - SO

9. Any Other Business

MC asked KS to add Clinical Summit to the next agenda.

S’OC advised he needs the paper for this in time for the next Exec Committee.

10. Next Meeting

Wednesday 7th February 2018

Minutes of the Executive Committee, meeting held on

7 February 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Medical Director
Dr Shaun O'Connell (SOC)	Medical Director
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Tracey Preece (TP)	Chief Finance Officer
Dr Kev Smith (KS)	Director of Primary Care and Population Health
Denise Nightingale (DN)	Executive Director of Transformation

In Attendance

Simon Cox (SC) items 7.6 to 8.4 Chief Officer, Scarborough & Ryedale CCG
Abby Combes (AC) items 7.6 to 8.4 Head of Legal Services & Governance

The agenda was discussed in the following order:

1. **Apologies**
   There were no apologies.

2. **Declaration of Interests**
   There were no Declarations of Members' Interest in relation to the business of the meeting. All declarations were as per the Register of Interests.

3. **Minutes from the previous meeting**
   The minutes of the Executive Committee held on 17th January were deferred to the next meeting.

   Matters Arising: The action tracker was updated, a number of items were on the agenda.

   Parkinson's Nurse – SOC reported that the nurse's employment was likely to be with the geriatricians or a federation / practice but that this had yet to be decided. It would not be with the neurology department or the CCG. The project outcomes were ratified at Clinical Executive and if possible a nurse prescriber would be recruited. If this was not possible then attempts would be made to secure them on a non medical prescriber course once recruited.

   Paper Referral Switch Off Governance Proposal - SOC confirmed Paula Evans and Aaron Brown had been consulted about this project and were happy with the process.

5. Finance, QiPP and Contracts

5.2 Latest Financial Position

It was too early in the month for the latest financial position. Forecast outturn remained at £22.5m, all risk and mitigations were now incorporated into actual forecast following discussion and agreement with NHS England.

5.3 Additional Clinical Cancer Capacity

The Committee discussed the current 1 day per week clinical cancer capacity within the CCG and the support of Macmillan Cancer to 1 session of this. The Committee felt that 1 day per week was insufficient allocated time to the Cancer agenda and agreed that an increase to 2 days should be considered as part of the current GP consultation. This would also be in line with other CCG's.

The Committee supported in principle the increase to 2 days acknowledging there may be additional financial implications, KS to take forward and confirm the support of Macmillan Cancer to a further session.

5.4 Anticoagulation Local Enhanced Service

KS referred to the work that had previously taken place to encourage Vale of York Practices to offer Level 4 Anticoagulation Services during 2016/17 and move away from a hospital based service. The uptake had been slow with a number of Practices stating that the current payment level was not sufficient to cover their costs.

The committee were asked to agree the payment level of £196.40 per patient per year for the 2018/19 financial year. It was noted that this figure had been suggested from 2 large Practices in the Vale of York.

SOC advised the impact of increasing the anticoagulation contract payment to £196.40 would be £187,000 per annum.

The committee approved in principle the £196.40 payment level.

MC/KS/SOC to take forward and agree a plan with Heads of, report due back to the Executive Committee in March

6. Performance & Delivery

6.1 NHS Commissioning Capability Programme

PM outlined the compulsory Commissioning Capability Programme. The programme would require engagement and an initial meeting was planned with NHS England to receive an overview of the programme and timescales.

PM to provide further details at the next meeting.

6.2 Performance Update

This item was deferred to the next Finance & Performance Committee meeting.

No formal response had been received from the Trust following the Q4 actions letter however it had been discussed at the System Transformation Board with the Trust and modelling was being undertaken to cost the financial impact of the agreed actions.

7. Service, Quality & Safety

7.1 Armed Forces Covenant

The committee noted the report on the local Armed Forces Covenant which the CCG had already signed up to with a number of partners led by the City of York Council.

The committee were asked to agree and approve the next steps to embed the spirit of the covenant in the work of the CCG and its member practices.

AP advised the committee of a planned meeting with Jim Khambatta, Armed Forces Commissioning Manager, NHS England to scope out further details. A suggestion was also made on a possible joint North Yorkshire approach with Hambleton, Richmondshire & Whitby CCG given their connections with Catterick Garrison. AP to take forward and bring back a proposal to the Executive Committee.

7.2 Parkinson's Nurse Update

This item was covered under matters arising

7.3 Paper Referral Switch Off

This item was covered under matters arising

7.4 Freestyle Libre

The committee had highlighted their concerns at a previous meeting that costs may exceed the estimates and that it may not be cost neutral.

To help manage this SOC advised the committee that Laura Angus (LA), Lead Pharmacist had developed an audit tool and the team were currently exploring how to make this an electronic tool. It was felt an electronic tool already in existence did not give the level of detail required and work would therefore continue on developing our own tool, if this was possible it would give details after 6 months use to assess the cost effectiveness.

A decision was still needed on which validated patient experience questionnaire to use, LA to action

Within the commissioning statement, SOC suggested that there was more clarity needed around impaired hypoglycaemia awareness (moving to language the DVLA uses) which colleagues supported.

SOC/LA to take forward and bring back to the Executive Committee

7.5 IVF

MC reminded the committee of previous conversations regarding IVF and that the newly adapted and agreed Yorkshire and Humber policy had not been uploaded to the CCG website.

SOC reported that the policy had been checked again and was now ready for publication and the committee supported this. MC confirmed a QIA had been completed.

SOC to inform relevant parties.

SC & AC joined the meeting at this point

7.6 Draft Terms of Reference for Joint Committee

The committee received the draft Terms of Reference for the Joint Committee and the Governance Paper on the Acute Commissioning System.

AC provided a background to the Joint Committee whose primary purpose would be to arrange and commission acute services on a York Teaching Hospitals NHS Foundation Trust footprint. The Joint Committee would initially work to identify the areas of work where a “system” approach would be beneficial to the outcomes for patients and make the best use of public finances. It was hoped the Joint Committee would include NHS East Riding of Yorkshire CCG, NHS Scarborough & Ryedale CCG and NHS Vale of York CCG. AC advised that East Riding CCG had not confirmed their involvement at this stage and we were awaiting their feedback.

The committee supported the work in progress and provided feedback. The final paper would be presented for formal approval at the 3 CCG’s Governing Body meetings in March with a proposed starting date of April for the Joint Committee.

5.1 Turnaround Headlines

SC provided an update on behalf of Dharminder.

A second Aligned Incentives Contract workshop had taken place with good attendance. Confirm and Challenge sessions were under way for 2018/19 plan and the next Financial Recovery Board meeting would be used to review early plans.

7.6 MCC Recommendations

The committee approved the recommendations as received and were particularly pleased the Wound Formulary had been agreed.

KS opened a discussion re the difference between formulary positions against other commissioning positions – should we have rationale for why we such treat decisions differently? Are Impact Assessments needed? MC/SOC to take forward.

7.7 MSK Shared Decision Making (SDM) & 6 Week Pause

SOC reported the lack of a clearly recorded governance process for imposing a 6 week delay in the MSK process. A discussion ensued around the history and rationale for a 6 week delay. There was a view that a prolonged delay after SDM may lead some patients to decide to have surgery. It was agreed to not mandate a delay but to ensure patients were given detailed information on how to inform the Referral Support Service team that they wished to proceed to surgery. SOC to work on clear guidance for patients and practices.

8. Strategy

8.4 Gluten Free Foods

Following previous discussions the CCG had received advice that consultation would be required again if the CCG wished to match Scarborough and Ryedale CCG's policy as this would be a different outcome to that already consulted on.

AC reported that the Department of Health had recently concluded a consultation which had recommended retaining a limited range of bread and mix products on prescription.

After discussion, the committee agreed to maintain the current policy of providing just bread and flour to all age groups and to cease the pilot of provision of funds via debit cards.

SOC to bring back to the Executive Committee to ratify the detail of the decisions suggested.

SC & AC left the meeting

7.8 NICE Guidance Update paper

MC outlined the paper which provided an update on NICE Guidance and a proposal for improved oversight. The committee discussed the capacity that would be required to work through the next steps and the resource required to do this.

The committee felt that no further emphasis was required at this stage on NICE guidance. PM advised that the new clinical chair, Nigel Wells would be asked to review this along with other items in due course.

8.1 Microsuction Proposal

SOC reported the background to the microsuction proposal. The proposal had been to the Clinical Executive who did not support the commissioning statement. Clinical Executive had acknowledged the work to decommission hospital ear waxing removal but were concerned about the impact on primary care. It was therefore agreed to explore the actions to decommission microsuction and syringing in general practice.

The committee also discussed East Riding of Yorkshire CCG who had already de- commissioned the service and agreed to enquire about their experience.

The committee agreed the need to work up the pathway review in planned care through the acute transformation process and acknowledged public consultation may be required.

SOC to take forward and bring back to the Executive Committee for approval

8.2 Humber, Coast and Vale STP – The Way Forward

The committee noted the paper which had been circulated for information**.** PM stressed the importance of remaining engaged with the STP, Chris O'Neill and Simon Pleydell would be invited to more CCG meetings in this respect.

8.3 Malton Hospital Community Beds

Humber Foundation Trust (HFT) had accepted the proposal via email to deliver 12 beds for the Vale of York CCG patients, a formal response was expected. Regular meetings were now taking place with Fiona Bell and HFT and a further meeting was planned with SC & Michele Moran, Chief Executive of HFT.

The committee requested a full update from Fiona Bell with a summary of progress *(circulated 7.2.18)*

11. National & Regional Issues

11.1 Developments across North Yorkshire

PM advised that the 3 North Yorkshire CCG's were being placed into Special Measures. Part of this process would involve an extensive review of capacity and capability carried out by PWC.

11.2 Guidance on Influenza Vaccine Ordering 2018-19

The committee noted the guidance which had been sent to all practices and CCG's regarding the 2018-19 influenza vaccine ordering.

12. People, Support and Development

12.1 Data Protection & Confidentiality Policy

The committee approved the amendments to the policies.

It was also agreed by the committee that any future minor amendments to the Information Governance policies could be approved outside of the Executive Committee meeting by MC & TP, these would then be ratified at the next meeting.

13. Corporate

13.1 NHS70 Parliamentary Awards

The committee agreed a nomination for the NHS70 Parliamentary Awards, Fiona Bell to take forward confidentially.

17. Any Other Business

17.1 Governing Body Draft Agendas March

The committee agreed the draft agendas for the March Governing Body meetings.

Next meeting Wednesday 21st February

Minutes of the Executive Committee, meeting held on

21 February 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Medical Director
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Tracey Preece (TP)	Chief Finance Officer
Dr Kev Smith (KS)	Director of Primary Care and Population Health

Apologies

Dr Shaun O'Connell (SOC)	Medical Director
Denise Nightingale (DN)	Executive Director of Transformation

In Attendance

Simon Cox (SC) to item 5.3	Chief Officer, Scarborough & Ryedale CCG
Caroline Alexander to item 7	Assistant Director of Delivery and Performance
Fiona Bell to item 5.3	Deputy Director of Transformation and Delivery
Dharminder Khosa to item 6	Director of Turnaround & Delivery
Elaine Wyllie (EW) item 5.1	Strategic Programme Consultant
Anne Ellis Playfair (AEP) item 5.5	Audit Manager, Audit Yorkshire
Jo Baxter	Management PA

The agenda was discussed in the following order:

1. **Apologies**
   There were no apologies.

2. **Declaration of Interests**
   There were no Declarations of Members' Interest in relation to the business of the meeting. All declarations were as per the Register of Interests.

3. **Minutes from the previous meeting**
   The minutes of the Executive Committee held on 7 February were approved. The minutes of the 17th January were deferred to the next meeting.

   Prior to commencing the formal agenda, the committee discussed the "Heads of" fortnightly meeting and the best way forward. The "Heads of" meeting had been changed to a Thursday to ensure updates and actions from the Executive Committee were disseminated as soon as possible after the meeting. The committee agreed to continue with the meeting and in addition agreed an Executive Committee member on a rotational basis would circulate a bullet point summary immediately after the meeting.

The committee also asked for “Heads of” to suggest a way forward for two-way feedback. AC to take forward

4. Acute System Review York System

SC reported that the Draft Terms of Reference for the planned Joint Committee would be presented to the Governing Body for approval in March. A meeting was planned with NHS Improvement and NHS England to share the medium term financial plan for this work. It was hoped this session would confirm support for the proposal and an opportunity to agree the next steps to work through.

Malton Hospital Update

SC updated the committee on progress with the integrated community services procurement in Scarborough and Ryedale.

Through discussion, it was acknowledged the need for a fuller understanding of community services across the Vale of York and the committee agreed to work through the details of the resource required.

PM also suggested the possible introduction of additional management capacity from NHSE. PM to take forward**.**

5. Finance, QiPP and Contracts

5.1 Joint Commissioning Project Update

EW joined the meeting to provide a verbal update on progress in relation to the Joint Commissioning Project. A formal report would be completed by the end of March in readiness for the Governing Body meeting in April.

The primary focus of the project was to understand the potential joint commissioning opportunities there might be with local authority partners. EW had held discussions with colleagues from both North Yorkshire County Council and City of York Council. A meeting with East Riding of Yorkshire Council was still being pursued. EW had also met with Executive Committee members individually to gather their views with further meetings planned.

There were some themes emerging through the discussions held to date:

- The locality framework was well recognised, understood and supported by stakeholders
- Joining together of primary care provision around the Primary Care Home model appeared to be gaining strength and was seen as a positive move by stakeholders
- Relationships with other health commissioners were important and would need to be considered in establishing collaborative commissioning models

- Relationships with partners were different and the focus on a place based approach was helpful

Early discussions had taken place around the services in scope they would like with further meetings required in this respect. The required governance was being considered and other CCG models were being viewed for guidance.

The committee agreed the need to prepare a CCG list of services they felt should be in scope. KS/DN/MC to meet with EW to discuss further.

EW/SC/FB left the meeting

5.3 Latest Financial Position

This item also incorporated item 5.2 Turnaround Headlines

TP reported that a year-end settlement with York Teaching Hospital NHS Foundation Trust had been agreed on the 20th February 2018, for the 17/18 contract at a fixed value of £195.1m. East Riding of Yorkshire CCG had been agreed at £42.0m.

This mitigated risk now for the year-end and allowed full focus on 2018/19.

The Expert Determination process was formally stood down on Friday 16th February.

TP highlighted that there was still impact into 2018/19 for some of the challenges and these were being resolved with the clinical pathway as the core driver for example; rehab services, Emergency Department Front Door, assessment activity.

A year-end settlement had also been agreed for Scarborough and Ryedale CCG which was trading out on activity, due to forecast differences in Q4, but with a fixed and agreed deduction to settle all 17/18 disputes, challenges and penalties.

TP reported that the forecast outturn at month 10 remained at £22.5m deficit. All risk and mitigations were now incorporated into actual forecast. Following the anticipated release of the 0.5% and Cat M at month 12 to further improve the position, this would deliver an in-year deficit in line with 2016/17 so would support the message of stabilisation.

A consistent methodology had been agreed by the 4 Chief Finance Officers of the North Yorkshire CCGs for CHC and Mental health out-of-contract balances at the year-end. This was supported in principle by the CCG's external auditors Mazars.

In relation to 2018/19, TP reported that a number of presentations were going to Finance and Performance Committee (F&P) for 18/19 planning in relation to the first draft of the financial plan and bottom-up QIPP planning.

TP updated briefly on the Planning Guidance for 2018/19 which gave guidance on access to the Commissioners Sustainability Fund (CSF) which required a plan to deliver the control total of £14m.

The first draft of the financial plan which included all outputs from the Confirm and Challenge sessions currently taking place had a gap however governance process over the coming weeks, starting with F&P would aim to close this.

The bottom up QIPP plan was being prepared by Dharminder and would also be discussed at F&P.

PM Directions meeting update

TP provided an update from a recent Directions meeting with NHS England. The 18/19 Planning Guidance framework was linked to the original Legal Directions and meant the CCG was unable to exit legal directions without a Financial Plan that met the control total. F&P would need to consider. A discussion took place around timescales and how the positive strategic story might be told, CA was working on this.

5.4 Future options for Delivery of Out of Hospital Services

This item was discussed briefly under agenda item 4.

5.5 Draft Internal Audit Plan 2018/19

AEP presented the draft internal audit plan that required refreshing to ensure it provided assurances on the strategic priorities and strategic paths and highlighted any risks going into 2018/19. AEP sought feedback on the plan prior to submission for approval at the next Audit Committee.

The committee discussed the proposed planned allocation of audit days and agreed that the allocation of 8 days to CQUIN should be utilised elsewhere. The plan had been completed some time ago and CQUIN now offered limited scope.

A discussion ensued and the committee agreed a number of days should be allocated to Process for development and decision making for Commissioning Thresholds and to look at an audit of quality in cancer/mental health/children. TP and AEP to meet and reallocate days in line with suggestions.

DK left the meeting

6. Performance & Delivery

6.1 De-escalation from Legal Directions and Special Measures Framework

This item was discussed under item 5.3.

6.2 Directions Meeting

This item was discussed under item 5.3.

6.3 Feedback Children's Cancer Process

CA updated the committee on a recent discussion held with Mr McPate on an issue he had raised on breaches children's urgent referrals for suspected cancer to dermatology services at York Teaching Hospital NHS Foundation Trust.

The issue had been effectively resolved and the outcome discussed with Mr McPate, however Mr McPate had requested that his desire for the CCG to prioritise all access to care for children and his on-going commitment to advocating on behalf of local children be formally noted by the Committee on behalf of Governing Body.

CA left the meeting

7. Service, Quality & Safety

7.1 Local Digital Roadmaps

A robust discussion was held around the need to appoint a Local Digital Roadmap lead for the CCG. KS advised the committee that Scarborough and Ryedale CCG had recently appointed for the role and would be willing to share the resource with Vale of York.

The committee agreed further work was required alongside the running costs priorities exercise. A separate discussion was also needed on the mechanisms of sharing the post with Scarborough & Ryedale CCG. KS to take forward.

7.2 Clinical Senate Review on Mental Health Services in the Vale of York

The committee received and noted the update.

7.3 CCG Structure after running costs exercise

The committee reviewed and agreed various posts to finalise the structure for the CCG.

It was agreed to reinforce the principles around the management of the running cost budget which included Executive Committee approval of all new posts and any recruitment to existing posts, even if within budget. MC/TP to action.

7.4 Dementia

The committee noted the on-going work to improve dementia diagnosis rates and supported the proposal to incentivise use of the dementia toolkit to achieve the national ambition of 66.7% and ultimately, the Humber Coast and Vale STP ambition of 72%.

7.5 Personal Health Budgets

The committee approved the policy which had been amended to reflect discussions that had taken place with CHC, Finance and Local Authority colleagues. The paper would be presented at the next Governing Body meeting.

8. Strategy

8.1 Draft Terms of Reference for York Improvement Board

This item was not discussed, the committee agreed to circulation outside of the meeting for comments.

8.2 Update from the Council of Representatives meeting

KS advised that the Council of Representatives had endorsed the nominations of Andy Field as Central Locality GP representative on the Governing Body and Helena Ebbs as North Locality GP representative on the Governing Body.

South Locality had not reached a consensus for a nomination and it had therefore been agreed to re-open nominations which would be taken to the next Council of Representatives meeting.

8.3 Localities Update

Localities were working on plans for improved access for GP's, use of £3 per head monies and considering development of urgent treatment centres.

10. Local Issues

10.1 Safer York Partnership Community Safety Strategy 2017-2020

The committee received the paper and suggested a representative for the Vale of York CCG. A question was raised if representation should be an Executive member and the committee agreed to confirm at the next meeting.

17. Any Other Business

Commissioning Capabilities Programme

PM provided an update from the initial session and the opportunities and support that the 12 week programme could offer the CCG. It was expected that the Accountable Officer and Clinical Chair would participate along with a representative from City of York Council.

There would be a further 2 spaces available and PM requested thought be given outside of the meeting to who would gain the most value from the programme.

Covalent Expiring Contract

MC sought the views of the committee on the current Covalent contract. The contract was expiring in February and as Covalent was now only used by the CCG for risk reporting the committee discussed the options and longer term position.

The committee agreed it was an opportunity to consider other options for risk reporting and explore the alternatives.

MC/TP to bring back to the Executive Committee in due course.

Next meeting Wednesday 7th March

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Vale of York
Clinical Commissioning Group

Item 14

Chair's Report: Finance and Performance Committee

Date of Meeting	22 February 2018
Chair	David Booker

Areas of note from the Committee Discussion

The Committee recorded appreciation to the Chief Finance Officer and the Finance Team for achieving a stabilised, on plan financial outcome for the CCG. The achievement of an Aligned Incentives Contract was seen as a critical milestone for the CCG in 2018/19.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Minutes of the Finance and Performance Committee Meeting held on 22 February 2018 at West Offices, York

Present

David Booker (DB) (Chair)	Lay Member and Finance and Performance Committee Chair
Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer
Keith Ramsay (KR)	CCG Chairman
Dr Kevin Smith (KS)	Director of Primary Care and Population Health

In attendance

Caroline Alexander (CA) – part	Assistant Director of Delivery and Performance
Fiona Bell (FB) - part	Deputy Director of Transformation
Jenny Brandom (JB)	Deputy Chief Nurse
Beverley Hunter (BH) – part	Head of Mental Health and Learning Disability
Helena Nowell (HN) – for items 1 to 5	Planning and Assurance Manager
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Michele Saidman (MS)	Executive Assistant
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)
Dr Nigel Wells (NW) - part	Clinical Chair Designate

Apologies

Michelle Carrington (MC)	Chief Nurse/Executive Director of Quality and Nursing
Denise Nightingale (DN)	Executive Director of Transformation

DB welcomed NW to the meeting.

1. Apologies

As noted above.

2. Declarations of Interest 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 25 January 2018

The minutes of the previous meeting were agreed subject to the amendment that CA be listed under 'In attendance', not 'Present'.

The Committee:

Approved the minutes of the meeting held on 25 January 2018 subject to the above amendment.

4. Matters Arising

F&P45 Financial Performance Report: TP advised that the summary section of the report now aligned with the format of the Integrated Performance Report and work to change the main report was continuing. However it would be in to the new financial year before the full change was complete in order to maintain continuity at year-end and direct resources to final accounts and 2018/19 planning.

F&P47 Cancer 62 day performance: PM referred to NW's appointment as Clinical Chair of the CCG from 1 April 2018 and the confirmation by two of the three localities of their GP representatives on the redesigned Governing Body. PM advised that NW would review clinical capacity with the three GP locality representatives and noted that this was also part of the current consultation process for 2018/19.

F&P48 Financial Performance Report: TP reported that, due to a timing issue, the information from the Financial Recovery Board was not included. She would circulate the meeting notes separately and consider future arrangements in this regard. An update on Aligned Incentives Contracts would be provided at item 6 below.

A number of other items were noted as ongoing or on the agenda.

The Committee:

1. Noted the updates.
2. Noted that TP would circulate the Financial Recovery Board minutes.

"Good News"

TP reported that Alistair Mason, Management Accountant, had won 2017 Finance Student of the Year at the Yorkshire and Humber Region Healthcare Financial Management Association (HFMA) Awards.

KS reported that Laura Angus, Lead Pharmacist, had graduated from the NHS Leadership Academy's Future Clinical Commissioning Leaders Programme and Becky Case, Head of Transformation and Delivery, had graduated from the Nye Bevan Programme with the NHS Leadership Academy Award in Executive Healthcare Leadership.

The Committee commended these achievements.

5. Risk Update Report

PM presented the report which provided details of current events and risks managed by the Finance and Performance Committee, sought confirmation of the cohort of corporate risks for escalation to the Governing Body, gave an overview of programme risk registers and provided an update on risks arising from published Improvement and Assessment Framework indicators that informed the Board Assurance Framework.

PM referred to the emerging risks reported to the previous meeting - Continuing Healthcare and Transforming Care / Section 117 Vulnerable People Risks, also at item 11 below, and the multispecialty community bed provision in the Ryedale area – and noted an additional emerging risk from the contract with York Teaching Hospital NHS Foundation Trust. The latter would be included in discussion at item 6 below.

With regard to continuing healthcare and Section 117 PM expressed concern that the full position regarding service provision and financial impact was not yet fully understood, emphasising that the Committee would be kept informed. SP referred to her correspondence with the North Yorkshire CCG Audit Committee Chairs about issues relating to the position of clients, data cleansing and financial information. She had received a full response from NHS Scarborough and Ryedale CCG's Chief Finance Officer acknowledging the concerns and detailing work to address them. This included members of the NHS Scarborough and Ryedale CCG Finance Team now working with the NHS Vale of York CCG Finance Team, regular discussion by the North Yorkshire CCG Chief Finance Officers and ongoing work to validate the position. In response to SP noting that the financial audit report from Internal Audit was still awaited, TP advised that Internal Audit had attended each meeting of the Partnership Commissioning Unit Transition Board adding that she would formally request any concerns from the transition be reported to the Audit Committee. TP confirmed that the North Yorkshire CCG Chief Finance Officers had agreed a year-end financial methodology and forecast position for continuing healthcare which was supported in principle by NHS England and the external auditors.

PM referred to the risk relating to multispecialty community bed provision in the Ryedale area advising that this was not expected to impact on patients registered with the CCG's Practices. Following notice served by York Teaching Hospital NHS Foundation Trust on the community beds an interim arrangement led by Humber NHS Foundation Trust had been agreed. PM assured members that the CCG was working actively with the new provider and that the Executive Team was receiving regular updates. He emphasised that the CCG's priority was continuity of service at no additional financial cost and that assurance was also being sought from a patient experience perspective. Members noted a further commercial in confidence risk in this regard and KS advised that the CCG was in discussion with the Ryedale GPs. PM assured members that they would be informed as soon as possible in the event of any escalation associated with this risk.

KS referred to the anti-coagulation service established as a Local Enhanced Service by the Vale of York Clinical Network which was no longer in existence. There were two risks for consideration by the Committee: York Teaching Hospital NHS Foundation Trust may serve notice on the current contract and therefore patients could be transferred to General Practice causing potential issues with their capacity; secondly,

anti-coagulation services had not been agreed by GP Practices and there was the potential for different services in different locations. KS also highlighted variation in Practice approaches to provision of the service and reported that Practices currently remunerated for its provision were not willing to continue for the same rate. In this regard TP advised that, following consideration of a number of options, Practices would be offered a higher rate per patient. KS additionally reported that work was taking place to establish a single default provider across the CCG that was not the hospital to provide anti-coagulation for patients with complex needs or whose Practice did not offer the service. He noted the potential for "double running" to be required for a time to maintain the service. Further discussion included emphasis of anti-coagulation as an enabler for patients, aspects of advantages and disadvantages of NOACS (novel oral anticoagulants) versus warfarin, and assurance that the anti-coagulation service would be maintained. An update would be provided at the next meeting. PM additionally advised that the CCG would undertake a clinically led, semi structured learning review on how this position had developed.

The Committee:

1. Agreed the proposed wording for the risk relating to community bed provision at Malton Hospital.
2. Confirmed that the risks requiring Governing Body scrutiny were as detailed in the report.

HN left the meeting

6. Financial Performance Report Month 10

In presenting this report TP referred to discussion at the previous meeting about the Expert Determination relating to outstanding contract disputes with York Teaching Hospital NHS Foundation Trust. She reported that, following the agreement of all parties, the process had not been progressed as a year-end position had been agreed. TP thanked the lay members for their support in this regard.

With regard to the year-end settlement TP explained that since writing the report the significant and extensive negotiations with York Teaching Hospital NHS Foundation Trust had resulted in finalising the year-end contractual position at a value of £195.1m to incorporate activity and all areas of dispute. She noted that a year-end settlement agreement had also been reached for other main associate commissioners as part of the arrangement. TP highlighted that this was the lowest recent level of contract growth. She added that there was the expectation for the 0.5% CQUIN (Commissioning for Quality and Innovation) payment to be paid to York Teaching Hospital NHS Foundation Trust at month 12 but would await and follow national guidance.

TP highlighted that the forecast outturn deficit of £22.5m was now a straight forecast of the anticipated year-end position. This remained within the previously reported risk adjusted forecast of £22.5m which previously was £16.0m with a further £6.5m identified as risk as at Month 9. TP also confirmed that NHS England supported the £195.1m position with York Teaching Hospital NHS Foundation Trust but noted that some of the penalties and disputes would require resolution for 2018/19. In this regard clinical pathway review and audit was taking place to identify associated costs.

On behalf of the Committee DB commended the achievement of a settlement agreement and the fact that the Expert Determination had not taken place. In this regard TP wished to specifically acknowledge the work undertaken by Liza Smithson, Head of Contracting, David Caphane, Senior Contract Analyst, and Gordon Masson, Finance and Contract Analyst.

In response to DB seeking clarification about the contract challenges being carried forward in to 2018/19 TP referred to the work taking place to establish Aligned Incentives Contracts. The aim was to reduce system costs through jointly identifying service costs, level of affordability, associated cost reduction schemes and timescales.

Members sought and received clarification on the work taking place to progress the Aligned Incentives Contract. TP highlighted agreement of principles, detailed work and project plans, and learning opportunities from the East Riding of Yorkshire where Aligned Incentives were already in operation. PM noted that a meeting of NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs and York Teaching Hospital NHS Foundation Trust was taking place with the regulators on 23 February to review progress of the system financial plan. This was a start of the process for the removal of legal Directions. PM also noted the Lay Members' Summit taking place on 1 March and the imminent publication of the Care Quality Commission York Local System Review report.

With regard to other areas of the Financial Performance Report TP reported that the North Yorkshire Chief Finance Officers had discussed in detail forecasting for continuing healthcare, funded nursing care and mental health out of contract placements; validation work was still taking place. TP explained that the CCGs and external audit had agreed that it was reasonable for existing methodology embedded for the last three years to be used for the forecast.

TP expressed a level of confidence in the CCG achieving the forecast outturn deficit of £22.5m and highlighted this in the context of stabilisation of the risk adjusted underlying position which remained in line with the opening recurrent underlying position of £22.4m.

Members expressed appreciation to the Finance Team for their work in achieving the reported position. PM added personal endorsement to TP for her work.

The Committee:

1. Received the Financial Performance Report as at the end of January 2018.
2. Expressed appreciation to TP and the Finance Team for their work.

7. Update on Better Care Fund

AP reported that, following approval by the Government on 20 December 2017 of the City of York Better Care Fund, the Section 75 Agreement had now been signed confirming agreement to pool the funds for the 2017/19 Plan. He highlighted that the previous eight national conditions had been replaced by four conditions, namely: plans to be jointly agreed; NHS contribution to adult social care to be maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services, which

may include seven day services and adult social care; and managing transfers of care. Beyond this there was flexibility in how the Better Care Fund was spent over health, care and housing but improved performance was required in respect of delayed transfers of care, non elective admissions (General and Acute), admissions to residential care homes and effectiveness of reablement.

AP explained that the Better Care Fund Performance and Delivery Group, chaired by Pippa Corner (PC), Head of Joint Commissioning, was refreshing governance and assurance arrangements. Its revised terms of reference had been approved by the City of York Health and Wellbeing Board on 24 January. There would be a clearer focus on targeted performance issues and the performance scorecard and a performance framework was being developed for the CCG and City of York Council schemes. Sessions to relaunch the Better Care Fund were being planned for May 2018 with a collaborative approach to evaluating the schemes at conference sessions.

With regard to the quarterly returns to NHS England on the delivery of the Better Care Fund Plan and progress against the High Impact Changes, AP advised that the self assessments were being co-ordinated with North Yorkshire County Council to ensure consistency.

AP reported on a successful bid by City of York Better Care Fund for additional income for three schemes: support for the discharge liaison team at weekends, therapy input to step down beds and reablement co-ordination at weekends. He also noted an invitation from NHS England to provide feedback on the assurance process at an event in London in March 2018 which PC was attending with the NHS England Senior Information Support Officer.

AP additionally referred to the 13 recommendations from the Care Quality Commission York Local System Review. The themes were based on a single plan for York, enabling integration and Right Care, Right Time, Right Place.

Detailed discussion ensued about the proposed relaunch of the Better Care Fund plans, including highlighting that this was one way of integrated working and an example of pooling funds between health and social care. The need for a patient centred approach was also emphasised. With regard to the culture change to joint commissioning PM noted that Elaine Wyllie, Strategic Programme Consultant, was working across the three Local Authorities on a joint commissioning approach. She would present a report to the Governing Body in April on 2019/20 service integration plans, strategic commissioning and pooling resources for change.

The Committee:

Noted the update

8. Contract Trading Report Month 9

TP noted the revised format of the report to focus on key areas and requested feedback from members.

TP referred to the earlier discussion of the York Teaching Hospital NHS Foundation Trust contract. She advised that agreement of year end positions with the CCG's other main acute providers was expected with the possible exception of Harrogate District NHS Foundation Trust where work was ongoing to resolve counting and coding issues.

TP reported that the overspend on the contract with Medequip for community equipment was a concern for all four North Yorkshire CCGs. An emergency summit, which would be attended by clinical and contracting representatives, had been arranged for 26 February to agree a more detailed action plan to address the concerns and formalise contract management arrangements. TP noted that the Executive Committee had authorised increased clinical resource but there was an issue in identifying this additional capacity. She also noted that the wheelchair contract was being rebased in the out of hospital programme.

In response to KR seeking clarification about the activity relating to the £2.4m under-trade with Ramsay Hospital and £2.9m over-trade with York Teaching Hospital NHS Foundation Trust, TP explained that the former only carried out trauma and orthopaedics work and the latter had for the first time done more of this work than planned. PM additionally reported that he and TP had met with representatives from Ramsay Hospital. This had been part of development of an independent strategy for market management, including supply and demand and contractual processes, which would be considered by the Executive Committee.

CA and BH joined the meeting

TP provided further clarification on the resolution of the challenges with York Teaching Hospital NHS Foundation Trust for 2017/18 as discussed at item 6 above. She confirmed that work was continuing with clinical input and clinical audit to resolve these for 2018/19.

TP reported that the Financial Recovery Board had met twice. This was a forum where the Executives provided support and challenge to staff leading the programmes of work. Each area of the QIPP tracker was reviewed and those identified as at risk or of high value were followed up via a detailed action log. Any slippage was noted as it occurred.

The Committee:

Received and noted the Contract Trading Report which gave continuing assurance regarding review of the major contracts of the CCG, noting the challenges that would remain going forward.

9. Winter Planning Update: Current Issues and Mitigations in Discharge Processes at York Teaching Hospital NHS Foundation Trust

AP referred to the report that provided a description of the issues in the discharge processes within York Teaching Hospital NHS Foundation Trust and how they integrated with other providers and services. It described the processes undertaken to evaluate the challenges in the system and mitigations instigated through the Complex Discharge Task and Finish Group, a subordinate to the Accident and Emergency Delivery Board. The report also aimed to provide assurance that the current Complex Discharge Task and Finish Group work plans were addressing the issues identified.

In response to KR requesting detailed discussion at the next Committee on the projected achievements of the Complex Discharge Task and Finish Group, CA proposed that this take the form of a confirm and challenge session. She noted that both the CCG's winter plan for 2018/19 and the wider system plans required inclusion in the Financial Recovery Plan to be submitted by 30 April 2018 therefore detailed discussion was required to inform this.

The Committee:

1. Received the update on current Issues and Mitigations in Discharge processes at York Teaching Hospital NHS Foundation Trust.
2. Agreed that the projected achievements of the Complex Discharge Task and Finish Group be included in a confirm and challenge session at the next meeting.

10. Integrated Performance Report Month 9

CA presented the report which comprised performance headlines, performance summary against all constitutional targets, and programme overviews relating to planned care, unplanned care, mental health, learning disability and complex care, primary care and included annexes providing core supporting performance information.

CA advised that there were no areas that required escalation and noted that the latest York Teaching Hospital NHS Foundation Trust performance information, which had not been available for the report, would be shared remotely and included in the confirm and challenge sessions being undertaken during March. The performance confirm and challenge sessions would support dedicated performance confirm and challenge discussions at the March Finance and Performance Committee and be used to support refreshing the CCG performance recovery plans for 2018/19. This would incorporate all NHS Constitutional targets and Integrated Assurance Framework indicators. CA added that the January validated figure for A&E four hour delivery was 81.5% which was 3% higher than the same period in 2017. She also noted the cancer 62 day treatment and 14 days urgent performance had both improved and all targets had been met by York Teaching Hospital NHS Foundation Trust in December and January.

CA reported that York Teaching Hospital NHS Foundation Trust had commissioned a provider emergency care system external review. This was discussed in the context of supporting the recovery of the 95% trajectory which the Trust needed to access the Sustainable Transformation Funding. The previous two Emergency Care Improvement Programme [ECIP] reviews and the Utilisation Management Review were also noted and a discussion ensued around how this latest external review would augment the findings and recommendations from those reviews.

CA sought and received confirmation that the Committee would provide assurance through the national planning process regarding alignment of the CCG and provider trajectories for performance and how this would be delivered as part of the financial recovery plan for the system and for the CCG. She noted that technical guidance was still awaited and that there had been no confirmation regarding additional monies for elective care in quarter four to support elective care long waiting patients after winter.

The Committee:

Received the Integrated Performance Report as at month 9.

11. Section 117 / Transforming Care Update

BH presented the report which provided an update on the Section 117 statutory duties, embedding of case management systems and processes through the Partnership Commissioning Unit team transition, the Transforming Care programme and estimated financial impact for 2018/19 relating to learning disability patients moving from existing commissioned beds to community placements.

In respect of Section 117 BH highlighted the work with partners on decision making, establishment of safe and robust decision arrangements to the Vulnerable People's Team with ongoing management and review, noting that funding liability would follow this. A new approach was being developed with Local Authorities to ensure patient focused care and the system to support delayed transfers of care for patients in mental health in-patient units was being reviewed. BH also noted non recurrent funding for additional capacity for undertaking patient reviews.

With regard to Transforming Care BH explained that there were currently 16 CCG patients with highly complex needs in various inpatient facilities. The initial understanding of the cost of some moves to community placements was a c£1.4m risk to the CCG. The Committee asked that this pressure be incorporated in to the financial plan for 2018/19.

Discussion ensued on the need to ensure this personalised care for the vulnerable was provided through maximising the allocation and through partnership responsibility. BH noted that work was taking place to develop services both locally and across the Sustainability and Transformation Partnership. PM additionally referred to the Joint Commissioning Report as mentioned at item 7 above.

The Committee:

Received the Section 117 and Transforming Care programme update.

BH left the meeting and FB joined

12. Confirm and Challenge on Emerging Priorities for 2018/19

Financial Recovery Plan

CA's presentation described the CCG's financial recovery history, the focus for 2018/19 financial recovery planning, the approach for prioritising financial recovery opportunities and the emerging financial efficiency priorities for the 2018/19 finance plan by programme area – planned care, out of hospital, complex care, prescribing, primary care and management costs – with associated target savings. The £13.5m total left a gap of between half a million and one million against the target. CA noted the Turnaround Director's validation of the 56% 2017/18 QIPP delivery and embedding of lessons learnt from 2016/17. She explained that the first submission of the 2018/19 Financial Recovery Plan to NHS England was 2 March with the final submission on 30 April.

Members sought and received clarification on the information presented. Discussion included aspects of partnership working and emphasis on establishment of an Aligned Incentives Contract as a key enabler to implement change. PM additionally highlighted the context of the Governing Body redesign advising that NW would lead clinical discussions, including the patient perspective, with York Teaching Hospital NHS Foundation Trust.

Draft Financial Plan 2018/19

TP presented the draft Financial Plan which comprised: financial key points from the 2018/19 Planning Guidance; summary key assumptions; key metrics; dashboard headings for 2017/18 to 2018/19; dashboard headings with growth, investment, pressures and adjustments; investments, pressures and adjustments; and inflation, efficiency and growth. TP explained that setting a plan which delivered the CCG's £14m deficit control total would enable access to £14m from the national Commissioner Sustainability Fund and highlighted what the £3.2m increased funding was expected to fund.

Members discussed in detail the potential approaches to meet the c£3.5m control total shortfall. The importance of an Aligned Incentives Contract was reiterated and the need to ensure a realistic QIPP target was emphasised. In response to discussion about potential for savings in the running costs budget JS advised that CCG running costs had been kept the same in the allocations but efficiencies could be locally determined.

NW left the meeting

Following confirmation of the Committee's support for Financial Plan that met the £14m deficit control total, members agreed principles to inform further consideration by the Executive Team for development of a plan for consideration in the Governing Body Part II meeting on 1 March. The principles were based on:

- Review of growth to ensure benchmarking against other CCGs
- Confirm the full year effect of QIPP and part year effect of investments
- Meet Mental Health Investment Standard, not met in 2017/18
- Approach to acute contracts
- Full year effect of Health Optimisation thresholds
- Better Care Fund
- Winter

TP proposed review of the areas of primary care and mental health as a starting point.

CA additionally referred to the confirm and challenge sessions to date across both Vale of York and Scarborough and Ryedale CCGs and discussion at the System Transformation Board. She proposed the inclusion of:

- Learning from existing Aligned Incentives Contracts
- Prioritising for 2018/19 areas that could be actively influenced by the CCG and supported by primary care providers

- Avoidance of premium spend
- Patient optimisation before surgery
- QIPP plans should not jeopardise provider achievement of the Sustainability and Transformation Fund
- Active engagement and support from clinicians across primary and secondary
- Review estates in the context of services transforming. In this regard CA noted that the Sustainability and Transformation Partnership was considering the development of bids for capital investment from the HCV STP.

PM commended the comprehensive work to enable progress to be made but with recognition of the associated challenges to deliver the scale of financial recovery.

PM sought and received support in principle from the Committee to try and secure continuation of Dharminder Khosa's services as Turnaround Director working across NHS Vale of York and NHS Scarborough and Ryedale CCGs for a minimum of a further six months.

The Committee:

1. Noted that TP would present an updated draft Financial Plan at the Part II Governing Body meeting on 1 March 2018.
2. Supported in principle the proposal for Dharminder Khosa to continue as Turnaround Director for a minimum of a further six months.

13. Key Messages to the Governing Body

The Committee recorded appreciation to the Chief Finance Officer and the Finance Team for achieving a stabilised, on plan financial outcome for the CCG. The achievement of an Aligned Incentives Contract was seen as a critical milestone for the CCG in 2018/19.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

14. Next Meeting and Forward Plan

The next meeting would be 9am to 1pm on 22 March 2018.

Item Number: 15

Name of Presenter: Dr Kevin Smith

Meeting of the Governing Body

Date of meeting: 5 April 2018

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 – February and March 2018.

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 has approved these recommendations.

Responsible Executive Director and Title	Report Author and Title
Dr Kevin Smith Executive Director of Primary Care and Population Health	Laura Angus Lead Pharmacist

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee February 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA497: Golimumab for treating non-radiographic axial spondyloarthritis.		Golimumab is recommended, within its marketing authorisation, as an option for treating severe non-radiographic axial spondyloarthritis in adults whose disease has responded inadequately to, or who cannot tolerate, nonsteroidal anti-inflammatory drugs. If patients and their clinicians consider golimumab to be one of a range of suitable treatments, including adalimumab, etanercept and certolizumab pegol, the least expensive (taking into account administration costs and patient access schemes) should be chosen. Assess the response to golimumab 12 weeks after the start of treatment. Continue treatment only if there is clear evidence of response, defined as: • a reduction in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score to 50% of the pre-treatment value or by 2 or more units and • a reduction in the spinal pain visual analogue scale (VAS) score by 2 cm or more.	Red	The list price of golimumab is £762.97 for a 50 mg pre-filled syringe/pen and £1,525.94 for a 100 mg pre-filled pen. Merck Sharp & Dohme has agreed a PAS with the Department of Health. This will make the 100 mg dose of golimumab available to the NHS at the same cost as the 50 mg dose. Therefore annual cost (50 – 100 mg SC once a month) = £9,156. NICE do not expect this guidance to have a significant impact on resources; that is, it will be less than £5 million per year in England (or £9,100 per 100,000 population). This is because the technology is an option alongside current standard treatment options and the drugs are similarly priced. YFT estimate use in 1-2 patients per year.
2.	TA503: Fulvestrant for untreated locally advanced or metastatic oestrogen-receptor positive breast cancer.		Fulvestrant is not recommended, within its marketing authorisation, for treating locally advanced or metastatic oestrogen-receptor positive breast cancer in postmenopausal women who have not had endocrine therapy before.	Black	No cost impact as not recommended.
NHSE commissioned Technology Appraisals – for noting					
3.	TA498: Lenvatinib with everolimus for previously treated advanced renal cell carcinoma.		Lenvatinib plus everolimus is recommended as an option for treating advanced renal cell carcinoma in adults who have had 1 previous vascular endothelial growth factor (VEGF)-	Red	No cost impact to CCGs as NHS England commissioned.

		targeted therapy, only if: • their Eastern Cooperative Oncology Group (ECOG) performance status score is 0 or 1 and • the company provides lenvatinib with the discount agreed in the patient access scheme.		
4.	TA499: Glecaprevir–pibrentasvir for treating chronic hepatitis C.	Glecaprevir–pibrentasvir is recommended, within its marketing authorisation, as an option for treating chronic hepatitis C in adults, only if the company provides the drug at the same price or lower than that agreed with the Commercial Medicines Unit.	Red	No cost impact to CCGs as NHS England commissioned.
5.	TA500: Ceritinib for untreated ALK-positive non-small-cell lung cancer.	Ceritinib is recommended, within its marketing authorisation, as an option for untreated anaplastic lymphoma kinase (ALK) −positive advanced non-small-cell lung cancer in adults, only if the company provides it with the discount agreed in the patient access scheme.	Red	No cost impact to CCGs as NHS England commissioned.
6.	TA501: Intrabeam radiotherapy system for adjuvant treatment of early breast cancer.	The Intrabeam radiotherapy system is not recommended for routine commissioning for adjuvant treatment of early invasive breast cancer during breast-conserving surgical removal of the tumour. Use of the Intrabeam radiotherapy system is recommended only using machines that are already available and in conjunction with NHS England specified clinical governance, data collection and submission arrangements.	N/A	No cost impact to CCGs as NHS England commissioned.
7.	TA502: Ibrutinib for treating relapsed or refractory mantle cell lymphoma.	Ibrutinib is recommended as an option for treating relapsed or refractory mantle cell lymphoma in adults, only if: • they have had only 1 previous line of therapy and • the company provides ibrutinib with the discount agreed in the commercial access agreement with NHS England.	Red	No cost impact to CCGs as NHS England commissioned.

<table>
<tr><th colspan="5">Formulary applications or amendments/pathways/guidelines</th></tr>
<tr><td>8.</td><td>RAG status for Spiriva Respimat® for COPD</td><td>It had been identified that Spiriva Respimat® (tiotropium) is currently on the formulary as amber specialist recommendation for COPD. However this status is not consistent with the primary care COPD pathway. Also other LAMA inhalers for COPD are on the formulary as green drugs. The group was agreed that Spiriva Respimat® should be changed to green for COPD.</td><td>Green</td><td>Confirmation of RAG status.</td></tr>
<tr><td>9.</td><td>Triple combination inhalers for COPD: Trelegy® and Trimbow® and updated COPD pathway.</td><td>The group reviewed two new triple combination inhalers containing LABA/ICS/LAMA for the management of COPD for addition to the formulary:
Trimbow® MDI - Formoterol 5mcg/beclomethasone 87mcg/glycopyrronium 9mcg per inhalation
Trelegy® Ellipta (DPI) – Vilanterol 22mcg/fluticasone 92mcg/umeclidinium 55mcg
The group noted evidence from clinical trials demonstrating that open or closed triple therapy with LABA/ICS/LAMA improved lung function (FEV1) and the rate of moderate to severe exacerbations to a greater degree than dual therapy with LABA/ICS, though there were some caveats to the evidence. It was also noted that the triple therapy inhalers were less costly than various combinations using two separate inhalers on the formulary to achieve triple therapy i.e. LABA/ICS + LAMA.
The group approved the addition of both products to the formulary as green drugs on the basis of cost effectiveness as well as practical benefits to patients – simplification of treatment regimens and potentially improved adherence. The COPD pathway has been updated to reflect the new products.</td><td>Green</td><td>The triple therapy inhalers are cost saving as they are cheaper than using two separate inhalers on formulary to achieve triple therapy.

Comparative costs:<table><tr><th>Product/Device</th><th>Annual cost</th></tr><tr><td colspan="2">MDI options</td></tr><tr><td>Trimbow® (beclometasone/ formoterol/glycopyrronium)</td><td>£539.93</td></tr><tr><td>Fostair (beclometasone/formoterol) plus Spiriva Respimat (tiotropium)</td><td>£634.82</td></tr><tr><td colspan="2">DPI options</td></tr><tr><td>Trelegy® Ellipta (fluticasone/vilanterol/umeclidinium)</td><td>£539.93</td></tr><tr><td>Relvar Ellipta (fluticasone/vilanterol) plus Incruse Ellipta (umeclidinium)</td><td>£600.60</td></tr><tr><td>Duoresp Spiromax (budesonide/formoterol) plus Seebri Breezhaler (glycopyrronium)</td><td>£673.04</td></tr><tr><td>Fostair Nexthaler (beclometasone/formoterol) plus Eklira Genuair (aclidinium)</td><td>£702.76</td></tr><tr><td>Symbicort Turbohaler (budesonide/formoterol) plus Eklira Genuair (aclidinium)</td><td>£808.08</td></tr></table>Note: DPI combinations above are examples, other combinations possible.</td></tr>
<tr><td>10.</td><td>Fiasp® (10 mL vial and cartridges only) for management of T1DM</td><td>The group reviewed an appeal against the current position of Fiasp® i.e. black issued in May 2017.
It was agreed that Fiasp cartridges and 10 mL</td><td>Amber specialist recomme</td><td>No significant cost impact expected. The cost of Fiasp is comparable to that of other short-acting insulins. Estimated number of eligible</td></tr>
</table>

		vials only would be added to the formulary as an amber specialist recommendation drug for use in the following patient cohorts: • Patients with T1DM on a basal bolus regimen or insulin pump therapy who have failed to achieve their individualised HbA1c target AND have a post prandial glucose (PPG) level >9 mmol/l at 2 hours post meal. • Pregnant women with diabetes with a PPG level >7.8 mmol/l at 1 hour post meal. After giving birth, women will be expected to transfer back to their original short acting insulin unless they continue to meet other criteria above to continue Fiasp. The ONSET 1 & 2 trials evaluating Fiasp in T1DM & T2DM patients respectively demonstrated a significant improvement in PPG at 1 hour post meal compared to Novorapid (secondary outcome measure). The appeal included information suggesting that although there is a lack of direct evidence that correcting post prandial hyperglycaemia improves clinical outcomes, treatments aimed at reducing PPG levels may be beneficial and help to lower HbA1c. In addition for pregnant women, NICE recommend stringent post prandial glucose targets which some may not achieve due to insulin resistance.	ndation	patients per year are: 120 T1DM patients (80 patients from York and up to 40 from Scarborough) 5-10 pregnant women with diabetes across both York and Scarborough.
11.	Nebivolol for heart failure and hypertension – **for patients unable to tolerate other beta blockers**.	The group reviewed an appeal against a previous MCC decision not to commission nebivolol for heart failure and hypertension on the basis of lack of cost-effectiveness compared to other beta-blockers. The appeal outlined that nebivolol had an odd pricing structure whereby the 5 mg tablets are much cheaper than the other strengths; 28x5 mg tablets cost £1.00, compared to £18.17 for 2.5 mg and £6.31 for 10 mg tablets. The 5 mg tablets are quadrisected and licensed to be divided into 4 equal doses if necessary. Therefore this strength can be used to achieve a range of doses from 1.25 mg to 10 mg. In addition some data were provided	5 mg tablets – Green 2.5 & 10 mg tablets - Black	Low/ no significant cost impact expected. Annual cost of nebivolol per patient using 5 mg tablets only: £6.50 to £26 for dose range 2.5 to 10 mg daily. In comparison, annual costs of other beta-blockers on formulary range between £7.67 to up to £77 depending on dose.

		suggesting greater cardioselectivity of nebivolol over other beta-blockers and demonstrating efficacy for heart failure and hypertension. The group agreed to add nebivolol 5 mg tablets to the formulary as a green drug for patients unable to tolerate other beta-blockers; the other strengths (i.e. 2.5 mg and 10 mg) will remain black. The formulary will be annotated to state that the 5 mg tablets are cross-scored and can be divided into 4 equal doses.		
13:	Darbepoetin alfa for use in chronic renal disease – guideline for use	Darbepoetin alfa is currently amber shared care on the Y&S formulary. However the Trust will now be doing all of the prescribing and not transferring to primary care therefore a red RAG status was agreed. The information contained in the shared care guideline was however thought to be useful as it included instructions and advice for primary care on management of these patients. Therefore this document has been retitled as a guideline for use with a different appearance to SCGs but with the same format.	Red	None expected as use is current practice.

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee March 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1	TA506: Lesinurad for treating chronic hyperuricaemia in people with gout		Lesinurad is not recommended within its marketing authorisation, that is, with a xanthine oxidase inhibitor for treating hyperuricaemia in adults with gout whose serum uric acid is above the target level despite an adequate dose of a xanthine oxidase inhibitor alone.	Black	No cost impact as not recommended.
NHSE commissioned Technology Appraisals – for noting					
3.	TA504: Pirfenidone for treating idiopathic pulmonary fibrosis		Pirfenidone is recommended as an option for treating idiopathic pulmonary fibrosis in adults only if: • the person has a forced vital capacity (FVC) between 50% and 80% predicted • the company provides pirfenidone with the discount agreed in the patient access scheme and • treatment is stopped if there is evidence of disease progression (an absolute decline of 10% or more in predicted FVC within any 12‑month period).	Red	No cost impact to CCGs as NHS England commissioned.
4.	TA505: Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma		Ixazomib, with lenalidomide and dexamethasone, is recommended for use within the Cancer Drugs Fund as an option for treating multiple myeloma in adults only if: • they have already had 2 or 3 lines of therapy and • the conditions in the managed access agreement for ixazomib are followed.	Red	No cost impact to CCGs as NHS England commissioned.
5.	TA507: Sofosbuvir–velpatasvir–voxilaprevir for treating chronic hepatitis C		Sofosbuvir–velpatasvir–voxilaprevir is recommended as an option for treating chronic hepatitis C in adults, only if it is used as below	Red	No cost impact to CCGs as NHS England commissioned.

<table>
<tr><td></td><td></td><td>and the company provides the drug at the same price or lower than that agreed with the Commercial Medicines Unit.

• Patients with history of previous treatment with direct-acting antivirals, hepatitis C virus genotypes 1-6, with or without compensated cirrhosis: recommended for 12 weeks.
• Patients with no history of previous treatment with direct-acting antivirals, hepatitis C virus genotype 3, with or without compensated cirrhosis: recommended for 8 weeks.</td><td></td><td></td></tr>
<tr><td colspan="5">Formulary applications or amendments/pathways/guidelines</td></tr>
<tr><td>8.</td><td>Colesevelam for bile salt malabsorption (BSM).</td><td>Following a re-submission the group approved a formulary application for Colesevelam for bile salt malabsorption (BSM). This is because there are limited treatment options for these patients.
This recommendation was subject to an ongoing audit of use and demonstration of continued clinical benefit being carries out.</td><td>Amber Specialist Initiation</td><td>Currently 2 people require colesevelam in one gastroenterology clinic over the course of one year. This suggests perhaps 12 people (if 2 people for every consultant clinic in a year)
The numbers are likely to stay small.
Comparative drug costs
Colestyramine – Assumes use of 2 to 5 sachets per day
Colesevelam – assumes use of 6 to 7 tablets per day
<table>
<tr><th>Product</th><th>Annual primary care cost per patient - Drug tariff price</th></tr>
<tr><td>Colestyramine</td><td>£155 to £387</td></tr>
<tr><td>Colesevelam</td><td>£1384 to £1614</td></tr>
</table></td></tr>
<tr><td>9.</td><td>RAG status of dopamine agonists pramipexole and ropinirole for restless legs</td><td>Ropinirole is currently included in the formulary for this indication but pramipexole is not.
Agreed to assign a Green RAG status to</td><td></td><td>The cost of ropinirole is highly variable depending upon dose. It should be initiated at a low dose and titrated up according to response</td></tr>
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<td>syndrome</td>
<td>ropinirole for the treatment of restless legs syndrome when symptoms seriously impair quality of life and non drug based measures have failed.

At current drug prices, and depending on the dose used, pramipexole is the cheapest of the two agents. Ropinirole is the preferred choice of York Neurologists from a safety perspective as the dosing of pramipexole in terms of salt and base can cause confusion.</td>
<td></td>
<td>and tolerance.
This decision formalises what is already prescribed in current practice; therefore no further cost impact is expected.

Ropinirole dose titration
<table>
<tr><th>Dose</th><th>Cost for one year per patient (Drug Tariff Feb 2018)</th></tr>
<tr><td>250mcg daily</td><td>£78</td></tr>
<tr><td>500mcg daily</td><td>£91</td></tr>
<tr><td>1mg daily</td><td>£227</td></tr>
<tr><td>2mg (typical maintenance dose)</td><td>£206</td></tr>
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<td>10.</td>
<td>Asthma pathway</td>
<td>The group approved the addition of Fobumix Easyhaler to the formulary as previously no DPI that is an easyhaler on formulary.
The respiratory group are aware that new NICE guidance came out in Nov 2017 for the management of asthma. The NICE guidance is slightly different to the BTS/SIGN guidance.
The NICE guidance refers to using FeNO testing for diagnosis. At this current time this is not available in primary care. There are a few errors within the NICE guidance, for example the ICS doses, these have been highlighted to NICE for corrections.
The respiratory group considered the clinical evidence for LABA to be stronger than for using LRTA and hence at this time, the decision is to continue to use BTS/SIGN as the basis for CCG/primary care asthma guidance.
The CCG/primary asthma guidance will be reviewed in line with the review date – i.e. April 2019, unless there is significant reason to review it sooner.</td>
<td>Green for Fobumix Easyhaler</td>
<td>The pathway is based on BTS guidance and includes products already included within the formulary. No further cost impact is expected.
No cost impact expected from the addition of Fobumix Easyhaler to the formulary as it is comparable in cost to both Symbicort and Fostair which are also on the formulary and included in the asthma pathway.

<table>
<tr><th>Product (drug, strength, formulation)</th><th>Cost per month</th></tr>
<tr><td>Fobumix Easyhaler® 80/4.5 120d</td><td>£26.99</td></tr>
<tr><td>Fobumix Easyhaler® 160/4.5 60d</td><td>£16.99</td></tr>
<tr><td>Fobumix Easyhaler® 160/4.5 120d</td><td>£26.99</td></tr>
<tr><td>Fobumix Easyhaler® 320/9 60d</td><td>£26.99</td></tr>
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11.	Mycophenolate mofetil Shared Care Guideline for non-transplant indications	The group approved the attached shared care guideline following minor wording amendments.	Amber SCG	This SCG formalises the Amber Shared Care commissioning position and includes products already in the formulary which are used in current practice; therefore no further cost impact is expected. Generic should be used to minimise expenditure.
13.	Infant formulae guidance	Approved to assist GPs and Health Visitors in ensuring appropriate prescribing of infant formulae in primary care, for infants aged 0-12 months (with age exceptions as stated), where breast milk or standard infant milk products routinely available to purchase are not suitable due to allergy, having used MAP guideline interactive tool to determine appropriate treatment option/s.	N/A	No significant cost impact expected.
14.	Erectile dysfunction medal ranking	The current erectile dysfunction medal ranking formulary has been updated; the main changes to this version are the prices of the medicines. Generic Sildenafil still remains the most cost effective preparation.	N/A	No significant cost impact expected. Generic Sildenafil still remains the most cost effective preparation.
15.	Local Enhanced Scheme discrepancies with formulary with regard to antipsychotics	The group reviewed the following discprencies around antipyschotics between the formulary and Local Enhanced Scheme and agreed the following actions: 1. Flupentixol (po/inj) - To keep injection on amber LES list, but to remove oral formulation as oral formulation is classed as BLACK on formulary. 2. Paliperidone (po) - Black on York formulary but on amber LES list - To remove from the amber LES list. 3. Zuclopenthixol (po/inj) – on current amber LES list - To keep zuclopenthixol oral and zuclopentixol decanoate injection on the amber LES, however remove zuclopentixol acetate from the LES as it is classed as BLACK on formulary. 4. Pericyazine (po) - not on formulary but	N/A	No significant cost impact expected.

		being prescribed – agreed continue LES for only those patients that have been prescribed this historically, but not any new patients 5. Perphenazine (po) - not on formulary but being prescribed agreed continue LES for only those patients that have been prescribed this historically, but not any new patients 6. Pimozide (po) - not formulary but being prescribed agreed continue LES for only those patients that have been prescribed this historically, but not any new patients 7. Pipotiazine (inj) now discontinued, no longer available. – Remove from LES list.		
16.	Ciprofloxacin 2 mg/mL ear drops (Cetraxal®) in single-dose container for treatment of acute otitis externa in adults and children ≥ 1 year.	Historically, ciprofloxacin eye drops have been used in the ear off-label for ear infections. However, this product now offers a licensed option and it has been indicated that the Trust ENT department would prefer to use a licensed product. This was approved by MCC.	Green	Ciprofloxacin 2 mg/mL ear drops (Cetraxal®) cost £6.01 for 15x0.25mL ampoules. 1 course of treatment comprises 1 ampoule twice daily for 7 days. Drops licensed for use in the eye e.g. Ciloxan® 0.3% w/v eye drops cost £4.70 for 5 mL.