Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

2 January 2020 9.30am to 12.45pm

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

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

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

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Presentation	Patient Story	To Receive	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
4.	Pages 4-22	Minutes of the meeting held on 7 November 2019	To Approve	All
5.	Verbal	Matters arising from the minutes		All
6.	Pages 23-28	Accountable Officer's Report	To Receive	Phil Mettam Accountable Officer

STRATEGIC – 10.30am				
7.	Pages 29-65	Life in times of change; health and hardship in North Yorkshire: The 2019 Director of Public Health Report for North Yorkshire Full report available at: https://www.nypartnerships.org.uk/DPHAR	To Receive	Dr Lincoln Sargeant Director of Public Health for North Yorkshire
ASSURANCE – 11.00am				
8.	Pages 67-89	Quality and Patient Experience Report	To Receive	Michelle Carrington Excutive Director of Quality and Nursing / Chief Nurse
9.	Pages 91-107	Learning Disabilities Mortality Review Annual Report	To Receive	Christine Pearson Designated Nurse Safeguarding Adults
10.	To follow separately	Board Assurance Framework Risk Management Policy and Strategy	To Approve	Abigail Combes Head of Legal and Governance
11.	Pages 109-118	Audit Committee Terms of Reference	To Ratify	Abigail Combes Head of Legal and Governance
FINANCE AND PERFORMANCE – 12 noon				
12.	Pages 119-134	Financial Performance Report 2019/20 Month 8	To Receive	Simon Bell Chief Finance Officer
13.	Pages 135-182	Integrated Performance Report Month 7	To Receive	Caroline Alexander Assistant Director of Delivery and Performance

RECEIVED ITEMS – 12.40pm

Committee minutes are published as separate documents

14.	Page 183	Chair's Report Executive Committee: 16 October, 20 November and 4 December 2019
15.	Page 184	Chair's Report Audit Committee: 28 November 2019
16.	Page 185	Chair's Report Finance and Performance Committee: 24 October and 28 November 2019
17.	Page 186	Chair's Report Primary Care Commissioning Committee: 21 November 2019
18.	Page 187	Chair's Report Quality and Patient Experience Committee: 12 December 2019
19.	Pages 189-203	Medicines Commissioning Committee: 11 September, 9 October, 13 November 2019.

NEXT MEETING

20.	Verbal	9.30am on 5 March 2020 at West Offices, Station Rise, York YO1 6GA	To Note	All

CLOSE – 12.45pm

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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Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 7 November 2019 at West Offices, York YO1 6GA

Present

Dr Nigel Wells (NW) (Chair)	Clinical Chair
Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
David Booker (DB)	Lay Member, Chair of Finance and Performance Committee
Dr Helena Ebbs (HE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member, Chair of Audit Committee and Remuneration Committee
Julie Hastings (JH)	Lay Member, Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee
Dr Andrew Lee (AL)	Executive Director of Primary Care and Population Health
Phil Mettam (PM)	Accountable Officer
Paula Middlebrook (PMo)	Deputy Chief Nurse
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Dr Chris Stanley (CS)	Central Locality GP Representative
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Caroline Alexander (CA) – items 13 to 15	Assistant Director of Delivery and Performance
Victoria Binks (VB) – item 3	Head of Engagement
Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality
Abigail Combes (AC) – item 7	Head of Legal and Governance
Karen Hedgley (KH) – item 9	Designated Nurse Safeguarding Children and Children in Care
Dr Shaun O'Connell (SOC) – item 12	GP Lead for Acute Transformation
Fiona Phillips (FP)	Deputy Director of Public Health, City of York Council
Michèle Saidman (MS)	Executive Assistant
Sarah Tilston (ST) – item 12	Senior Service Improvement Manager – Acute System Transformation Team, NHS Scarborough and Ryedale CCG

Apologies

Simon Bell (SB)	Chief Finance Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing / Chief Nurse
Sharon Stoltz (SS)	Director of Public Health, City of York Council

There were four members of the public present including a representative from Healthwatch York.

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

Bill McPate

Does the CCG have any plans to engage the wider public in the transformation of primary care taking place? Engagement with Patient Participation Groups reported at item 8 of the agenda is noted but many patients will soon be receiving services delivered in different ways such as medication reviews within practices and referrals under social provider arrangements. Informing the public generally of the principal objectives of Primary Care Networks and the welcome improvements expected would help to prepare them for the changes they will experience as patients.

Response

The move to Primary Care Networks (PCN) is an opportunity for the CCG to engage local communities in the development of services and the improvement of patient experience. To do this the CCG is creating plans to work closely with local communities and groups and with Patient Participation Groups and their lay representatives to support more creative and effective engagement in Primary Care Network areas.

Working with Primary Care Networks, local communities and groups

The local population is growing and people are living longer. Many people are living with long term conditions such as diabetes and heart disease, or suffer with mental health issues and may need to access their local health services more often. Primary Care Networks are working with community, mental health, social care, pharmacy, hospital and voluntary services to deliver these to meet the needs of their local areas.

Primary Care Networks enable the greater provision of proactive, personalised, coordinated and more integrated health and social care. Their work will move from reactive working such as providing appointments to proactive care for the people and communities they serve. Patient and public engagement and involvement to reach out to local people will play a key role in this.

Working with Patient Participation Groups

The CCG currently attends Vale of York Patient Participation Groups on a regular basis to capture feedback from patient representatives - a great way to find out the issues that may arise in primary care and share positive news and feedback. It is also an important route to share the work of the CCG, and its partners, that has an increased focus on improving the population's health.

Here are some examples of our attendance at recent meeting:

- **Pocklington and MyHealth Patient Participation Group:** Our Head of Engagement supported David, who is a multiple carer for his wife and son, to present at Pocklington Patient Participation Group in October 2019. He wanted to raise awareness of what it means to be a carer and the help and support he needs when booking appointments, arranging medication, signposting for additional support. As a result the Patient Participation Group and practice is looking at how they can support carers. David also went to MyHealth Patient Participation Group to deliver the same presentation.

- **Haxby Patient Participation Group:** Our Head of Engagement and Head of Community Strategy attended the Haxby Patient Participation Group patient speaker event to talk about developing community strategy and how we can build resilience within our communities.

- **Pickering Patient Participation Group:** An update was given on the CCG's priorities and development of Primary Care Networks. The CCG has arranged for Yorkshire Ambulance Service to attend the next Patient Participation Group to answer their concerns around patient transport services for rural patients.

- **Tollerton Patient Participation Group:** A presentation was given focusing on the CCG priorities, development of Primary Care Networks and the benefits of GPs in the North Area working closer together on integrating care for frail and elderly patients.

- **Selby Posterngate Patient Participation Group:** After attendance at the Patient Participation Group to promote NHS70, the CCG and PPG members helped organise a community day at Selby Hospital as part of NHS 70 with over 30 different stall holders.

Patient Participation Group Network

Following the CCG's recent research the Communications, Marketing and Engagement Team propose to develop a Patient Participation Group network. This network will be co-produced with Patient Participation Group representatives, practices and other healthcare providers across the Vale of York. It is expected that this would take the form of an event hosted twice a year, potentially within each locality – North, York and South localities.

Aim	How will this be achieved
Provide an environment for networking and sharing best practice	Bi-annual meetings hosted by the CCG in three localities to provide opportunities for Patient Participation Groups to work with other Patient Participation Groups and share best practice.
Provide updates on health and care developments in the local area and facilitate a better informed population	Key speakers to attend and present on topics relevant to the local area. This may include topics such as the Long Term Plan, development of Primary Care Networks, social prescribing etc.

Create co-produced content	Working with local Patient Participation Groups and lay representatives to create the content, agenda and format of the networking events. Establish small working group.
Support Patient Participation Groups and lay representatives to gather and act on patient feedback	Provide Patient Experience Toolkit (PET) training
Use the Patient Participation Group to champion the voice of the wider community, by increasing representation and feedback from seldom heard groups	Gather examples and share best practice of where Patient Participation Groups have championed the voice of the wider community. Key speaker on topic to illustrate how the wider community can be represented and involved in work of the Patient Participation Groups.
Strengthen a culture of feedback and learning, illustrating how Patient Participation Groups have influenced changes in the local community	Sharing of best practice – speakers from Patient Participation Groups Presentation on importance of feedback 'you said, we did'. Promoting NHS England involvement resources
Provide resources to support Patient Participation Groups in their work, such as research into the views of those who use the practice or organising health promotion events and improving health literacy.	Create a toolkit of resources for Patient Participation Groups to help them with meetings, action planning, setting agendas. Promoting NHS England involvement resources
Involvement in work encouraging patients to take greater responsibility for their own and their family's health	Presentation on healthy communities Key speaker topic on areas such as managing long term conditions.

Prior to commencing the agenda NW welcomed everyone to the meeting and noted official guidance to NHS organisations in the pre-election period in view of the forthcoming General Election on 12 December. He highlighted that discussion should take account of the following:

- no new decisions or announcements of policy or strategy;
- no decisions on large and/or contentious procurement contracts;
- no participation by official NHS representatives in debates and events that may be politically controversial, whether at national or local level.

AGENDA

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

As noted above.

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

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

VB joined the meeting

3. Patient Story

VB introduced a video, which had previously been shown at the Quality and Patient Experience Committee, about a new co-production approach to develop improved delivery to families using maternity services.

VB gave the background to Better Births, which was published in February 2016, and set out a Five Year Forward vision for NHS maternity services in England. It recognised that the vision could only be realised through local groups, such as maternity voices partnerships. As a result there is now a focus on how to make meetings more accessible to a wider audience so that more service users can get involved in helping to shape local maternity services, through a coproduction model.

The York and District Maternity Voices Partnership had held an open meeting in a community location on 18 September 2019. Emily Pickard, recently appointed Lay Chair of York and District Maternity Voices Partnership, had been joined by families (including young children and babies) and practitioners, including representatives from Treasure Chest and York and Selby IAPT (Improving Access to Psychological Therapies) Service. The aim had been to involve the population in shaping future services based on discussion of three areas: what is working well, what could be improved and what would be one good idea.

AB joined the meeting during this item

VB explained that feedback from the September session and over 500 responses from a recent survey were being collated for discussion at a meeting with the maternity services in January 2020. The hope was that some of the feedback would lead to practical changes in the way care is delivered, as well as feeding into the strategic work across the Humber, Coast and Vale Local Maternity System. VB also noted that York Television had recorded a session, available at https://www.youtube.com/watch?v=YWM8GnXw88g, promoting York and District Maternity Voices Partnership's work and advised that similar events were being planned for other areas of the CCG footprint. Opportunities to learn from similar maternity voices partnerships were also being explored.

HE highlighted the need to consider different models of midwifery services in rural and urban areas.

VB left the meeting

4. Minutes of the Meeting held on 5 September 2019

The minutes of the meeting held on 5 September were agreed.

The Governing Body:

Approved the minutes of the meeting held on 5 September 2019.

5. Matters Arising from the Minutes

Two of the actions, communications relating to the managed repeat prescriptions and addition to the Governing Body Risk Register of Referral to Treatment and Total Waiting List at York Teaching Hospital NHS Foundation Trust, had been completed and an update on work relating to physical health checks for people with severe mental illness was at agenda item 12. In respect of the fourth action, presentation by Anti-Crime Services at a Protected Learning Time event, NW advised that this would be included at the 30 April 2020 event.

The Governing Body:

Noted the updates.

6. Accountable Officer's Report

PM referred to the report which provided an update on turnaround, local financial position and system recovery; operational planning; Primary Care Protected Learning Time; joint commissioning; Better Care Fund; system and winter resilience communication plans; primary care estates; emergency preparedness, resilience and response; Hambleton, Richmondshire and Whitby CCG move to Humber, Coast and Vale Health and Care Partnership; and strategic and national issues.

With regard to the financial position, which would be discussed later in the meeting, PM noted the forecast remained in line with the CCG's plan. Mitigation for identified risks had been included in the forecast outturn.

In referring to operational planning PM expressed appreciation to CA, MA-M and colleagues for their work on the plan that had, as required, been submitted the previous week for consolidation with the Humber, Coast and Vale plan. He noted that the Sustainability and Transformation Partnership's plan had been well received and commended at national level.

NW reported that feedback from the Protected Learning Time event on 15 October, not July as in the report, had been positive. In response to AB referring to anecdotal evidence about out of hours activity on the day and the following day NW advised that additional resources had been put in place in response to feedback from the July session; further consideration would be given for the next event.

PM noted that the CCG and City of York Council were meeting more frequently to discuss joint commissioning. PM also commended the recent launch of the All Age Learning Disability Strategy and advised that he had encouraged feedback from service users and carers about how to improve their health care experiences.

PM advised that formal approval of the Better Care Fund plans for 2019/20 was awaited. He requested that MA-M and the Assistant Director of Joint Commissioning, liaise with the Lead Officers for Primary Care in York and in North Yorkshire to ensure Primary Care Network engagement in the development of the plans. Discussion ensued in the context of opportunities for greater integration of services resourced from the Better Care Fund, the need for localised delivery of plans based on population health needs and concerns about equity. MA-M offered to explain the background and context of the Better Care Fund to HE, CS and RW outside the meeting and AB offered Local Medical Committee support if appropriate. FP additionally confirmed that she would liaise with Dr Lincoln Sargeant, Director of Public Health for North Yorkshire, to ensure a public health approach based on population health need across the CCG.

In terms of system resilience PM referred to significant pressure particularly on the Scarborough site, but also in York, Emergency Departments, noting that regular calls about the system were taking place at a national level and that locally a York and Scarborough Quality Improvement Board had been established which would meet for the first time on 20 November. AL additionally explained that short term support to create additional time limited capacity was currently being considered.

The primary care estates developments relating to Millfield Surgery and Tollerton Surgery were welcomed. NW observed with regard to primary care estates in the City that work was taking place in terms of consolidation and potential sharing of estates with the local authority. AL added that, as identified in the Board Assurance Framework, estates was a key concern noting the context of a number of premises no longer being fit for purpose, complexity of accessing capital, and pressure from the new Primary Care Network roles. PM additionally noted the intention for access to capital funding to be progressed both locally and regionally following the General Election restrictions.

PM welcomed Hambleton, Richmondshire and Whitby CCG's move to the Humber, Coast and Vale Health and Care Partnership, referring in particular to clinical network opportunities.

HE referred to the information about the RightCare Progressive Neurological Conditions Toolkit under strategic and national issues. She advised that a Parkinson's Nurse, funded by Parkinson's UK, was now working in South Hambleton and Rydale Primary Care Network and was developing collaborative, community based pathways which were not referral based.

The Governing Body:

1. Received the Accountable Officer's report.
2. Noted that Primary Care Network engagement in consideration of the Better Care Fund would be sought via the CCG's Lead Officers for Primary Care.

AC joined the meeting

7. Board Assurance Framework

In presenting the first draft Board Assurance Framework AC noted that this was in development and required populating by the Executive Directors who would update it at each Executive Committee meeting prior to a Governing Body meeting in public where it would be a standing agenda item. AC described the approach of linking the Board Assurance Framework to the CCG's strategic objectives - strengthen, improve, facilitate and influence, develop and deliver - noting that the full risk report was available to provide further detail. In view of concerns expressed by SB that there may be insufficient clarity of the link between the Board Assurance Framework groupings and the strategic objectives, AC sought members' views on whether the strategic objectives should replace the five groupings in the draft Framework. Members' preference was for the current five headings, not the strategic objectives five headings.

Members emphasised that the Board Assurance Framework must be self explanatory as one of the Governing Body's three pillars of business, namely operational performance, financial performance and risk. It should focus on outcomes, actions, impact of risks including illustration of improvement or deterioration, enable measurement of achievement against key indicators and identify lead responsibility for each risk.

The Governing Body:

1. Approved a Board Assurance Framework linked to the Strategic Objectives to be updated by the Executive Committee at its meeting prior to each Governing Body meeting. This should come to each public session of the Governing Body with the facility to defer specific items for further discussion in private in the event of legitimate reasons within consideration of the duty of transparency.
2. Requested an additional tab be added to highlight direction of travel.
3. Noted the Executive Committee would prioritise population of the Board Assurance Framework.

AC left the meeting

ASSURANCE

8. Quality and Patient Experience Report

PMo presented the report which provided a highlight update on progress in recent quality and safety activities across healthcare services commissioned by the CCG noting that a more detailed report had been discussed at the October meeting of the Quality and Patient Experience Committee. She advised that consideration was currently being given to increasing the perspective of quality in primary care and improving the link between the Quality and Patient Experience Committee and the Primary Care Commissioning Committee.

PMo reported a number of areas of concern relating to York Teaching Hospital NHS Foundation Trust, including the outbreak of clostridium difficile that had been declared over on 17 September 2019 after more than 27 weeks. She noted however that there was continued diarrhoea and vomiting particularly on the Scarborough Hospital site and advised that, although work was taking place, there were ongoing concerns such as delay to the deep cleaning programme and the impact from estates issues.

PMo referred to Serious Incidents at York Teaching Hospital NHS Foundation Trust relating to radiology. She reported that the CCG was receiving regular updates on quality involvement in the system radiology improvement plans and that radiology improvement working groups were being kept informed as appropriate.

In respect of the Care Quality Commission's unannounced inspection of York Teaching Hospital NHS Foundation Trust in July 2019, PMo explained that the focus had been mainly on the Scarborough and Bridlington sites and the former had been rated as 'Inadequate' for the 'Are services safe?' domain as detailed.

PMo also highlighted concerns mainly on the Scarborough Hospital site in respect of the number of Emergency Department trolley waits in excess of 12 hours. She noted a level of assurance in respect of these patients, some of whom had been admitted and others sent home, but advised that work was taking place to ascertain longer term impact and equally to try and avoid anyone being in the situation, also noting the context of winter impact. PM additionally referred to the establishment of a Patient Safety Improvement Board to be chaired by NHS England and NHS Improvement which was meeting for the first time on 20 November.

In response to clarification sought about de-logging of the 12 hour trolley wait Serious Incidents PMo explained that all such breaches were declared Serious Incidents and were subject to the appropriate processes. Discussion ensued in the context of seeking assurance that patients had not experienced harm, ensuring that CCG resources were appropriately directed in the system, expectations associated with the York Teaching Hospital NHS Foundation Trust's recently appointed Chief Executive and Chief Nurse and their new senior executive team structure. PM also highlighted their need to address cultural issues and the requirement for short, medium and long term actions. He additionally explained the context of risk to the CCG's financial plan due to their need for additional financial resources.

In response to further clarification sought about the concerns at Scarborough Hospital, PMo explained the challenge due to lack of space to decant patients for planned deep cleaning. She reported that North Yorkshire CCGs had recently commissioned additional care home beds but noted more were required and additionally advised that a business case was being developed by York Teaching Hospital NHS Foundation Trust to enable a more responsive approach to deep cleaning and environmental issues. PMo also referred to the additional infection prevention and control training described in the report and advised that there was a process for testing to identify any clostridium difficile cross contamination.

PMo highlighted the achievements of the 'React to Red' programme which had been shortlisted for Nursing Times and Health Service Journal awards. She reported that colleagues including MC and the Senior Quality Lead, had attended the latter event the previous evening where the work had been 'Highly Commended'.

HE commented on the fact that dementia was not included in the information about the joint approach to support care homes and the domiciliary sector. She noted that North Yorkshire County Council were supporting a GP dementia screening pilot in care homes as part of collaborative working and also emphasised the role of carers in raising identification of potential dementia cases.

In response to NW seeking clarification about the in excess of 14 months waiting lists for Attention Deficit Hyperactivity Disorder Services following the Care Quality Commission inspection, DN explained that this information related to services for adults advising that this contract was joint with the North Yorkshire CCGs; discussions were ongoing with Tees, Esk and Wear Valleys NHS Foundation Trust to establish a system plan. DN emphasised the need to address the Attention Deficit Hyperactivity Disorder Services waiting list at Contract Management Board in order to make progress and also noted associated financial risk. DN highlighted that the waiting list for this diagnostic service was not the only issue in relation to the Care Quality Commission report of its inspection.

In response to RW expressing concern from the GP perspective about a number of aspects relating to the context of absence of coordinated services for the transition from childhood to adulthood for Attention Deficit Hyperactivity Disorder patients, DN noted that this also applied to patients with autism. DN advised that Tees, Esk and Wear Valleys NHS Foundation Trust had organised an improvement event focused on autism but with consideration of wrap around support. AB additionally referred to GP concerns about prescribing and monitoring of specialised drugs. He also offered Local Medical Committee support in development of holistic pathway development.

The Governing Body:

1. Received the update on the quality and safety information and activity for the CCG's commissioned services.
2. Agreed that they were satisfied about being sighted on the current quality and safety concerns and assured that proposed actions were appropriate to manage effectively any quality and safety issues or risks.

KH joined the meeting

9. City of York Safeguarding Children Board Annual Report 2018/19

KH explained that this would be the last report in the current format as the Safeguarding Children Board had transitioned to the Safeguarding Children Partnership. The report highlighted aspects of the City of York Safeguarding Children Board during 2018/19 in terms of: leading areas of development in safeguarding children practice across the City; providing assurance that the CCG contributed effectively to the work of the partnership in safeguarding children; and highlighting the priorities and challenges for the newly established City of York Safeguarding Children Partnership during 2019/20 and how the CCG would play an integral role in taking these forward.

In response to HE highlighting the need to promote awareness of the Royal College of General Practitioner Safeguarding Children Guidelines and in particular understanding about children 'not brought' to appointments, NW noted that the Lead

GP for the guidelines was from Harrogate and Rural District CCG and advised that he would feedback these concerns. Discussion ensued in the context of the need to increase practices' understanding, potential to establish a standardised approach via the Primary Care Networks which would also support smaller practices and consideration at Primary Care Network level of funding for the reports and ensuring equity.

KH advised that the Nurse Consultant for Safeguarding in Primary Care undertook audits on the 'was not brought' processes from a system perspective, i.e. both primary and secondary care, and explained that response times to 'was not brought' were reviewed on a case by case basis in terms of risk to the child's health needs.

DB noted that the Quality and Patient Experience Committee received regular, detailed Safeguarding Children reports and, in response to his enquiry about the CCG's support, KH confirmed that colleagues were very supportive.

The Governing Body:

1. Noted the CCG's contribution to partnership working in order to safeguard children across the City of York.
2. Agreed that progress against the 2019/20 City of York Safeguarding Children Partnership priorities would be shared via the Designated Nurse's report to the Quality and Patient Experience Committee and, if necessary, any areas of concern would be escalated to the Governing Body.
3. Noted that NW would feedback concerns to the Lead GP for the Royal College of General Practitioners for the Safeguarding Children Guidelines.

KH left the meeting; SOC and ST joined the meeting

12. Update to Rapid Expert Input Project

In addition to the report circulated SOC and ST gave a presentation 'Rapid Expert Input and Transforming Outpatient Services' providing background and progress to date on the Referral Support System; identification of a number of inefficiencies, demanding targets and the impact on patients; aims of Rapid Expert Input; the current and future patient process; progress; implementation of phase one and, following its evaluation, phase two; specialties; risks and issues; other outpatient transformation initiatives and resulting expected improvements described in respect of a pilot in rheumatology. SOC emphasised that Rapid Expert Input was a clinically led decision making model that both reduced referrals and worked to the benefit of patients through a simplified outpatient referral process, avoiding duplication and ensuring more patients were booked in to the right clinic first time.

ST highlighted the role of Rapid Expert Input in relation to the national ambition of a 30% reduction in face to face outpatient attendances. She detailed the work to establish a high level technical solution accessible by both primary and secondary care clinicians advising that the aim was to complete Phase 1 by April 2020 and carry out an evaluation to inform implementation of the second phase. Phase 1 would initially be with specialties where champions had already been identified. ST

noted potential risk to the timescales due to unexpected absence of the clinical lead at York Teaching Hospital NHS Foundation Trust and capacity for support from GPs. With regard to the latter interest in specialties was being sought through writing out to practices.

Members sought and received clarification on a number of areas. Discussion included: addition of mental health services; aspects of patient choice; emphasis on the collaboration of GPs and secondary care clinicians working together; opportunities to learn from other areas where Referral for Expert Input had been implemented; the need for various approaches to be considered to engage further GPs in the work; and the context of development of future leaders in primary care.

In response to NW enquiring how the Governing Body could support this work to ensure an approach of 'Right Place, Right Time, Right Person' and the ambition of April 2020, SOC explained that the System Delivery Board had given full support to the project and the IT inter operability aspect was progressing. GP involvement particularly in writing guidelines and developing resource packages would be welcomed. ST requested that a swift governance sign off of the supportive clinical guidance be determined to avoid delays to implementation.

AB noted that the Local Medical Committee had been closely involved with this work. He commended the collaborative approach and offered continued support from the Local Medical Committee.

PM emphasised, and members agreed, that securing ST's continued full time support for this work was essential to meet the April 2020 timescale.

The Governing Body:

Received the update on the Rapid Expert Input project.

SOC and ST left the meeting

10. Safeguarding Adults Annual Report 2018/19

PMo referred to the report presented to provide assurance that statutory safeguarding adults duties were being executed. She noted that the report was being presented to all the North Yorkshire CCGs.

RW commended the MARAC process (Multi Agency Risk Assessment Conference) but commented on the change of timing to Monday mornings which was notably a busy time for GPs. NW advised the change did recognise this fact but had been implemented to avoid delays, and therefore risk, caused by the previous practice of waiting until a certain number of MARACs had been identified. He also noted there had been an increase in MARACs due to domestic violence over the year and expressed concern at the number of potential unknown cases.

The Governing Body:

Received the Safeguarding Adults Annual Report 2018/19.

11. Progress report on work relating to physical health checks for people with severe mental illness

In addition to the progress report, provided in accordance with the request from the previous meeting, DN requested consideration of next steps in light of further information since the report had been written. She explained that the Local Enhanced Service for physical health checks for people with severe mental illness had been offered on the basis that the CCG would respond to feedback from practices where it was implemented to inform a decision for 2020/21. She noted the context of practices' varying views about the checks and the risk in terms of equity.

DN presented the report which included a high level summary of quarter two data, summary of previous activity, detail of the Local Enhanced Service and its implementation, and information on free training and pathway guidance for practices. Three appendices comprised respectively the reporting requirements of physical health checks for people with severe mental illness, the quarter two data report and a heat map of the September 2019 severe mental illness register and physical health check performance.

DN advised that currently 16 practices had taken up the offer of the Local Enhanced Service noting that none were from the York City Centre Primary Care Network where there were 413 people with severe mental illness eligible for the health checks. She referred to the heat map, which demonstrated good performance in the context of the Quality and Outcomes Framework, highlighted how close some areas of performance were to the indicator requirements, noted the element of underspend against the Local Enhanced Service and sought members' views on whether the CCG could offer any support for improvement. In response RW suggested that the CCG fund for all practices the template used by GPs for patients with long term conditions which identified the requirements of the annual physical health checks for people with severe mental illness.

DB sought clarification on these services for the homeless referring to opportunities such as street clinics provided by both primary care and dental services in other areas. Discussion ensued particularly in the context of patient choice about registering with a GP. FP noted that local authority provision included hostels where registration with a GP was encouraged and AB advised that York Medical Group provided a clinic where registration was not required.

Further detailed discussion included: emphasis on prevention and the need for closer working between primary care and the local authorities; the complexity and inequity of the current position; recognition of good care demonstrated by the heat map; opportunities to learn from other areas; continued emphasis and focus on outcomes; potential for inclusion in a Protected Learning Time event; and the context of the CCG's legacy. AB additionally emphasised that GPs did not question the importance of this work; their concerns related to it not being funded and impact on resources.

DN reiterated the fact that the Local Enhanced Service was a pilot to inform a decision in 2020/21 and noted that further funding for this would impact on that available for other services. She also emphasised the aspect of commitment to

improve services for this group of patients, referred to the CCG's previous under investment in mental health services and suggested standardising a number of the indicators to improve achievement. It was agreed that discussion continue outside the meeting.

The Governing Body:

1. Received the update on work relating to physical health checks for people with severe mental illness.
2. Requested that further discussion continue outside the meeting.

FINANCE AND PERFORMANCE

CA joined the meeting

13. Long Term Plan for Vale of York and Humber, Coast and Vale Health and Care Partnership

CA and MA-M presented *Development of the Partnership Long Term Plan: Vale and Scarborough Activity and Finance Plan* and the *NHS Vale of York CCG Draft Financial Plan 2020/21 to 2023/24* which would be submitted later in the day. Members sought and received clarification of the presentations and confirmed their understanding that 2020/21 would be a challenging year due to the pressures described. All partners and stakeholders, including the regulators, would be kept informed of emerging situations.

Members additionally acknowledged the fact that the regulators had had confidence in the CCG in the current year on the basis of a non control compliant plan.

The Governing Body:

Approved the Long Term Plan for Vale of York and Humber, Coast and Vale Health and Care Partnership.

14. Financial Performance Report 2019/20 Month 6

In referring to this report MA-M advised, in summary, that the forecast outturn of £18.8m deficit was in line with the CCG's financial plan but noted an element of potential risk in month 7. He explained that non recurrent actions would be implemented to address this and ensure delivery of the plan, but that this was deteriorating the underlying position and would play out in 2020/21, increasing the challenge to delivering the required control total.

The Governing Body:

Received the month 6 Financial Performance Report.

15. Integrated Performance Report Month 5

CA referred to the report which provided a triangulated overview of CCG performance across all NHS Constitutional targets identifying causes of current performance levels and work being undertaken by CCG partners across a number of different forums and working groups in the local York and Scarborough and Ryedale system and wider Humber, Coast and Vale Health and Care Partnership to drive performance improvement.

CA noted that there were no significant changes since the previous report. She advised that a Winter Delivery Agreement was required to be developed and agreed at Humber, Coast and Vale Partnership level and which would bring together local sub-system winter plans across all care and health partners. CA noted the continued variation in Emergency Care Standard performance, OPEL escalation levels daily at York Teaching Hospital NHS Foundation Trust across both hospital sites and the on-going improvement work to deliver more sustainable improved performance and address quality concerns. CA advised that the Finance and Performance Committee had a standing item focusing on winter planning and resilience and the work of the CCG with partners in the York and wider North Yorkshire system to develop and deliver improved urgent and emergency care in and out of hospital.

The Governing Body:

Received the month 5 Integrated Performance Report.

CA left the meeting

RECEIVED ITEMS

The Governing Body noted the following items as received:

16. Executive Committee chair's report and minutes of 7 August, 4 and 18 September and 2 October 2019.

17. Audit Committee chair's report and minutes of 26 September 2019.

18. Finance and Performance Committee chair's report and minutes of 22 August and 26 September 2019.

19. Primary Care Commissioning Committee chair's report and minutes of 19 September 2019.

20. Quality and Patient Experience Committee chair's report and minutes of 10 October 2019. NW additionally proposed that the concerns highlighted relating to A and E performance be discussed at one of the newly established focused meetings of the Committee.

21. Medicines Commissioning Committee recommendations of 14 August 2019.

Additional Item: City of York Council Special Educational Needs and / or Disabilities (SEND) Inspection

PM reported that the Care Quality Commission and Ofsted Inspection into City of York Council's SEND services, scheduled to commence on 11 November, had been postponed. He advised that the Governing Body would receive the report when the inspection had taken place.

The Governing Body:

Noted the information relating to the City of York Council SEND services inspection.

22. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 2 January 2020 at West Offices, Station Rise, York YO1 6GA.

Close of Meeting and Exclusion of Press and Public

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

A glossary of commonly used terms is available at:

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

Appendix A

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 7 NOVEMBER 2019 AND CARRIED FORWARD FROM PREVIOUS MEETING

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
5 September 2019 7 November 2019	Update on work relating to physical health checks for people with severe mental illness	• Further update to the next meeting • Further discussion to take place outside the meeting	DN DN	7 November 2019
7 November 2019	Accountable Officer Report	• Primary Care Network engagement in consideration of the Better Care Fund to be sought via the CCG's Lead Officers for Primary Care	MA-M	
7 November 2019	Board Assurance Framework	• Additional tab to be added to highlight direction of travel	AC	2 January 2020

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
7 November 2019	City of York Safeguarding Children Board Annual Report 2018/19	• Concerns to be fed back to the Lead GP for the Royal College of General Practitioners for the Safeguarding Children Guidelines, in particular understanding about children 'not brought' to appointments	NW	

Item Number: 6

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Accountable Officer's Report

Purpose of Report *(Select from list)*
To Receive

Reason for Report

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

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

- ☒Financial
- ☐Legal
- ☐Primary Care
- ☐Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- ☐ Quality Impact Assessment
- ☐ Data Protection Impact Assessment
- ☐ Equality Impact Assessment
- ☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments: N/A
Recommendations The Governing Body is asked to note the report.
Decision Requested (for Decision Log)

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

GOVERNING BODY MEETING: 2 JANUARY 2020

Accountable Officer's Report

1. Turnaround, local financial position and system recovery

1.1 The CCG's overall financial position remains under pressure, but is still deliverable. Although we are now £1.0m overspent compared to our year-to-date plan at the end of November many of our actions to resolve this are profiled over the final months of the year. There are continuing cost pressures in prescribing, including national prescribing costs and QIPP (Quality, Innovation, Productivity and Prevention) slippage and the now confirmed shortfall on the System Recovery Schemes that have been added to the forecast outturn, all of which are detailed in the finance report. The CCG has developed and implemented plans to mitigate these to the extent that all risks and mitigations have now been built into the CCG's forecast outturn that remains in line with plan. However, these are largely non-recurrent in nature and therefore the underlying position is deteriorating and increasing the challenges going into 2020-21.

1.2 QIPP delivery at Month 8 is £1.6m off plan. This largely relates to prescribing, which always had a stretching target, by £744k, as PIB2 (Prescribing Incentive Scheme) has only just started and £1.1m from the System Recovery Schemes in plan, but not delivered up to November 2019. However, we have delivered £9.0m of savings for the year in total, with the forecast premised on delivering £11.2m.

2. Operational Planning

2.1 The CCG continues to work with all partners around developing joint priorities further to submitting the first local Vale-Scarborough long term plan as part of the combined Humber, Coast and Vale Health and Care Partnership (HCVCP) Long Term Plan on the 15 November 2019. Local working groups and teams are responding to the Partnership's request to shape the delivery of local and collaborative plans and programmes while waiting for the operational planning guidance expected from NHS England and NHS Improvement before Christmas 2019. The focus on opportunities to integrate care and support for local people and staff is a core driving theme, and more critical than ever given the pressures on many of our services.

2.2 This local and collaborative work will be supported through the allocation of transformational funding through the HCVCP from 2020-21 to 2023-24. This funding will be allocated on a 'fair share' or 'targeted' basis and provides a great opportunity for the CCG and providers to highlight and refresh joint priorities for improvement in our local places. The funding allocations will be finalised during January and February 2020 and all partner boards in York and

Scarborough will have an oversight on the allocations, their proposed impact and benefits.

2.3. The CCG and local partners are all working to build the resilience of local services and people during winter and actively learn from all actions we are collectively undertaking day in, day out. The local subsystem has had a number of funding allocations confirmed for social, acute and mental health care and the Health and Care Resilience Board is over-seeing how this funding is being targeted to provide additional capacity and support improvements in joint working across teams in health and care. The System Resilience Group is improving the approach for escalation and support provided across all teams for each other to help avoid any potential patient risk. The subsystem has also established a Quality Improvement Board to support mitigating these risks.

2.4 The Health and Care Resilience Board will be confirming its single work plan in January which will focus on critical joint work across which all partners will drive in the medium to long-term alongside the immediate resilience actions. CCG teams are providing strategic and practical support across all aspects of the delivery and governance of this single work plan. This work plan, collectively with the work of the System Resilience Group and Quality Improvement Board, forms the subsystem response to the Emergency Care Standard Risk Summit earlier in the year.

3. Primary Care Protected Learning Time

3.1 The next protected learning time event for primary care takes placed on the 23 January 2020. This event will focus on the latest study that suggests the arts, including regular visits to museums, art galleries, the theatre and concerts, can lower the risk of dying early. The study’s findings are important because of the current focus on NHS social prescribing and community service referrals to the arts to improve wellbeing and health. Previous studies have found that engaging with the arts can improve a person's physical and mental wellbeing, including depression, dementia, chronic pain and frailty. To ensure that patients continue to receive the care they need from their local GP practice, the local Out of Hours GP provider, Vocare, will be supplying clinical cover from midday to 6pm to those practices that choose to take up the learning and development opportunity.

4. Better Care Fund

4.1 Planning guidance for 2020-21 has still not been published but a further one year plan is expected to be required for each of the York, North Yorkshire and East Riding of Yorkshire areas.

5. Emergency, Preparedness, Resilience and Response update

5.1 The NHS winter monitoring period started on the 9 December 2019. The York and Scarborough system is holding weekly calls at 10am on a Monday and Thursday and these are followed by a call on these days with NHS England and NHS Improvement to update our regulators on the local system's performance and work to counteract any triggers, the current pressures across the system and escalation levels in line with the OPEL framework and the system's actions to alleviate pressures and to de-escalate.

5.2 As part of the Emergency Preparedness, Resilience and Response Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. The CCG attended the Local Health Resilience Partnership confirm and challenge event on the 18 November 2019. The Governing Body ratified the CCG's rating of 'Substantial' compliance.

5.3 Following the results of the General Election on 12 December 2019 NHS England and NHS Improvement's lead for the UK's Exit from the European Union scheduled teleconference calls on 18 December 2019 and 9 January 2020 to brief CCG Senior Responsible Officers and provide updates on the latest position and preparations.

5.4 The North Yorkshire and York Mass Treatment and Vaccination Plan was tested following a confirmed outbreak of measles that was confined to a single family in York during the summer 2019. In November 2019 there was also a suspected Avian Flu outbreak at a turkey farm in Thirsk. The CCG's Out of Hours GP Service, Vocare, was on standby to help with delivering the plan. Fortunately, on this occasion, Vocare's services were not needed.

6. Directions

6.1 The regulator of the CCG has taken the opportunity to refresh and revise the Directions previously conferred upon the CCG. These clarify that no new or additional actions are required beyond the system plan that is already in place. The correspondence also confirms that the CCG could be released earlier than the 12 month continuation on the basis of the delivery of plans for 2020-21.

7. Strategic and national issues

7.1 The 2020 GP Patient Survey launches on the 6 January 2020. Last year, more than 770,000 people gave feedback on around 7,000 GP practices across England. It is a key source of information about the performance of practices, CCGs and healthcare professionals.

7.2 The Primary care digital maturity assurance tool questionnaire is available for CCGs to complete through the NHS Digital Strategic Data Collection Service (SDCS). Returns are requested by 10 January 2020.

7.3 Following the success and positive feedback around the last coaching and mentoring programme, practice managers are again being offered free coaching and mentoring sessions between January and March 2020. Places are limited and are offered on a first-come first-served basis.

7.4 The GP Connect programme supports the development of products which enable different GP clinical systems to communicate. There will be a full rollout with TPP and EMIS Health to assist with practices' GP Connect appointment management capability. When fully implemented, 96% of GP practices will be covered and will mean that it will now be simpler for GP practices to view and book appointments into the access hubs for their patients. This functionality also supports appointment bookings via services such as NHS 111.

7.5 A new e-learning tool called ActNow has been developed for health and care staff to help them prevent delayed transfers of care. The tool can be used by nurses, allied health professionals and care staff to ensure patients have the best outcomes possible following care received in hospital. It includes resources to help staff take prompt practical actions and use every opportunity to ensure patients are cared for in the best place. Please pass them on to relevant colleagues and teams within your organisations.

7.6 The recent publication of Transforming imaging services in England: a national strategy for imaging networks sets out NHS England and NHS Improvement's proposal for implementing collaborative imaging networks across the country, to deliver better quality care and better value services for patients, and provide NHS staff with further opportunities to develop their career and increase their productivity. The NHS Long Term plan commits, by 2023, to have introduced new diagnostic imaging networks to improve turnaround times for imaging tests, improve access to subspecialist opinion and make best use of the workforce.

7.7 GP practice managers can advertise nursing vacancies through NHS Jobs by using the new 'bolt-on' website, which aims to increase the supply of General Practice nurses. Potential applicants can quickly filter to find local roles as a General Practice Nurse, Advanced Nurse Practitioner, Advanced Clinical Practitioner, Nursing Associate and Health Care Support Worker. The site also includes information about General Practice Nursing training and careers. CCGs are encouraged to share the new site with GP practices in their locations.

8. Recommendation

8.1 The Governing Body is asked to note the report.

Item Number: 7

Name of Presenter: Dr Lincoln Sargeant

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Life in times of change; health and hardship in North Yorkshire: The 2019 Director of Public Health Report for North Yorkshire

Purpose of Report *(Select from list)*
To Receive

Reason for Report

To note the content of the report of the Director of Public Health and consider how NHS Vale of York CCG will respond to the Director for Public Health's recommendations.

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

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

Recommendations

For NHS Vale of York CCG to consider:

Support deprived areas - North Yorkshire County Council, the Borough and District Councils should lead coordinated plans focused on areas of deprivation through collaboration with local communities and residents to reflect their priorities for reducing poverty and shaping healthy places.

Tackle rural poverty - Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.

North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing.

Reduce childhood inequalities - All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child's full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.

As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution pf child poverty across North Yorkshire to inform strategies and service delivery.

Work with military families and veterans - Military and related agencies should ensure that service and veteran-specific issues identified in the needs assessment are addressed.

All agencies should identify and trail military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant.

Create safe environments for high-risk groups - All agencies working with people with multiple health and social problems should consider a 'housing first' approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.

Develop priorities to mitigate the impact of changes to the benefit system - As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.

Improve community engagement - North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.

All agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations.

Decision Requested (for Decision Log)

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	

North Yorkshire Joint Strategic Needs Assessment 2019

North Yorkshire County Summary Profile

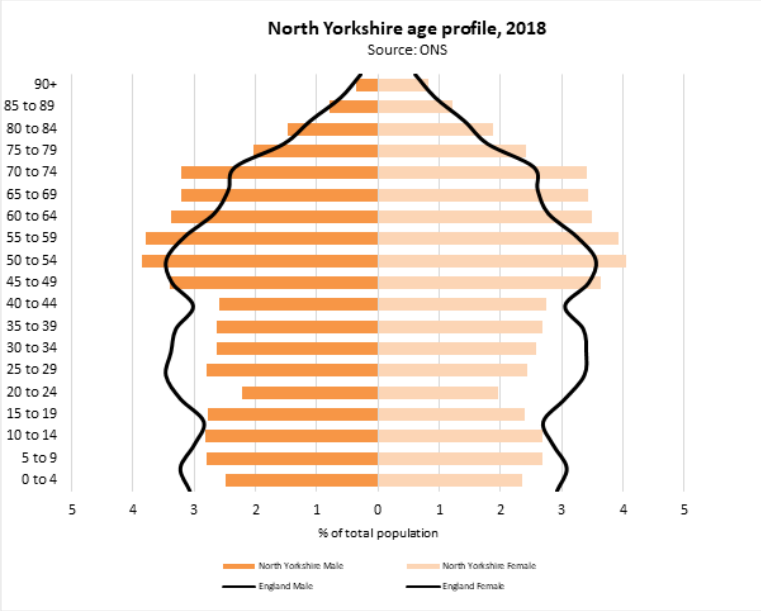
Introduction

This profile provides an overview of the population health needs in North Yorkshire. Greater detail on for the districts and CCGs in the county can be found in our Joint Strategic Needs Assessment (JSNA) resource at www.datanorthyorkshire.org. This document is structured into four parts: population, wider determinants of health, health behaviours and diseases and death. It identifies the major themes which affect health in North Yorkshire and provides links to the local response which meets those challenges.

Summary

- The population of North Yorkshire is ageing. By 2025, there will be 21,200 additional people aged 65+, a 14% increase from 2018, but a 4% decrease in the working-age population. This is likely to lead to increased health and social care needs with fewer people available to work in health and care roles.
- Overall population health in North Yorkshire is better than England. However, there are stark inequalities: life expectancy varies by 15 years between wards within North Yorkshire; the healthy life expectancy gap for men is even wider at 18 years.
- Rates of child poverty are higher than poverty in older people. Over 28,000 children are growing up in poverty in North Yorkshire, with about one quarter of them in Scarborough Borough.
- Cardiovascular diseases remain the leading cause of death in North Yorkshire and are the largest contributor to the life expectancy gap between the least and most deprived areas.

Overview: Population



The population pyramid shows that, overall, North Yorkshire has an older population than England, with more residents aged 45-89, and fewer aged under 45. There are noticeably fewer people aged 20-44 in North Yorkshire compared to the national demographics. The shape of the pyramid is typical of a population with long life expectancy and low birth rate.

There are about 67,200 people aged 65+ with a limiting long term illness in North Yorkshire. Of these people, 44% (29,300) report that their daily activities are limited a lot because of their illness (POPPI, 2019).

Within the county, 2.8% of the population are from black, Asian and minority ethnic groups, compared to 15% in England.

Produced by: Data and Intelligence Team
Strategic Support Service.

Population

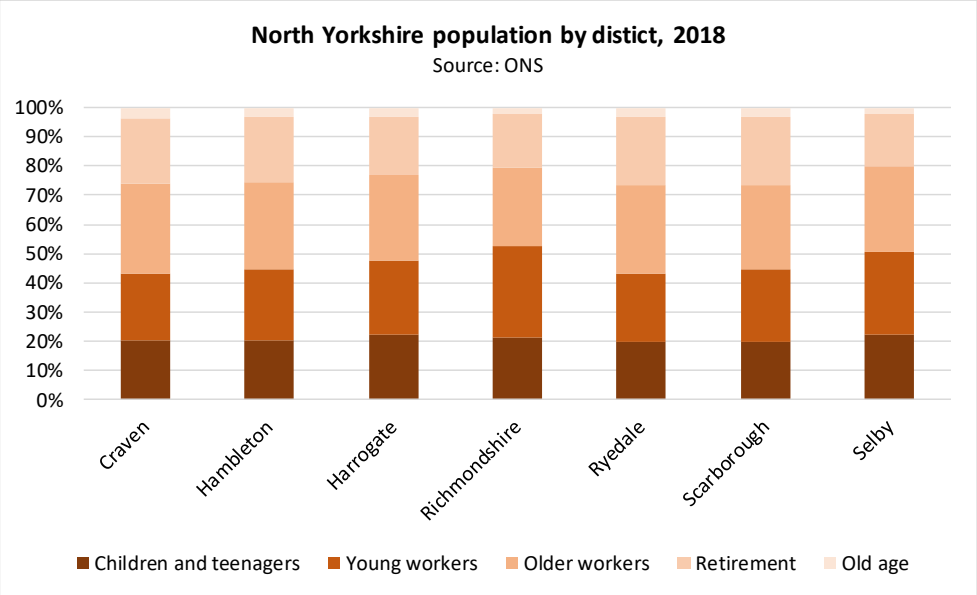
Current and projected population

The population of North Yorkshire is estimated to be 614,500 and is set to increase to 620,300 in 2025. The birth rate in the county is 59 births per 1,000 women, the same as the national birth rate.

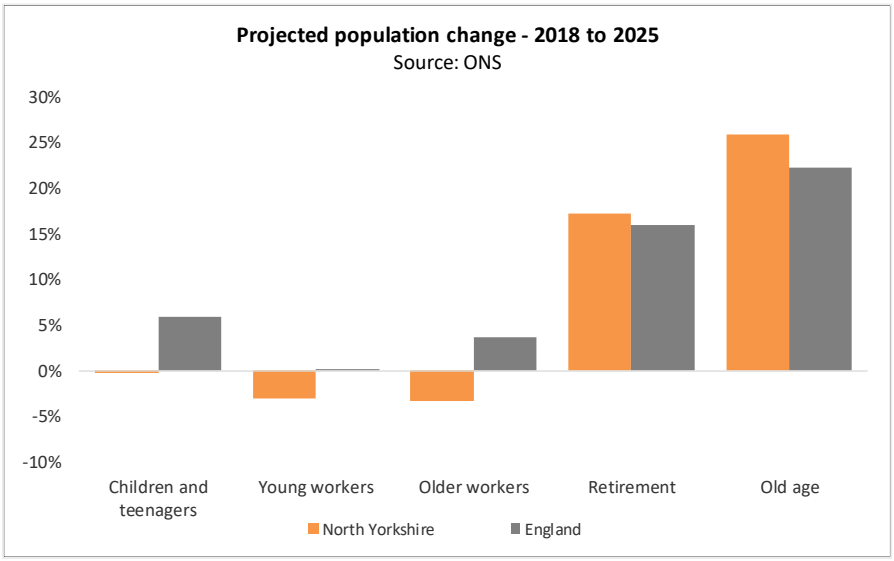
Selby has the highest population proportion aged 0-19 at 23%, while Ryedale has, proportionally, the least in this age group at just under 20%. Richmondshire has the greatest proportion of those in the young workers category (aged 20-44) at 31%, which is likely due to the military base located in the district. Most of the districts have around 30% of their population in the older workers category, although, Richmondshire has the lowest proportion in this age group at 27%. There is some variation in the retirement age grouping, with a range of 18% in Selby and Richmondshire and 23% in Scarborough and Ryedale. Finally, for those 85+, Hambleton has the greatest proportion of residents in this age bracket, at 3.8%, while Selby and Richmondshire have the lowest proportion at 2.3%.

Current and projected population

		2018				2025 (projected)			
		Males		Females		Males		Females	
		N	%	N	%	N	%	N	%
Children and teenagers	0-19	67435	22.6	62125	20.2	67200	22.6	62000	19.7
Young workers	20-44	78379	26.3	75737	24.7	76100	25.5	73400	23.3
Older workers	45-64	87010	29.2	90748	29.6	83100	27.9	88700	28.2
Retirement	65-84	58522	19.6	65928	21.5	69600	23.4	76300	24.2
Old age	85+	6658	2.2	12324	4.0	9300	3.1	14600	4.6



Projections indicate that the population aged over 85 is expected to increase in North Yorkshire by approximately 26% by 2025, compared with a 20% increase in England. A 17% increase is also anticipated for those in the retirement category in the county. Meanwhile, both the 45-64 and the 20-44 age groups are projected to decrease in North Yorkshire by 3%. There is some variation in the make-up of the projected populations in the districts within the county. Harrogate and Selby districts are projected to see an increase of 26% in the 85+ age group by 2025. Meanwhile, only Ryedale and Selby are expected to see a rise in the under 44s, with Ryedale projected to increase by 5.5% in the under 19 category and Selby projected to see growth of 4.2%.

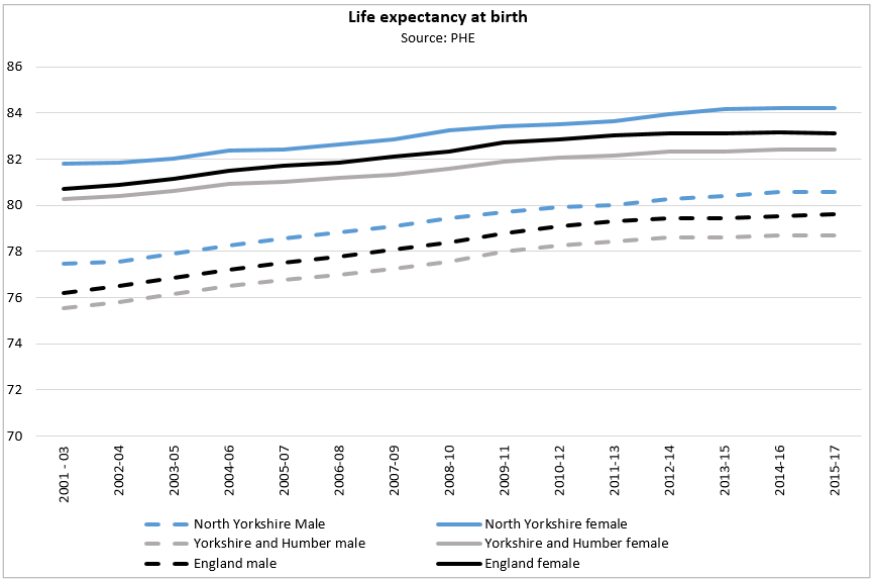


Produced by: Data and Intelligence Team
Strategic Support Service.

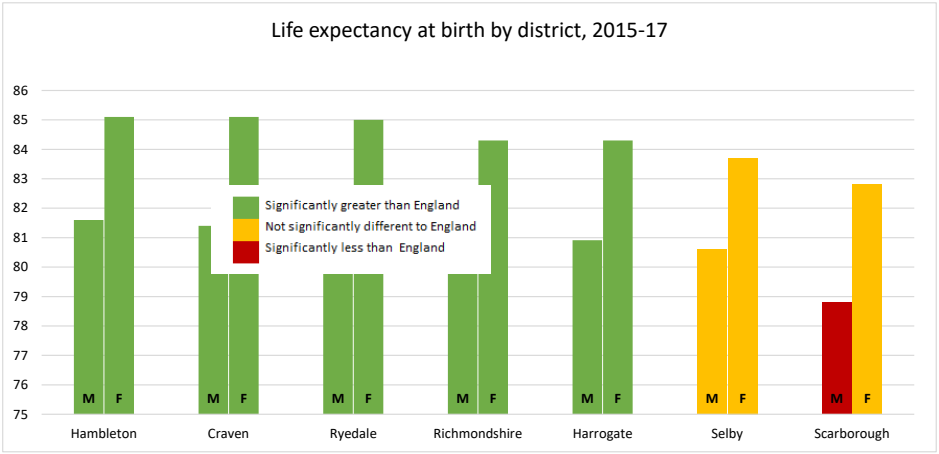
Population

Life expectancy

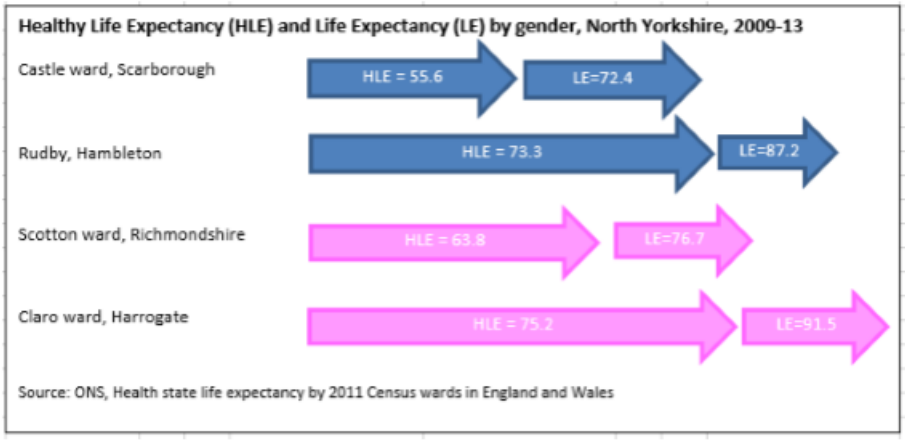
Life expectancy at birth is increasing for England. In North Yorkshire, it is estimated at 81 years for males and 84 years for females. This is higher for both sexes compared to both Yorkshire and the Humber (79 for males and 82 for females) and England (80 for males and 83 for females) in 2015-17.



There is not a lot of variation in the county in terms of life expectancy. Most of the districts have estimated life expectancy at birth which is significantly higher than England for both males and females. Scarborough (83y) and Selby (84y) both have female life expectancies statistically similar to England. For males, most districts have higher life expectancies compared with England, exceptions being Selby, which is statistically similar (81), and Scarborough, which has a significantly lower life expectancy for males (79).



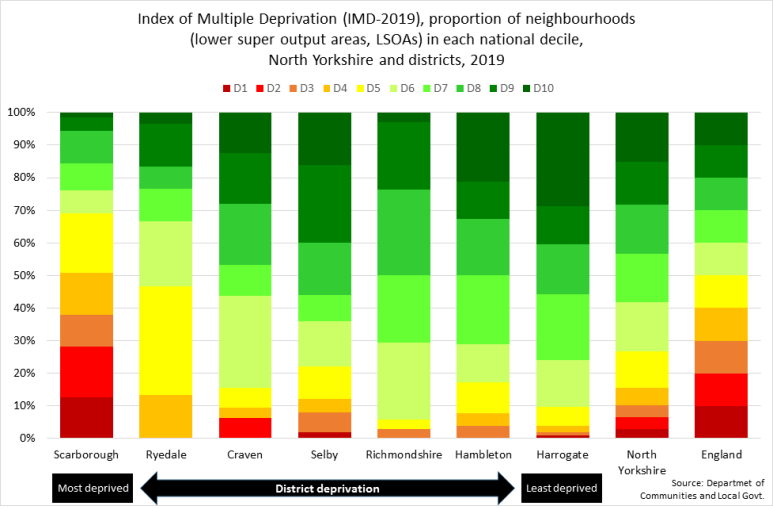
By comparing healthy life expectancy with the overall life expectancy, we can get a richer picture of years spent in good health. In North Yorkshire, there is considerable variation in the years spent in good health for both males and females, indicating inequalities within the county. There is a 15 year difference in life expectancy for males between the ward with the lowest overall life expectancy (Castle ward, Scarborough district) and that with the highest overall life expectancy (Ripon Minster ward, Harrogate district). In terms of healthy life expectancy, men in Castle ward can expect to live 56 years in good health but men in Ripon Minster ward spend 73 years in good health, a near 18 year difference of life spent in good health. For females, there is also a 15 year difference in life expectancy between the wards with the lowest and highest life expectancy. For healthy life expectancy, women in the ward with the lowest life expectancy (Scotton ward, Richmondshire) spend 62 years in good health, while in Claro ward in Harrogate they spend 75 years of their longer life in good health. For both sexes, the wards with the highest life expectancy exceed that seen by England and those with the lowest life expectancy are below the England figures.



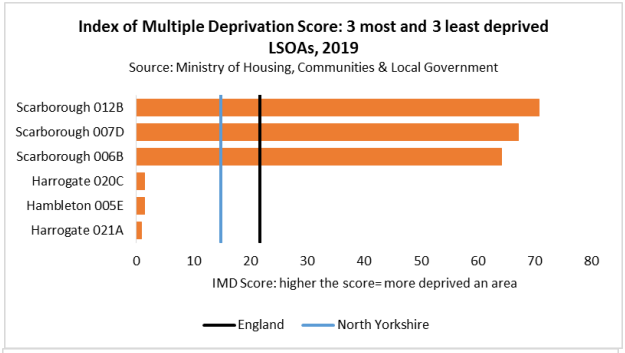
Wider determinants of health

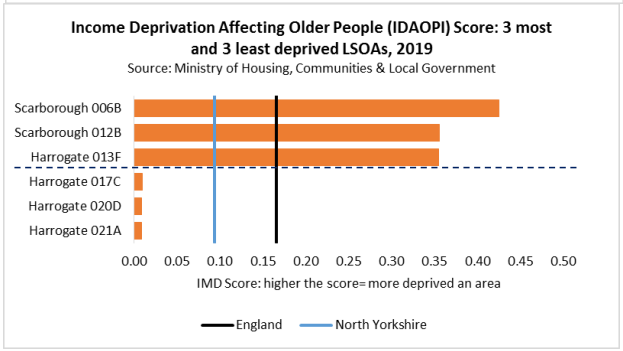
Poverty

The 2019 Index of Multiple Deprivation (IMD) identifies 24 Lower Super Output Areas (LSOAs) of the 373 LSOAs in North Yorkshire which are amongst the 20% most deprived in England, with a population of 36,000 people. Twenty of these LSOAs are in Scarborough district with a combined population of 30,000.

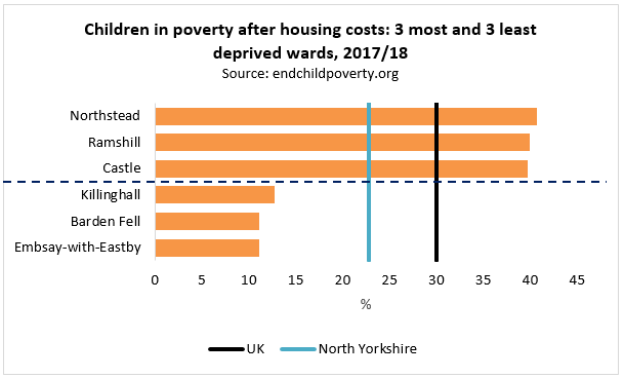


IMD also calculates deprivation for specific groups based on key indicators. The charts presented here highlight that Eastfield, Woodlands and North Bay wards in Scarborough have higher rates of overall deprivation. North Bay and Eastfield wards together with Harrogate Bilton Woodfield ward have higher rates of older people in deprivation. Across the county, around 23% of children (28,275) are living in poverty after housing costs, lower than the national average of 30%. However, this rises to 41% in the Northstead ward in Scarborough.

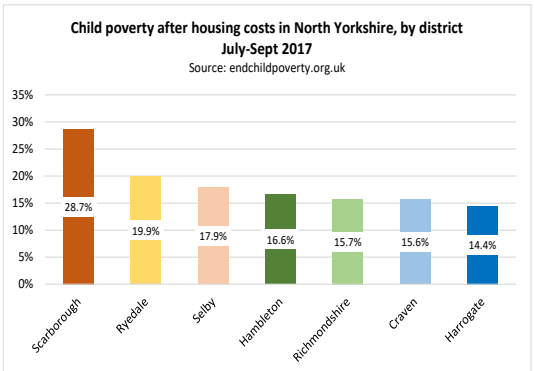


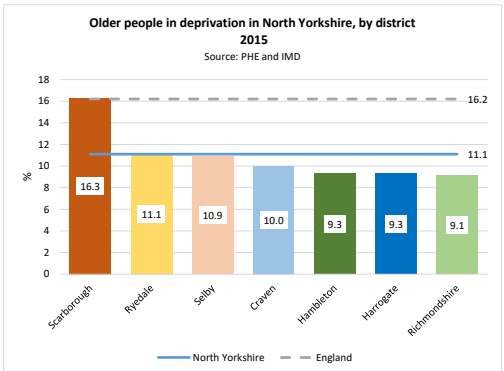


LSOA name	*Ward*
Scarborough 012B	Eastfield
Scarborough 007D	Woodlands
Scarborough 006B	Castle
Harrogate 013F	Harrogate Bilton Woodfield
Harrogate 020C	Harrogate Oatlands
Hambleton 005E	Romanby
Harrogate 021A	Harrogate Pannal
Harrogate 017C	Harrogate Stray
Harrogate 020D	Harrogate Pannal



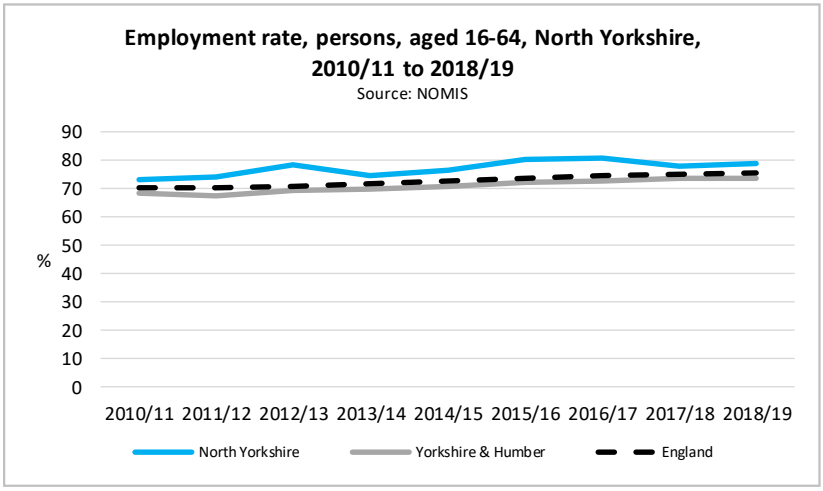
There is some variation in deprivation for both children and older people between districts. Recent figures from End Child Poverty indicate that nearly 31% of children in Scarborough are considered to live in poverty after housing costs, compared with 18% in Harrogate. (www.endchildpoverty.org.uk)





Wider determinants of health

Employment

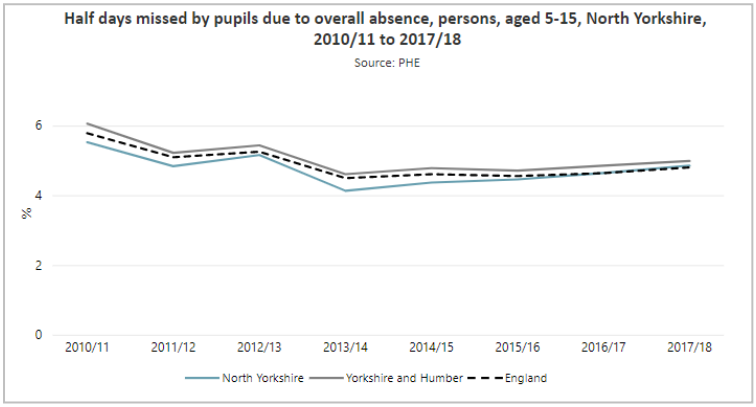


The employment rate in North Yorkshire is 79%, higher than both England (76%) and Yorkshire & Humber (74%) rates. The lowest employment rate in the county is in Craven (69%) where the employment rate has decreased by 1.3% between 2017/18 and 2018/19.

In 2018 , the Office for National Statistics reported that the median average weekly earnings in North Yorkshire were £423, significantly lower than England (£451 per week, which is skewed by higher earnings in the South East). The median average earnings for Yorkshire & Humber (£408), however, were not significantly different compared to North Yorkshire. The lowest average weekly earnings were in Richmondshire (£371), Ryedale (£375) and Scarborough (£398). Richmondshire, despite having the lowest earnings, but due to the wide confidence intervals, was not significantly different compared to England; whereas Ryedale and Scarborough were both significantly lower compared with England. The rest of the districts had average weekly earnings similar to England.

There is a large variation in the median earnings for men and women at the county, regional and national level. In 2018, men in North Yorkshire earned, on average, £489 per week, significantly higher compared to North Yorkshire. Women, however, earned £347 per week, significantly lower compared to North Yorkshire. The data includes earning information for both full and part-time work, which could explain some of the gap, as women are more likely to be in part-time employment. However, as income is related to a variety of health-related factors, including self-reported health and disability-free life expectancy, the reason for the gap in earnings between men and women in the county could be explored more fully.

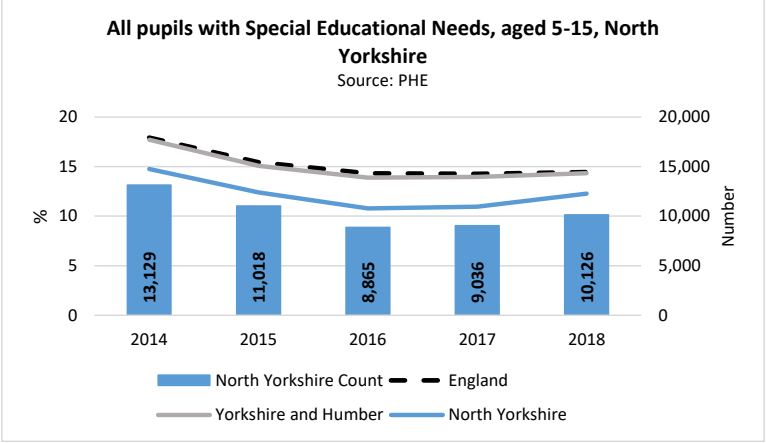
Education



Educational attainment and qualifications are directly related to health and health inequalities. Furthermore, low attendance at both primary and secondary school is linked to lower educational attainment. Tackling absenteeism is an important aspect of the Government's goal of increasing social mobility and helping all children meet their potential.

The proportion of half days missed by pupils due to overall absence (both authorised and unauthorised) in North Yorkshire is similar to England at Yorkshire and the Humber average . Harrogate has the lowest rate of pupil absence (4.4%) and this is significantly lower than the England rate. However, Scarborough has the highest rate (6%) and this is significantly higher than England. The proportion of overall absence has increased from 2015/16 to 2017/18 in the county, and this is in line with Yorkshire and Humber trends.

The proportion of pupils aged 5-15 with special educational needs in North Yorkshire has increased slowly between 2016 and 2018 but remains significantly lower than England.



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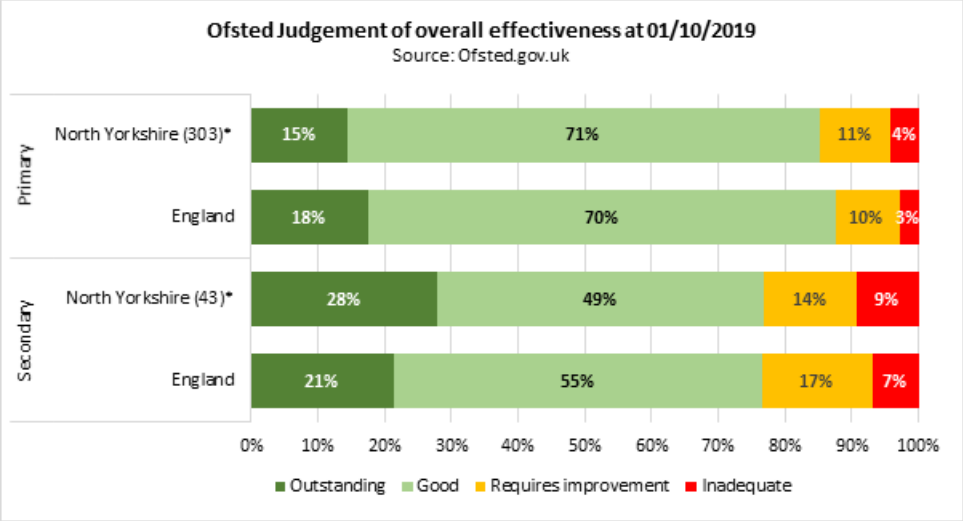
Wider determinants of health

Education

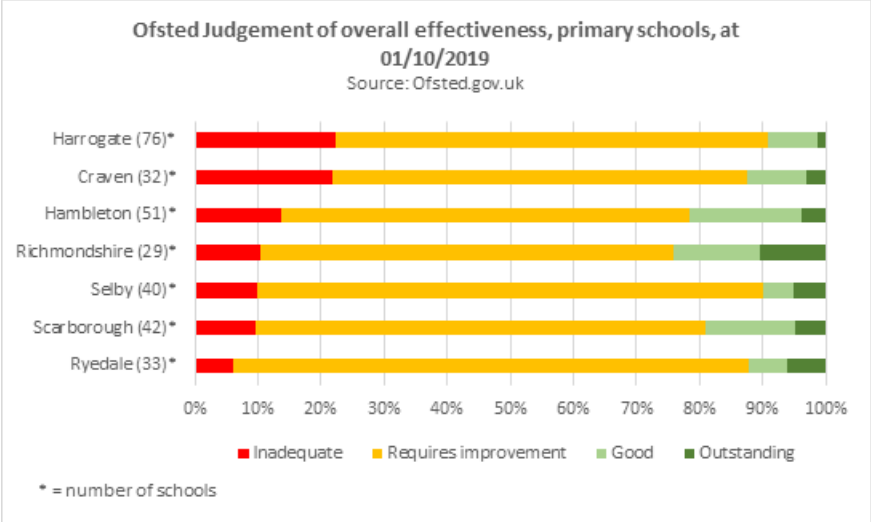
The chart below highlights the Ofsted judgement of overall effectiveness of primary and secondary schools in North Yorkshire compared to England.



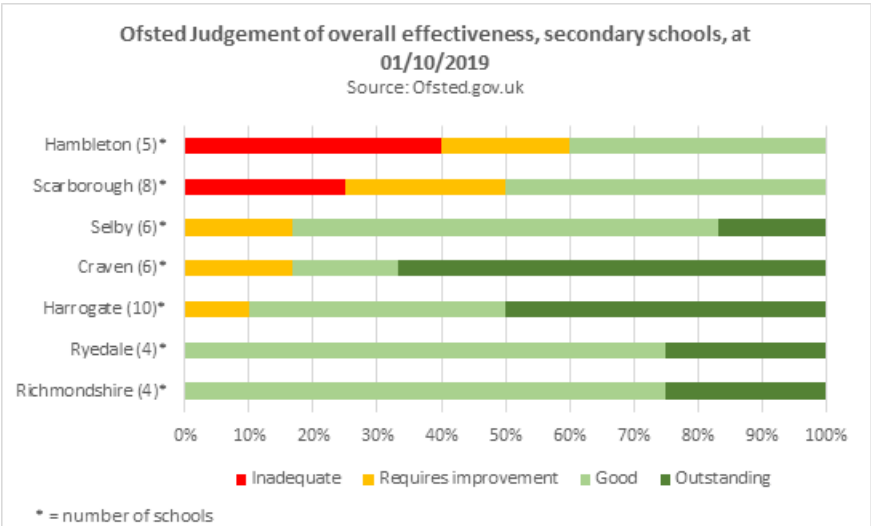
Ratings for primary schools are similar to national findings. However, for secondary schools, North Yorkshire has a higher proportion rated 'outstanding' compared with England but also higher proportion rated as 'inadequate'. Due to the small number of secondary schools in North Yorkshire (43), this needs to be interpreted with a degree of caution.

At a district level, there is some variation in the distribution of Ofsted judgements.

For primary schools, Richmondshire has the highest proportion of schools rated 'Outstanding' (10%). Harrogate and Craven have the highest proportions of primary schools rated 'Inadequate' at 22%.



There are relatively few secondary schools in the county and when broken down by district level, extra caution needs to be used when interpreting and comparing the data. There are four secondary schools rated 'Inadequate': two in each of Hambleton and Scarborough. Hambleton and Scarborough have no schools judged to be 'Outstanding'. Richmondshire and Ryedale districts have no secondary schools judged to be either 'Inadequate' or 'Requires improvement'.



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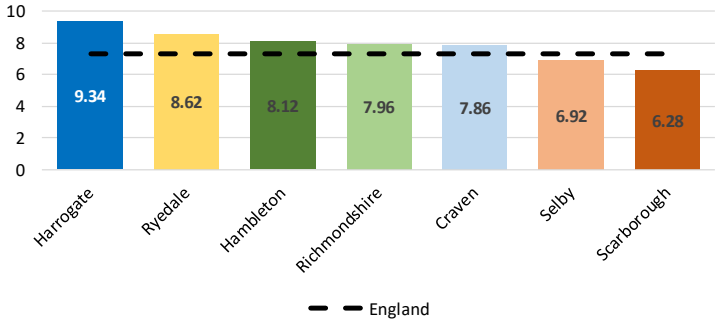
Wider determinants of health

Housing

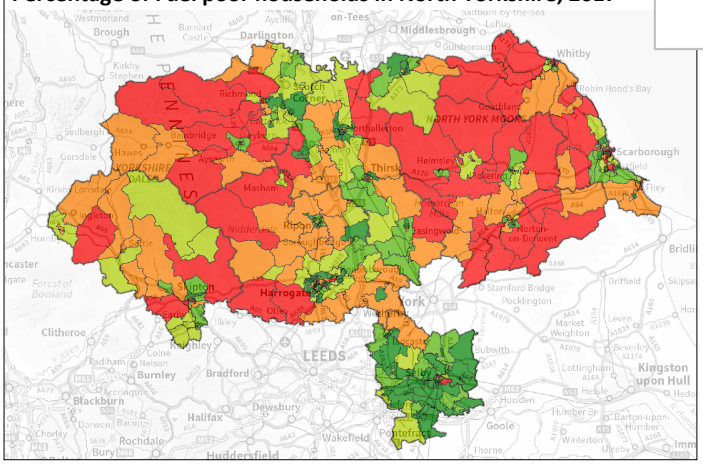
Housing affordability affects where people live and work. It also affects factors that influence health, including poverty, community cohesion, housing quality, and time spent commuting. There is increasing evidence of a direct association between unaffordable housing and poor mental health, over and above the effects of general financial hardship. Type of housing tenure may also be an important factor in determining how individuals experience and respond to housing affordability problems.

Data for housing affordability is not aggregated at the county level but is available at the district level. A ratio is calculated for each district, based on the ratio of lower quartile house price to lower quartile earnings. The lower the ratio, the more affordable housing is overall. In North Yorkshire, Harrogate has the largest ratio and Selby has the smallest; however, all districts other than Scarborough and Selby have higher ratios than the England average of 7.0.

Ratio of lower quartile house price to lower quartile earnings, all ages, persons, North Yorkshire, 2018
Source: PHE

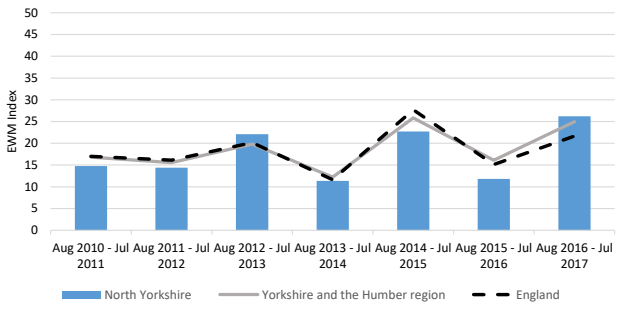


Percentage of Fuel poor households in North Yorkshire, 2017



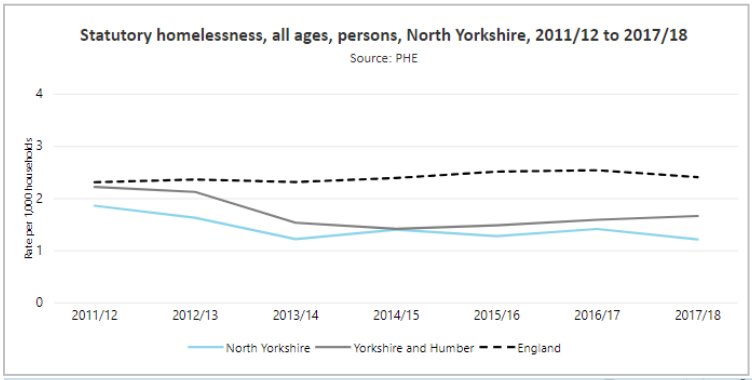
In 2017, 9% of households (24,045 households) in North Yorkshire were classified as fuel poor, lower than the national average (11%). Scarborough has the highest proportion of households classified as fuel poor at 12%. Merely tackling poverty would not necessarily relieve fuel poverty, as often housing type and access to affordable sources of energy are important. Tackling fuel poverty should in turn improve winter health, decreasing excess winter mortality and subsequently the pressure on the health and care system during the winter months. Further information on the North Yorkshire Winter Health Strategy 2015-20 can be found at the North Yorkshire Partnership website.

Excess Winter Mortality (EWM) Index, North Yorkshire
Source: PHE, England and Wales, August 2016 to July 2017



There is some variability in the excess winter mortality trend in the county over time, mirroring the trend seen in both Yorkshire and the Humber and England. In 2016/17 the Excess Winter Mortality index increased from 12 to 26 in the county and is now higher the national average of 22; however, this is not statistically significant. All districts in the county have values that are statistically similar to the England value. While there is some variation across the county, the small numbers mean that these data must be interpreted with caution.

Statutory homelessness, all ages, persons, North Yorkshire, 2011/12 to 2017/18
Source: PHE



The rate of homeless households has decreased in North Yorkshire since 2011/12 and is currently 1.2 per 1,000 households. This is below both the Yorkshire and the Humber (1.7 per 1,000) and England (2.4 per 1,000) rates. Richmondshire and Scarborough districts are the only districts that have rates of statutory homelessness that are not significantly lower than England. At around 2.2 per 1,000 households, the rates in Richmondshire and Scarborough are statistically similar to the England rate.

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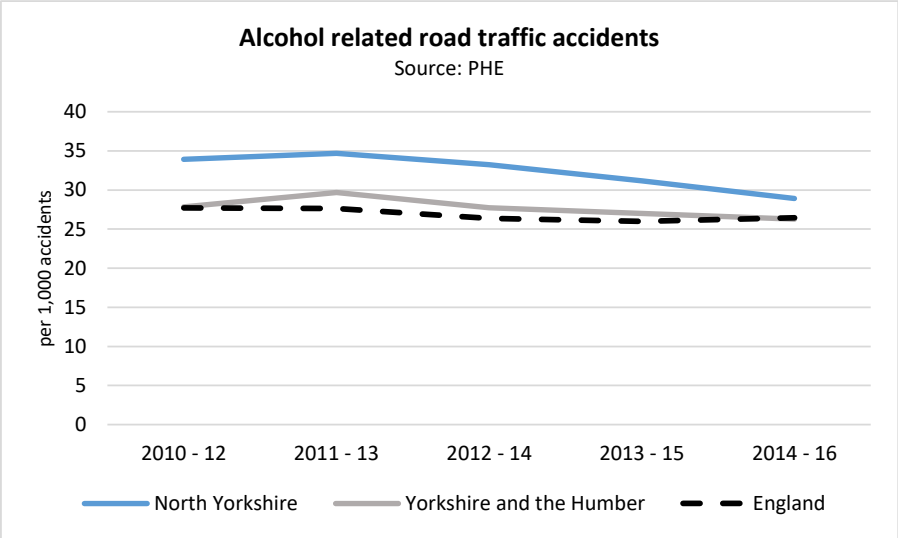
Wider determinants of health

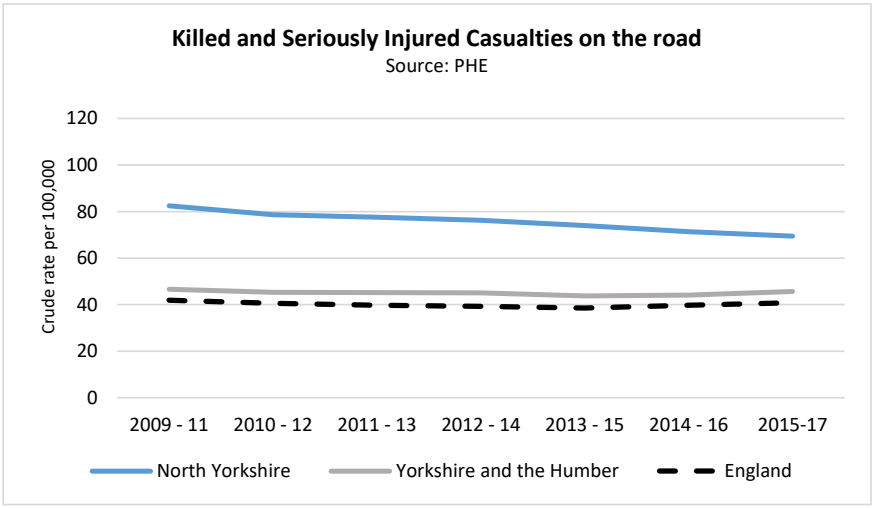
Transport

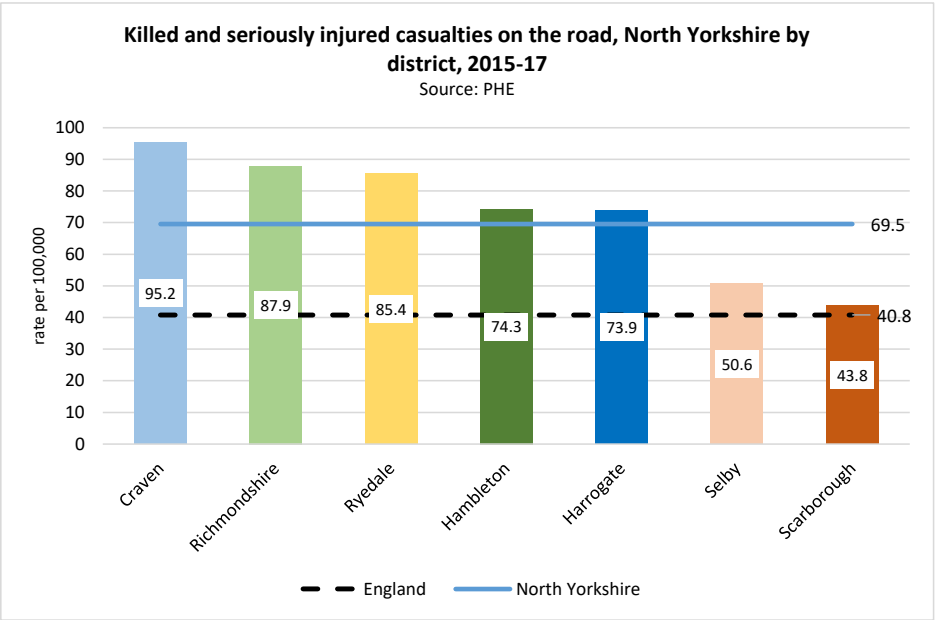


Alcohol consumption is responsible for around one in seven deaths in reported road traffic accidents in Great Britain. Any amount of alcohol affects people's ability to drive safely. The effects can include slower reactions, increased stopping distance, poorer judgement of speed and distance and reduced field of vision, all increasing the risk of having an accident or fatality.

The rate of alcohol-related road traffic accidents in North Yorkshire is 25 per 1,000 accidents and this is similar to the England rate of 26 per 1,000 accidents. Selby is the only district significantly higher than the national rate (46 per 1,000 accidents), and Scarborough is the only district that has a rate that is significantly lower than England rate at 13 per 1,000 accidents. All other districts are statistically similar to the national rate.

The rate of people being killed and seriously injured (KSI) casualties on roads in North Yorkshire is significantly higher than the national average at 70 per 100,000 population, versus 41 per 100,000 population in England. The Yorkshire and the Humber rate is also statistically higher than England, at 46 per 100,000. It is noteworthy that, while the regional and national rates are slowly increasing, the rate for North Yorkshire has been decreasing since 2009-11.



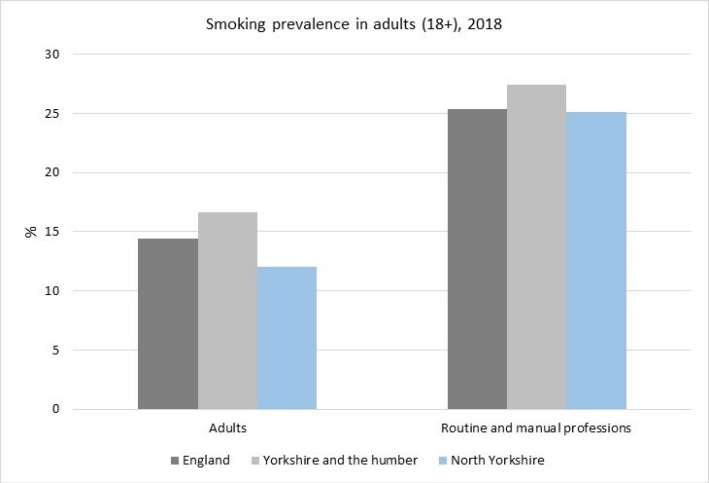


All districts in North Yorkshire have rates significantly higher than England, other than Scarborough (44 per 100,000 population), which is statistically similar to England . There are relatively small numbers of casualties and so must be interpreted with caution.

Across North Yorkshire, the rate of children killed and seriously injured on England's roads has decreased between 2013-15 and 2014-16 (from 22 per 100,000 population to 19 per 100,000 per population) and is now similar to the England average (17 per 100,000 per population). More information on staying safe on the road can be found in Safer Roads, Healthier Place: York and North Yorkshire Road Safety Strategy and at roadwise.co.uk.

Lifestyle and behaviour

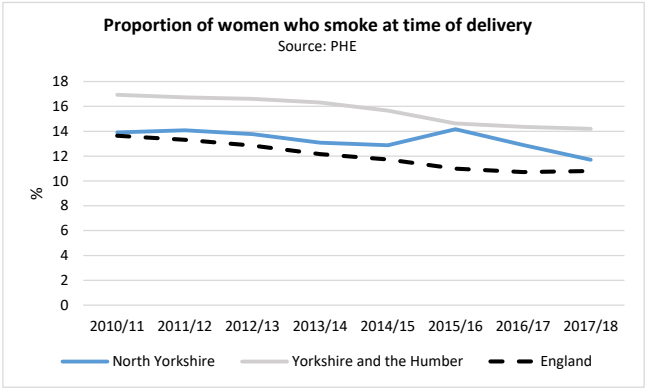
Smoking

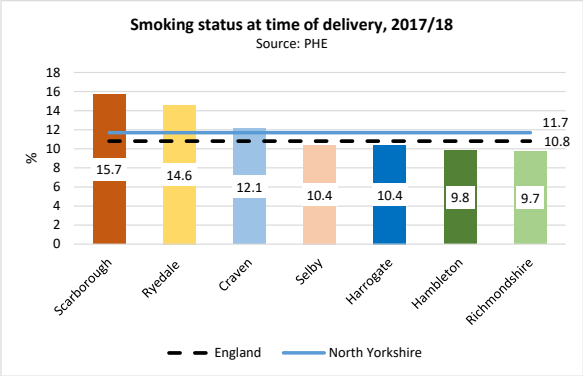


Smoking prevalence in North Yorkshire is significantly lower than England, at 12.0% versus 14.4%. Between 2017 and 2018 there has been a decrease in the proportion of smokers. All districts in North Yorkshire have smoking rates that are statistically similar to the England rate, other than Craven which has a rate of 13%, and is significantly lower than England.

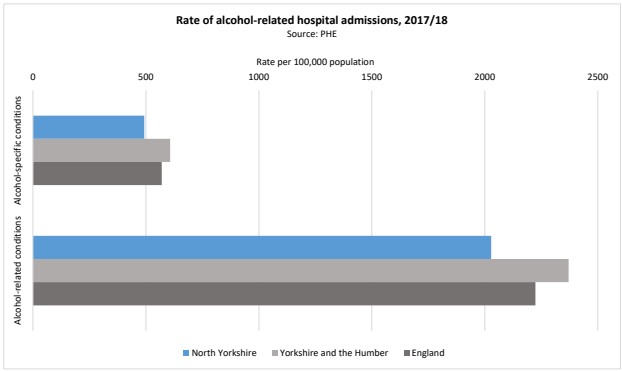
For adults in routine and manual professions, rates are higher than for the general population and prevalence in North Yorkshire is similar to England (25.1% locally vs 25.4% nationally). Craven district has the highest rates of smoking in routine and manual professions in the county.

Maternal smoking in pregnancy is detrimental for the health of both the mother and baby. In North Yorkshire, maternal smoking is currently estimated to be 11.7%, significantly higher than the England prevalence of 10.8%, but lower than the Yorkshire and the Humber rate. There are differences between the districts, with Richmondshire having the lowest rate (9.7%) in the county. Ryedale (14.6%) and Scarborough (15.7%) both have rates that are significantly higher than the England rate.





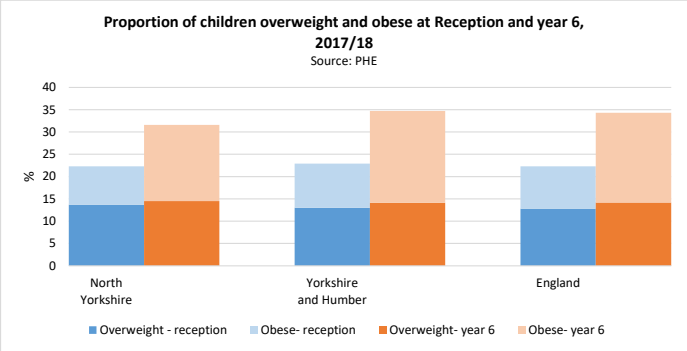
Alcohol



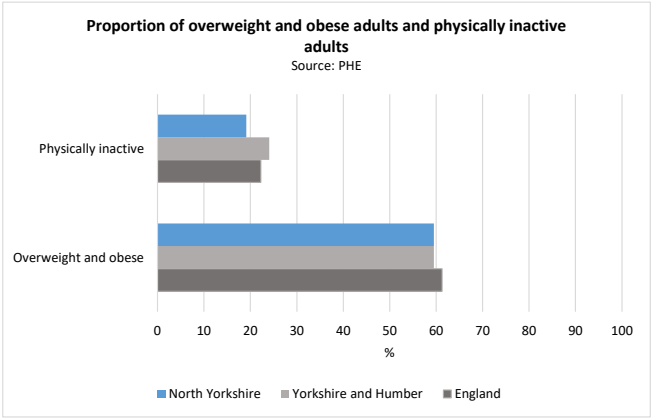
Implementing appropriate local interventions ensures we reduce misuse and harm associated with alcohol in our communities. Overall, the rate of admission episodes for alcohol-specific conditions in North Yorkshire is significantly lower than England, at 493 per 100,000 population compared with 570 nationally. Craven and Scarborough are the only districts with rates significantly higher than England. Alcohol misuse can be a contributing factor in many diseases, however, and it is important to also look at broader health conditions where alcohol may have had a role, including mental health. Comparing admissions for alcohol-specific conditions to admissions for alcohol-related conditions shows that most alcohol-related harm is due to prolonged use, manifesting in a wide range of health problems. For people admitted to hospital for alcohol-related conditions, the North Yorkshire rate is significantly lower at 2,028 compared with 2,224 per 100,000 population in England. Craven is significantly higher than England, at 2,441 per 100,000 population. Scarborough is similar to England (2,152 per 100,000) and the remaining districts have rates that are statistically lower than England. Further information on the 2014-2019 North Yorkshire Alcohol Strategy can be found on North Yorkshire Partnership website via the following link http://www.nypartnerships.org.uk/

Lifestyle and behaviour

Nutrition, activity and excess weight

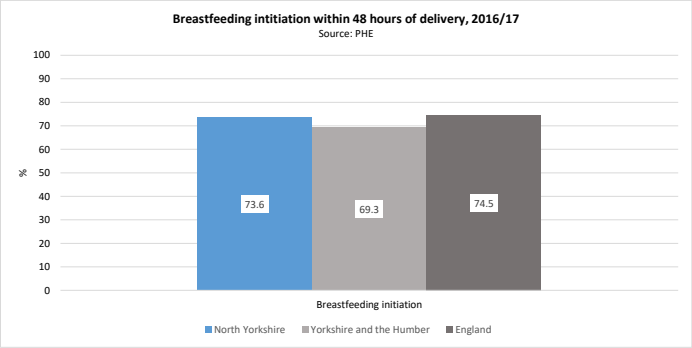


Childhood obesity is closely related to excess weight in adulthood. The proportion of children in Reception who are overweight or obese in North Yorkshire is similar to the figures seen in England (22% and 23%, respectively). Scarborough is the only district with a rate that is significantly higher than England, at 28%. The prevalence of children with excess weight in Year 6 is significantly lower in North Yorkshire at 32% compared with 34% in England. None of the districts have rates that are significantly higher than England. However, in North Yorkshire, there is a doubling of the proportion of obese children from Reception to Year 6, demonstrating that while the proportion of children in the county who carry excess weight is lower than the national average, it is still important to identify children at risk of excess weight early on. For overweight children, we only see a 6% increase between Reception and Year 6 but this could be that children change weight status (from overweight to obese) rather than indicating weight maintenance. Details of approaches to tackle excess weight across the lifecourse are in the strategy Healthy Weight, Healthy Lives: Tackling overweight and obesity in North Yorkshire 2016-2026.



Physical activity is associated with better health. Adults are identified as being inactive if they engage in less than 30 minutes of physical activity per week. The proportion of inactive adults in North Yorkshire is significantly lower than England at 19% compared with 22%. Craven (16%), Harrogate (15%) and Richmondshire (17%) all have proportions of inactive adults statistically lower than England. Targeting adults who are inactive will have a greater impact on the reduction of chronic disease, including those related to excess weight. Tackling obesity is a priority area for Government as a way to decrease premature mortality and avoidable ill health. The proportion of adults who are overweight or obese in North Yorkshire is 60%—statistically similar to England at 61%. There are no districts in the county with a statistically higher proportion of adults who are overweight or obese.

The Government recommends that adults eat at least five portions of fruit and vegetables daily. Self-reported fruit and vegetable consumption shows that North Yorkshire 62% of adults report consuming five portions a day, significantly better than the England average (57%). However, this indicates that nearly 40% of adults in North Yorkshire could improve their diet.



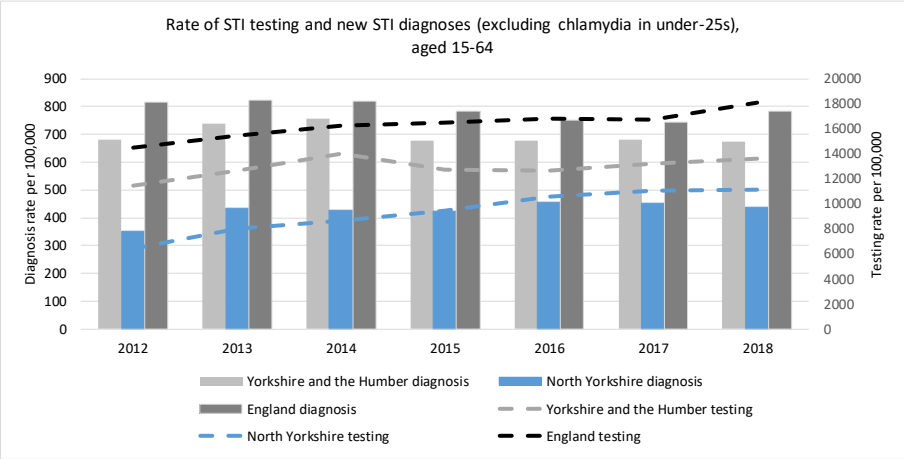
Breastfeeding provides benefits to the health and wellbeing of both mother and child. In North Yorkshire, approximately 74% of mothers in 2016/17 initiated breastfeeding within 48 hours of delivery. This is statistically similar to the England proportion (75%). In Harrogate, 83% of mothers initiate breastfeeding within 48 hours of delivery—the highest in the county. Scarborough, on the other hand, has the lowest initiation rate in the county at 61%. Both districts could provide learning opportunities regarding the benefits and barriers to breastfeeding initiation.

In order to increase breastfeeding, a strategy and action plan has been developed in partnership with York that is focusing on:

- Increasing initiation of breastfeeding in
- Increasing breastfeeding at 6-8 weeks
- Reducing the gap between breastfeeding rates in the most deprived areas/population groups and the York and North Yorkshire average

Lifestyle and behaviour

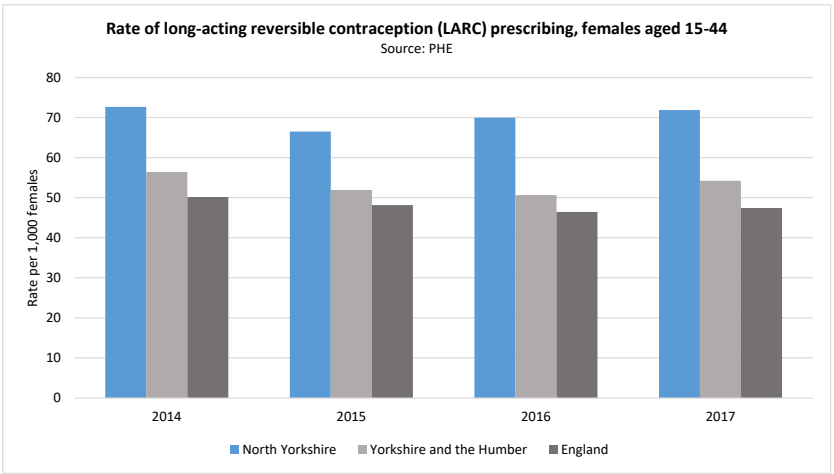
Sexual health



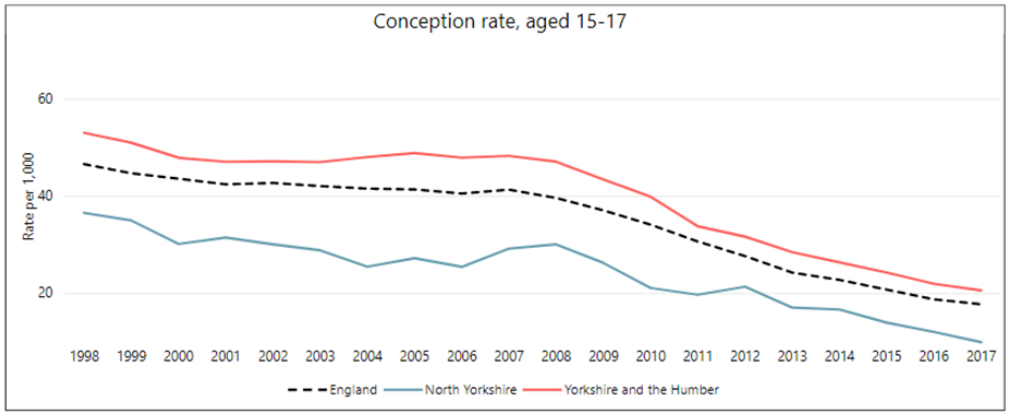
It is important that we have a good understanding of local sexual health needs in order to provide the most appropriate services and interventions. In North Yorkshire, the rate of new Sexually Transmitted Infection (STI) diagnoses for 2018 at 438 per 100,000 population is significantly lower than the rate of 794 per 100,000 in England. This excludes chlamydia diagnoses in the under 25's as they have their own active screening programme in place.

The STI testing rate for the same time period shows that North Yorkshire is significantly lower than England. All districts in the county follow the same pattern as North Yorkshire—significantly lower diagnoses of new STIs but also a significantly lower testing rate. There are many factors which can explain a low diagnosis rate; it is not necessarily indicative of a lower prevalence of disease. When accompanied by a low rate of testing, it is important to consider if all of those who need to be tested within the population have services that are accessible and available to them.

Long-acting reversible contraception (LARC) is recommended as a cost-effective and effective form of birth control. As part of the priority to make a wide-range of contraceptive services available to all, LARC prescription measurement is often used as a proxy measure for access to wider contraceptive services. An increase in access to contraceptive services is thought to lead to a reduction in unintended pregnancies. The prescription rate for LARC in North Yorkshire at 72 per 1,000 women aged 15-44 is significantly higher than the rate seen in England of 46 per 1,000 women. All the districts in the county have prescribing rates that are significantly better than the England rate, but Scarborough has the highest in the county at 87 per 1,000 women aged 15-44.



Unplanned pregnancies at any stage of life can have an impact on women's health and well-being. There is a great deal of attention paid to the experiences of teenagers who have an unplanned pregnancy, particularly in relation to the wider determinants of health including education, housing and poverty. The teenage conception rate in North Yorkshire is significantly lower than the overall England rate at 10 per 1,000 women aged 15-17 compared to 18 per 1,000 women aged 15-17, continuing an overall downward trend in teenage conceptions. No district in the county has a statistically higher rate of under-18 conceptions than England.



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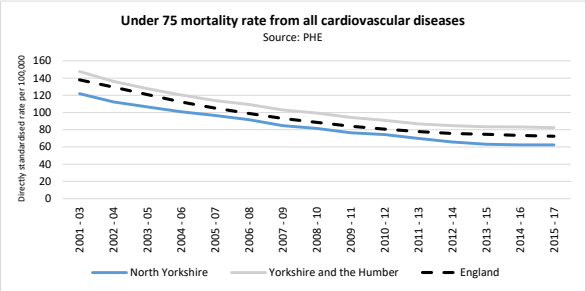
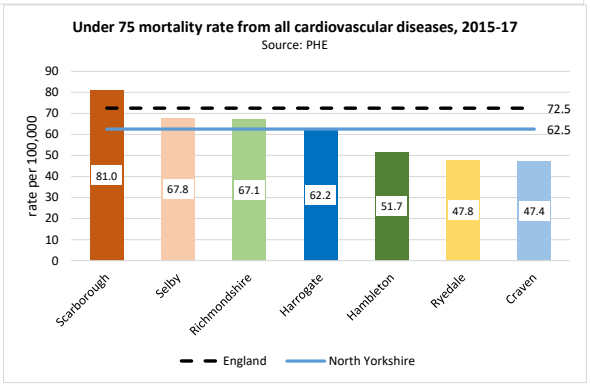
Diseases and Death

Major causes of death

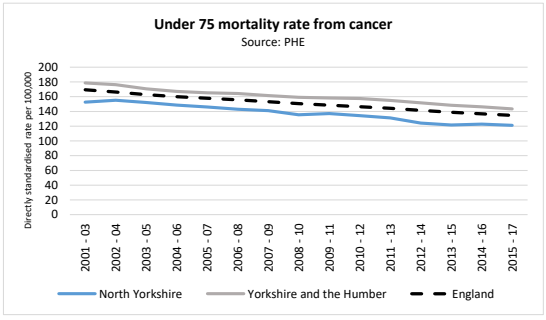
In North Yorkshire, there were 6,546 deaths in 2017. Nearly two-thirds of deaths fell under just three broad causes: 1,801 (28%) due to cancer; 1,827 (28.0%) due to circulatory disease; and 838 (13%) due to respiratory diseases.



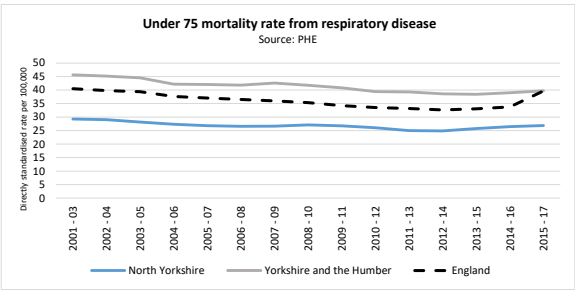
The rate of mortality for individuals aged under 75 from cardiovascular disease has decreased in North Yorkshire between 2001-03 and 2015-17, and at 63 per 100,00 population is significantly lower than both the national (73 per 100,000) and Yorkshire and the Humber (83 per 100,000) average. None of the districts in North Yorkshire have a rate statistically higher than the England rate. There is evidence of some variation between districts, with Scarborough having the highest rate of premature mortality from cardiovascular disease at 81 per 100,000. Though this is higher than the England rate, it does not reach statistical significance. Craven (47), Hambleton (52), Harrogate (62) and Ryedale (48) all have rates that are statistically lower than the England and Yorkshire and the Humber rates.



The rate of mortality for individuals aged under 75 from cancer has decreased in North Yorkshire between 2001-03 and 2015-17, and at 121 per 100,000 population and is now significantly lower than the national (137 per 100,000) and Yorkshire and the Humber (146 per 100,000) average. The most common death from cancer for individuals aged under 75 in North Yorkshire in 2017 were cancers of the trachea, bronchus and lungs (158 deaths). 66% percent of these deaths occurred in those aged between 65-74. There were no cancer-related deaths reported in the county in 2017 for anyone aged under 44.

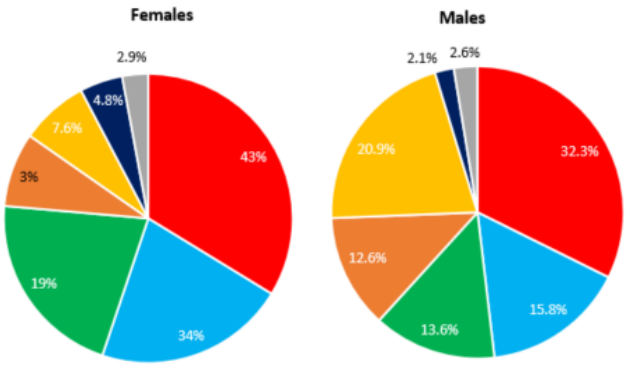


The overall rate of deaths in those under 75 related to respiratory disease in North Yorkshire is 27 per 100,000 population. This is statistically better than the rate in both England (34) and Yorkshire and the Humber (40). All the districts in the county had rates statistically lower than both England and Yorkshire and the Humber, other than Scarborough and Selby who were statistically similar to the England rate. However, the rate in North Yorkshire has slightly increased since 2013-15, so this should be monitored to determine if this is a lifestyle or behaviour related health trend, or if it is representative of shifting demographics in the county.



Inequality

The following charts show causes of death which contribute towards the life expectancy gap between the most deprived and least deprived areas in North Yorkshire (2015-17). The biggest contributors to the gap for women are circulatory and cancer diseases, accounting for more than 50% of the gap. For men, circulatory is the greatest contributor to the gap, accounting for 32% but other causes of death account for 21% of the gap, and this includes diabetes, infectious diseases and urinary conditions.



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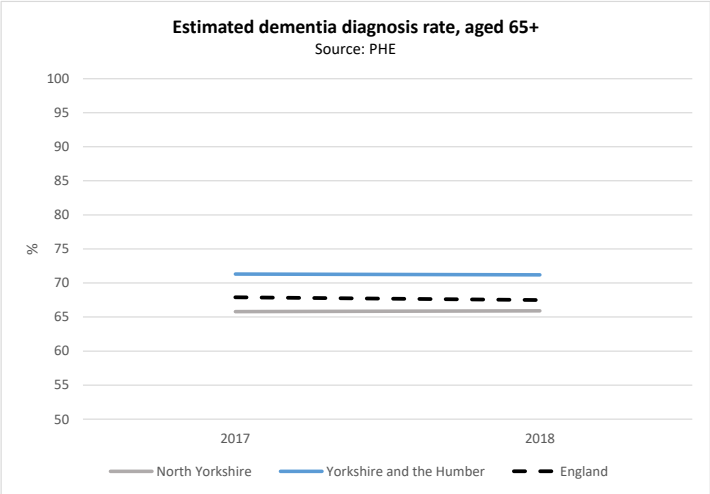
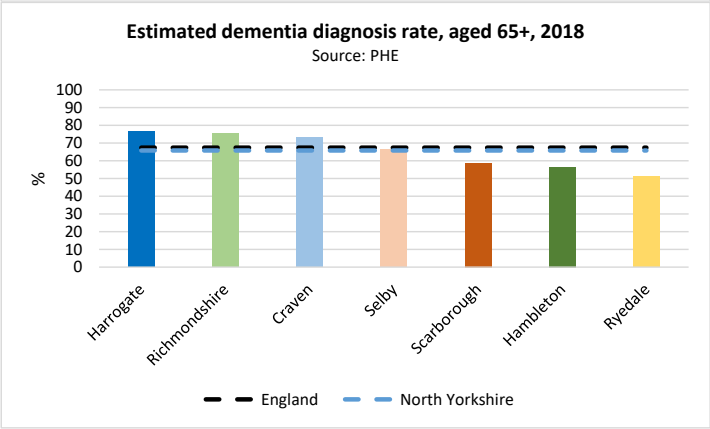
Strategic Support Service.

Diseases and Death

Dementia





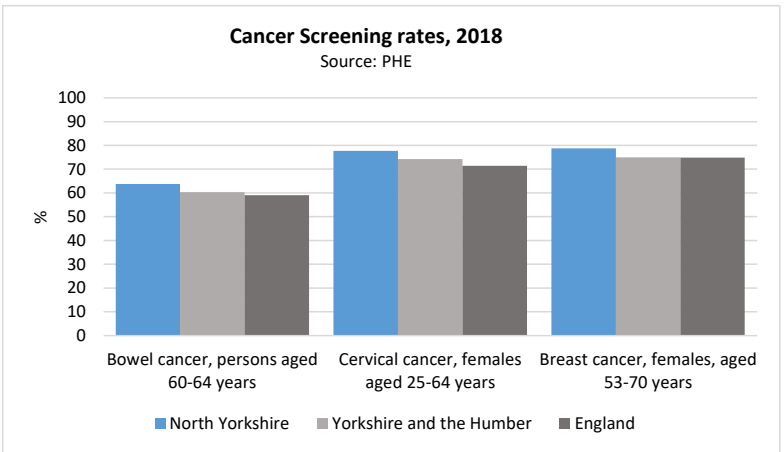
The Government and NHS has set a commitment that at least two-thirds of people living with dementia receive a formal diagnosis. Like the England rate, the North Yorkshire is statistically similar to the target of 66.7% (66% in North Yorkshire and 68% in England). There are 5,845 people aged 65+ with a formal dementia diagnosis in North Yorkshire.

Only Harrogate district has a diagnosis rate that is significantly higher than the target, with it being estimated that 77% of people living with dementia are diagnosed in the district. Hambleton (57%), Ryedale (51%) and Scarborough (59%) all have estimated diagnosis rates that are significantly lower than the 66.7% target.

Timely diagnosis of dementia enables the people living with dementia, their carers and healthcare staff to work together and plan accordingly. The lower rate of diagnosis in these districts needs to be investigated to determine how to improve early intervention for the portion of the affected population who do not have a formal diagnosis. NHS Health Check works to identify people at risk of vascular diseases, including vascular dementia to help improve health outcomes. More information on NHS Health Checks can be found via FingerTips website.

Cancer screening

Cancer screening supports early detection of disease. Screening programmes target key demographics to help with is early detection. In North Yorkshire, as for England, there is there is greater uptake of screening for cervical cancer when compared to bowel cancer. Despite the low uptake of screening for bowel cancer in North Yorkshire, the 2018 rate is significantly higher than the England average (64% locally compared to 59% nationally). All districts in the county have statistically higher screening rates for bowel cancer compared to the England average.



Breast cancer screening coverage was 79% in 2016-17, and was statistically higher than the England coverage rate of 75%. All districts but Scarborough were had statistically higher coverage rates than England. Scarborough's rate of 75% was statistically similar to England. Coverage for cervical cancer is also statistically higher in North Yorkshire compared to England, at 78% compared to 71%. All districts have significantly higher screening coverage for cervical cancer when compared to England. Screening rates for both breast and cervical cancers have shown some signs of decreasing in the county, and this should be monitored to ensure a decreasing trend does not emerge. Screening for cancer leads to diagnosis at an earlier stage, leading to improved outcomes and increased survival. There is minimal variation across the districts in screening coverage overall.

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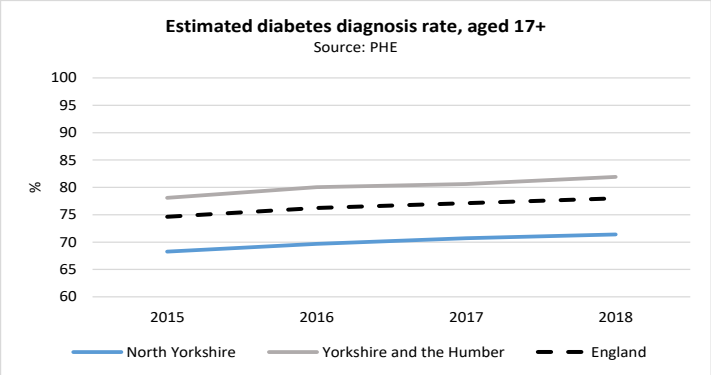
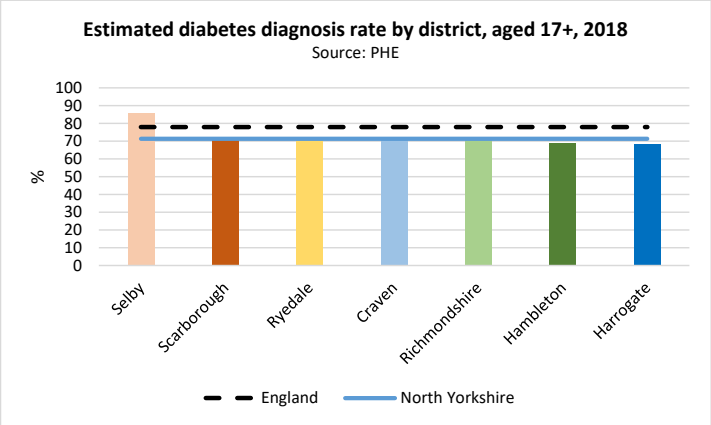
Diseases and Death

Diabetes



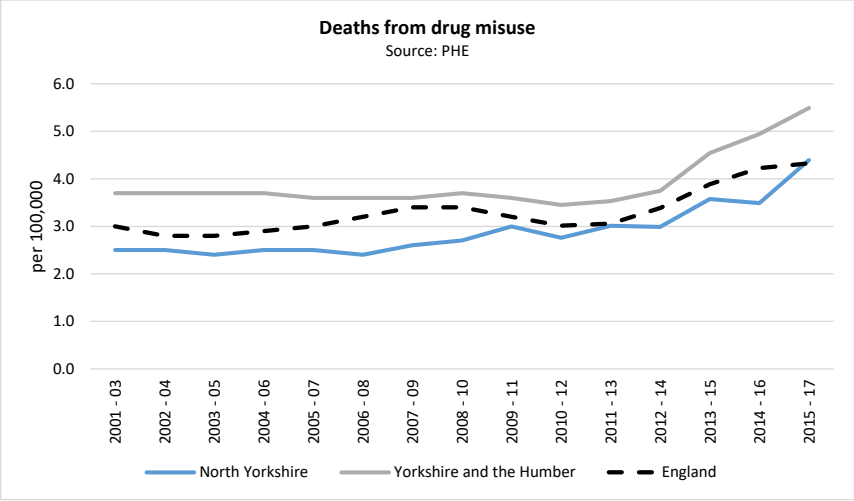


Complications from diabetes result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes is typically associated with excess weight, and can be prevented or delayed by lifestyle changes.

To implement effective interventions, it is important to identify all cases. The gap between observed prevalence (the number of diabetes cases recorded) and the actual prevalence (observed plus those who are undiagnosed) helps to quantify those who may be untreated. In North Yorkshire, it is estimated that only 71% of diabetes cases are diagnosed, significantly lower than both Yorkshire and the Humber (81%) and England (78%). Selby is the only district with a rate that is statistically better than England at 85% of cases diagnosed. All other districts are significantly below the England rate.

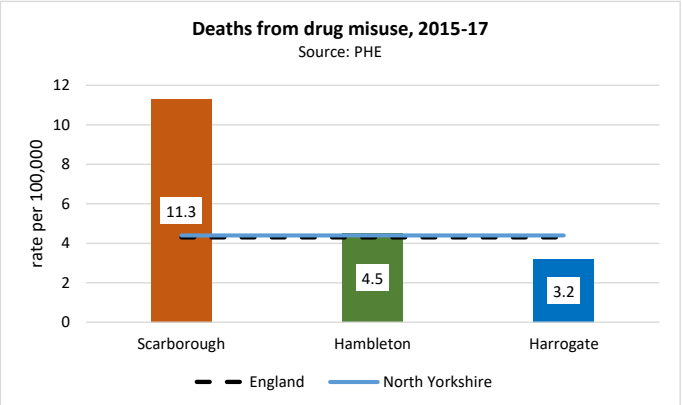
The NHS Diabetes Prevention Programme aims to identify those at high risk of developing diabetes and the NHS Health Checks programme routinely tests for those at risk of developing diabetes.

Substance Misuse



Overall, drug misuse is a considerable cause of premature morbidity in the UK. Recently, an increase nationally has been seen in drug-related deaths. In North Yorkshire, the rate of deaths from drug misuse in 2015-17 is statistically similar to England, at 4.4 per 100,000 population compared to 4.3 per 100,000 population. As seen nationally, the rate has increased slightly between 2014-16 and 2015-17 in the county. Between 2001-03 and 2015-17 deaths from drug misuse have remained similar to the England average.

Because of small numbers, data around deaths from drug misuse is not available for all the districts in the county. When we look at those with available, data, the only district in the county with a rate higher than the England or Yorkshire and the Humber average is Scarborough, at 11.3 per 100,000. Both Hambleton and Harrogate have rates that are statistically similar to England.



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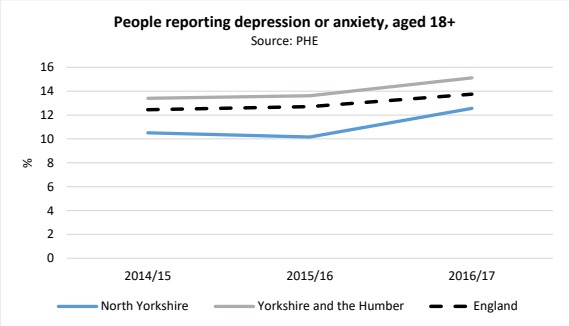
Diseases and death

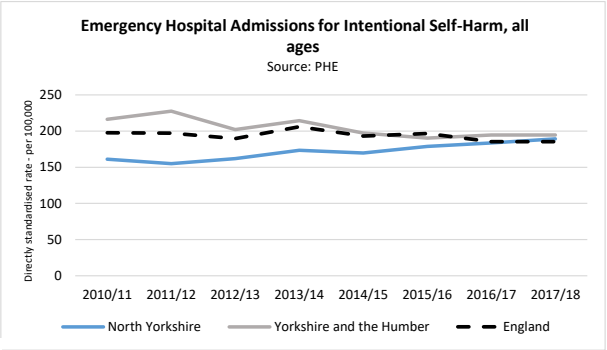
Mental Health

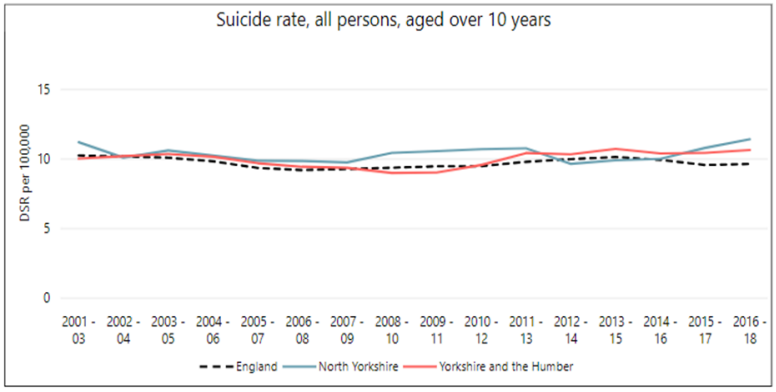
The percentage of individuals reporting depression or anxiety in North Yorkshire (13%) is statistically lower than the national average (14%). The percentage of individuals reporting depression or anxiety has increased by 2% in North Yorkshire from 2014/15 to 2016/17. Scarborough was the only district that had a rate that was significantly higher than the England rate, with 16% of people aged over 18 reporting anxiety or depression.



The rate of individuals with long-term musculoskeletal disease who report feeling depressed or anxious is significantly lower in North Yorkshire when compared to England (20% compared to 24%).

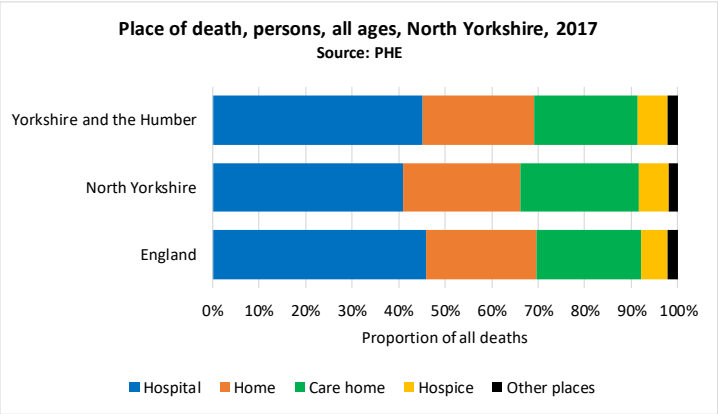
North Yorkshire has a similar rate of hospital admissions for intentional self harm (189 per 100,000 population) compared to the overall England rate (185 per 100,000 population). The proportion of hospital admissions for intentional self harm in the county has increased between 2014/15 and 2017/18. Craven and Scarborough both have rates significantly higher than the England rate, at 256 per 100,000 and 255 per 100,000, respectively.





Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. The suicide rate in North Yorkshire has maintained at around 10 per 100,000 population since 2002, and the 2016-18 rate is significantly higher than the England average (11.4 per 100,000 locally compared to 9.6 per 100,000 nationally). The suicide rate for males is higher than females in North Yorkshire and this is in line with national trends, and the rate for males in North Yorkshire is similar to the England rate (17 per 100,000 compared to 15 per 100,000). The North Yorkshire rate for females is also similar to the England rate (5.6 per 100,000 locally compared to 4.7 per 100,000 nationally). However, these are small numbers and should be interpreted with caution. Further information can be found in the Suicides Audit in North Yorkshire 2015 and on the North Yorkshire Partnerships Suicide Prevention webpage.

End of Life Care



The North Yorkshire Joint Health and Wellbeing Strategy includes an ambition to increase the number of people dying either at home or place that they chose by 2020. In recent years, the proportion of people dying at home in North Yorkshire has tended to increase. North Yorkshire has a similar proportion of people dying at home when compared to regional and national rates. Nearly 50% of people are still dying in hospital, but in North Yorkshire in 2016, 56% of people died at home, at a care home or hospice.

Prepared by:
Emel Perry, Public Health Intelligence Analyst
Leon Green, Senior Public Health Intelligence Specialist
Judith Yung, Public Health Intelligence Analyst

Contact: nypublichealth@northyorks.gov.uk

January 2019

North Yorkshire Joint Strategic Needs Assessment 2019
Vale of York CCG Profile

Introduction

This profile provides an overview of population health needs in Vale of York CCG (VoY CCG). Greater detail on particular topics can be found in our Joint Strategic Needs Assessment (JSNA) resource at www.datanorthyorkshire.org. This document is structured into five parts: population, deprivation, disease prevalence, hospital admissions and mortality. It identifies the major themes which affect health in VoY CCG and presents the latest available data, so the dates vary between indicators.

Summary

- **Life expectancy is higher than England**. For 2011-2015, female life expectancy in VoY CCG is 83.6 years (England: 83.1), and male life expectancy is more than three years lower than for females at 80 years (England: 79.4) [1].
- **There is a high proportion of older people**. In 2017, 19.6% of the population was aged 65 and over (68,900), higher than national average (17.3%). Furthermore over 9,100 (2.6%) were age 85+, compared with 2.3% in England. [2]
- **Some children grow up in relative poverty**. In 2015, there were 11.2% of children aged 0-15 years living in low income families, compared with 19.9% in England [1].
- **There are areas of deprivation**. Within the CCG area, 7 Lower Super Output Areas (LSOAs) out of a total of 206 are amongst the 20% most deprived in England, and one these LSOAs is amongst the 10% most deprived in England. This is in Selby West ward in Selby District. [3]
- **Many people have longstanding health problems**. The census in 2011 showed 54,300 people living with long-term health problem or disability (15.8% compared to 17.6% in England) [1].
- **The highest reported rates of ill health are** from: hypertension (13.4%); obesity (9.8%); depression (9%); asthma (6.1%); and diabetes (5.6%) [4].
- **Hospital admissions vary according to admissions route**. Non-elective admissions are most frequently due to respiratory problems (12.8%); injury, poisoning and certain other consequences of external causes (12.8%); and circulatory diseases (11.5%). Elective admissions are most common for neoplasms (19.5%); digestive disorders (12.8%) and musculoskeletal problems (11.3%) [5].

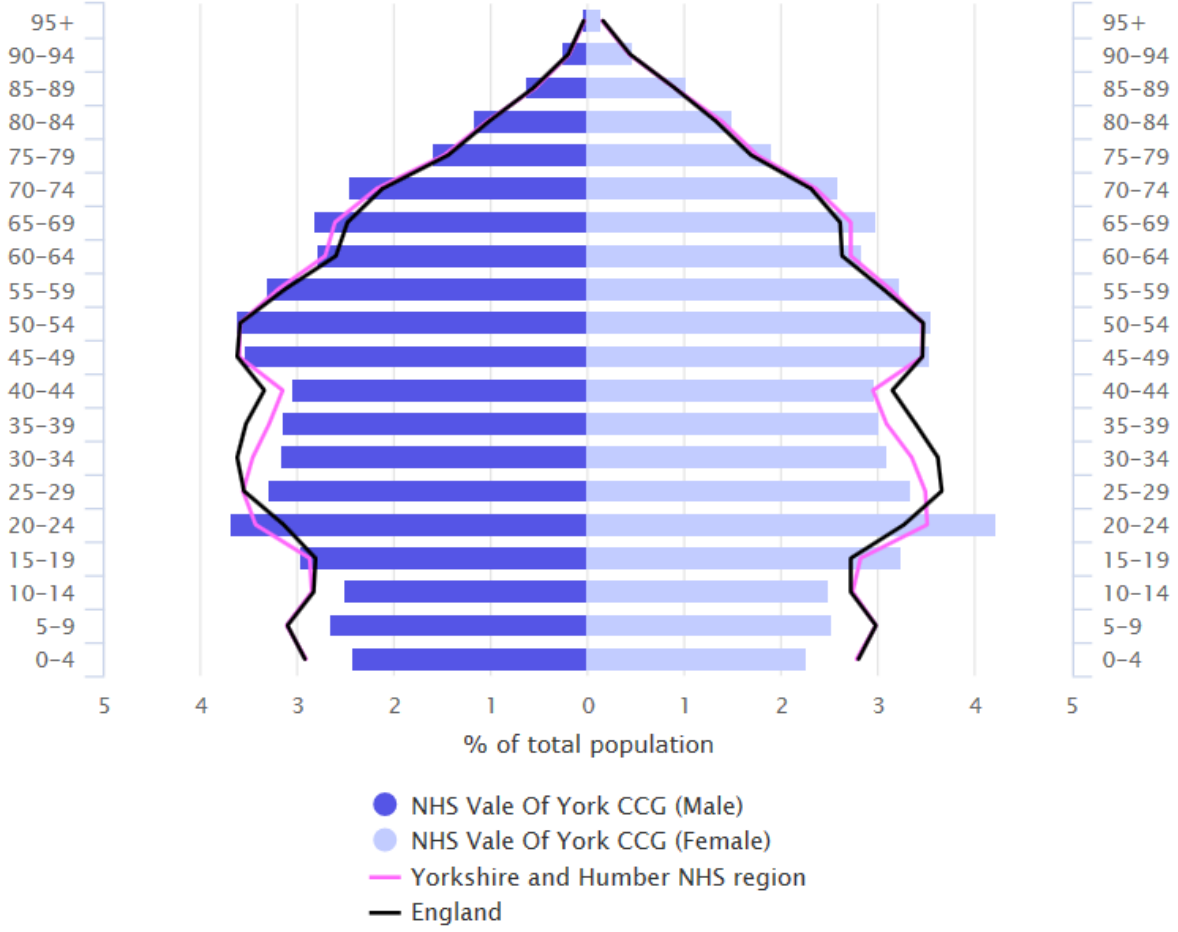
Population

There are 26 general practices in VoY CCG area with 357,000 registered patients (December 2018) [6]. In contrast, the ONS mid-year resident population estimate for 2017 gave a CCG-wide population of 359,600 [7]. The GP registered population in VoY CCG is 0.7% lower than the resident population, whereas in England, the registered population is 7% higher than the resident population.

The resident population is forecast to rise to 372,400 by 2025 (3.1% increase since 2018) and 388,500 by 2040 (7.6% increase since 2018) [8]. In England, the corresponding increases are 4% by 2025 and 10.3% by 2040. Local population growth is forecast to be lower than that seen nationally.

There is a high proportion of people aged over 65 (19.6%) in VoY CCG compared with England (17.3%). The proportion of people aged 5-14 (10.2%) is slightly lower than England (11.6%). The following age profile shows a lower proportion of the population in age groups 0-14 years and 25-39 years; and a higher proportion in age groups 15-24 years and 50-95+, compared with both England and the Yorkshire & Humber region.

Age Profile – GP registered population by sex and five-year age band 2017

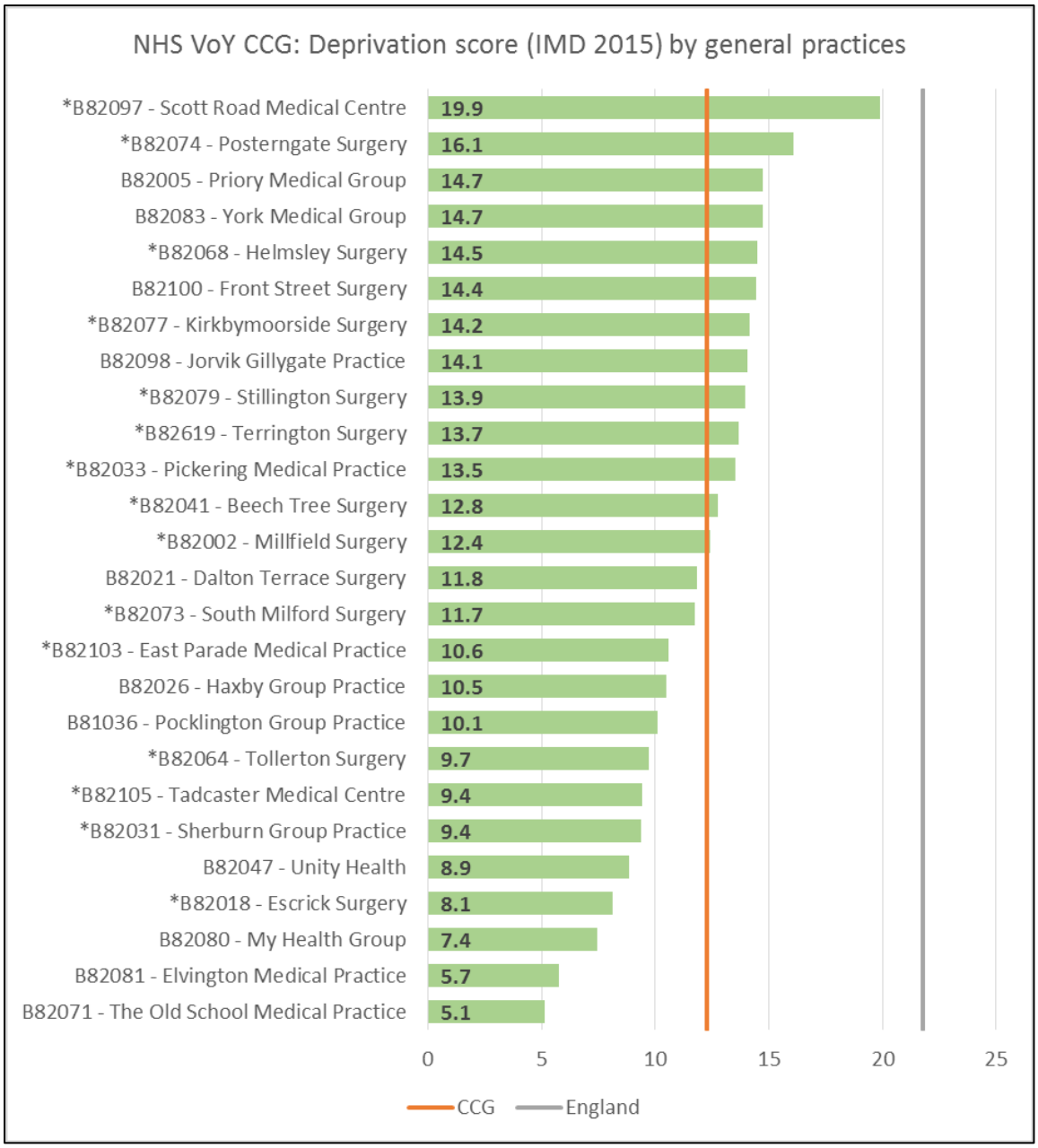


Source: National General Practice Profiles, PHE

Deprivation

In 2015, 11.2% of children aged 0-15 years living in low income families, compared with 19.9% in England [1]. The 2015 Index of Multiple Deprivation (IMD) identifies 7 Lower Super Output Areas (LSOAs) out of a total of 206 across the CCG which are amongst the 20% most deprived in England, and one these LSOAs is amongst the 10% most deprived in England. This is in Selby West ward in Selby. 5 LSOAs in York (in Westfield, Clifton and Guildhall wards) and one LSOA in Selby (Selby East ward) are amongst the 7 LSOAs (20% most deprived in England) [3]. A list of these 15 LSOAs can be found in Appendix 1.

Deprivation scores, using IMD-2015, have been estimated for general practices. They show no practices in VoY CCG have populations experiencing higher levels of deprivation than England.



Source: National General Practice Profiles, PHE

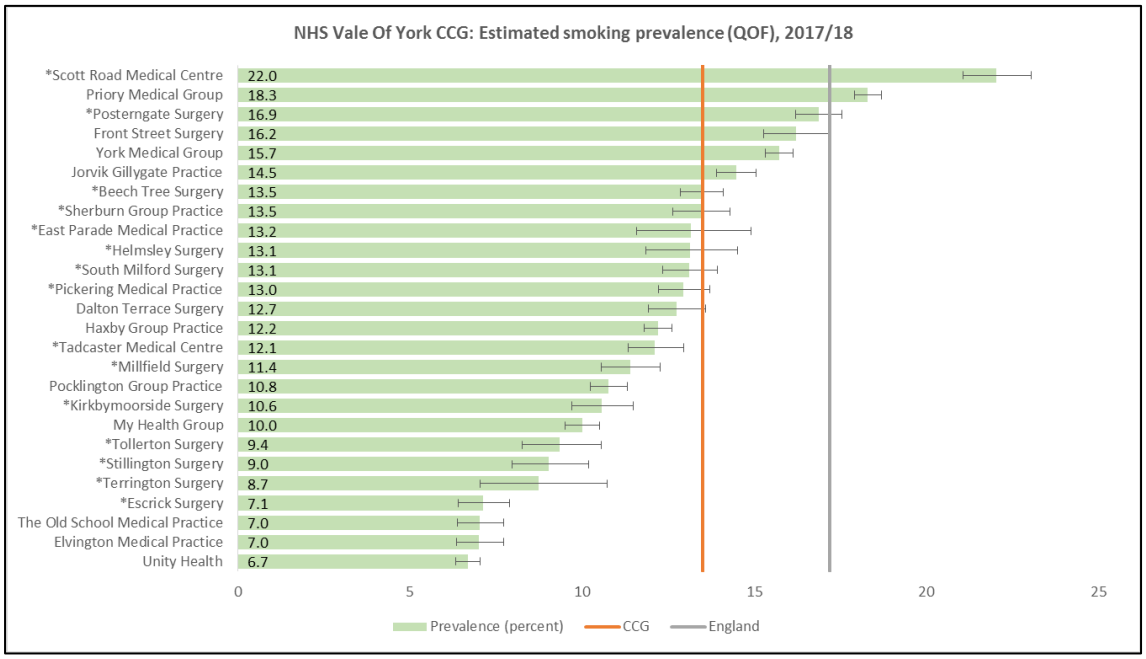
* Practices within North Yorkshire.

Lifestyle and behaviour

The lifestyle choices that people make and behaviours they follow in their lifetime can all have an impact on both their current and future health. Lifestyle diseases are defined as diseases linked with the way people live their life. They are commonly caused by alcohol, drug abuse and smoking as well as lack of physical activity and unhealthy eating.

Smoking

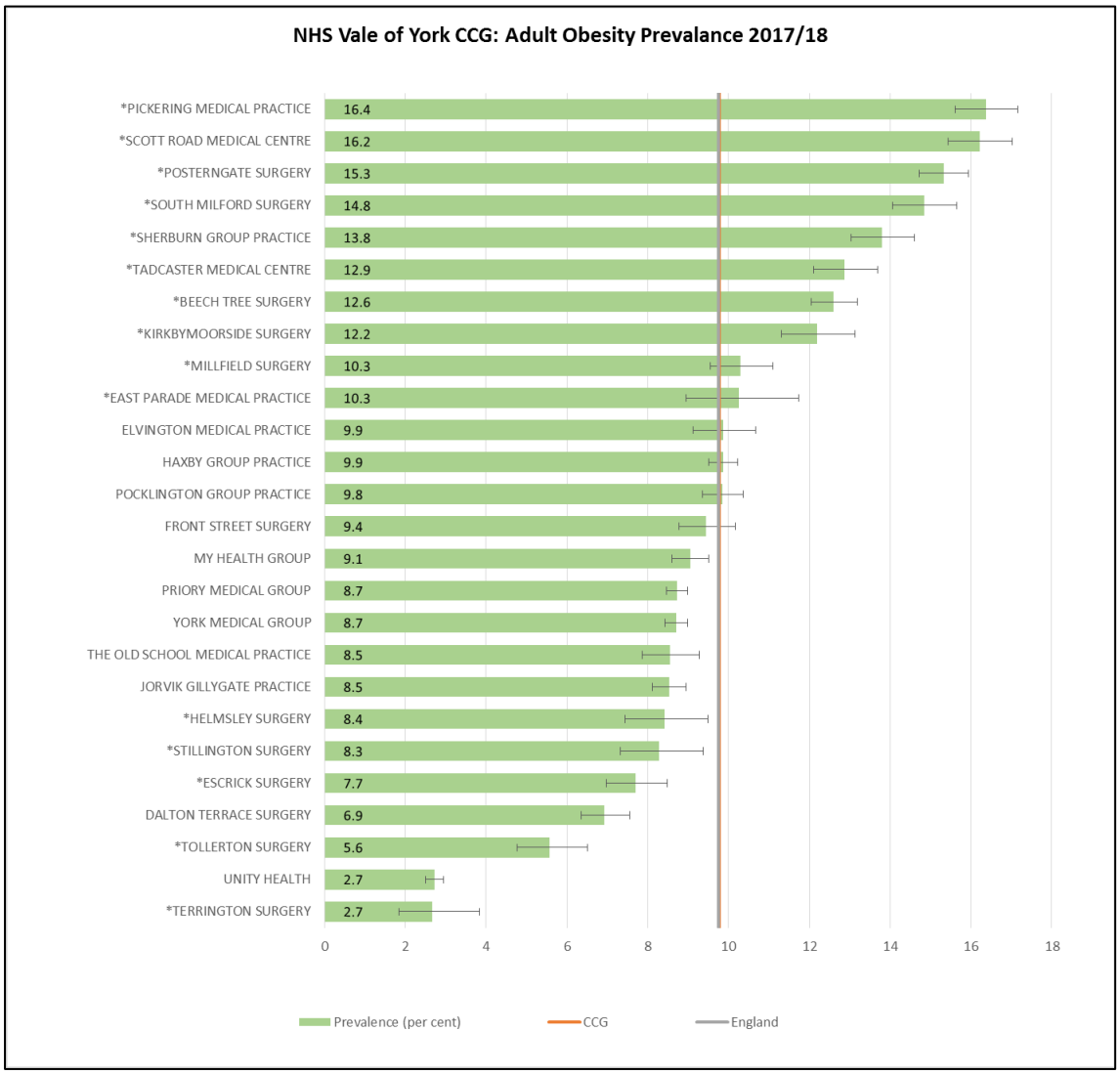
VoY CCG has a lower rate of smoking prevalence compared to England. Six practices have rates which are significantly higher than England and CCG average and over half of practices have significantly lower rates than CCG and England averages.



Source: National General Practice Profiles, PHE

Adult obesity

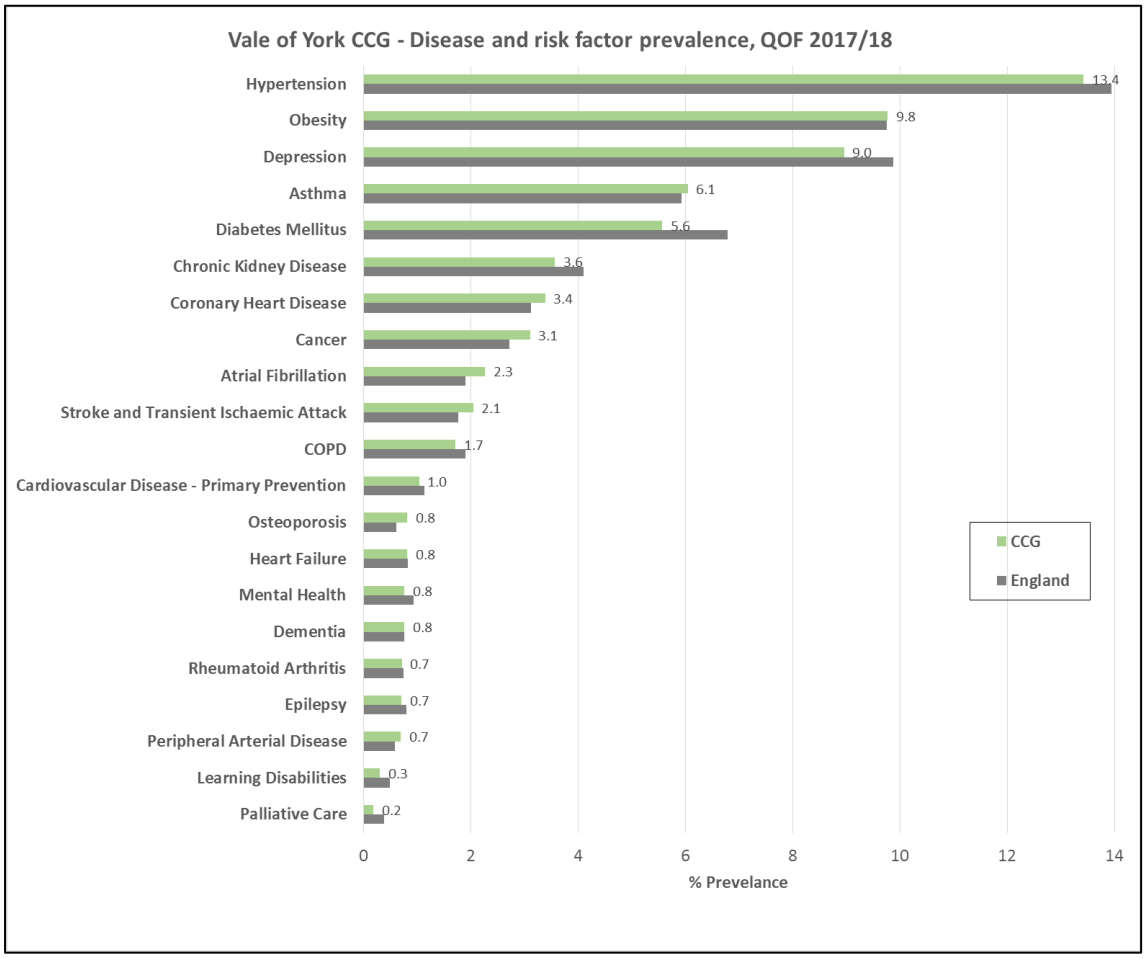
The adult obesity prevalence in VoY CCG is very similar compared to England (9.77% and 9.76% respectively). There are 28,700 adults with a recorded body mass index above 30 kg/m^2. Eight practices have rates which are significantly higher than VoY CCG as well as England, while 12 practices are significantly lower compared to VoY CCG and England.



Source: NHS Digital

Disease Prevalence

In VoY CCG, hypertension, obesity and depression are the most common health problems, followed by asthma and diabetes. The prevalence for about half of the diseases and risk factors is higher in VoY CCG than for England, but lower in about half.



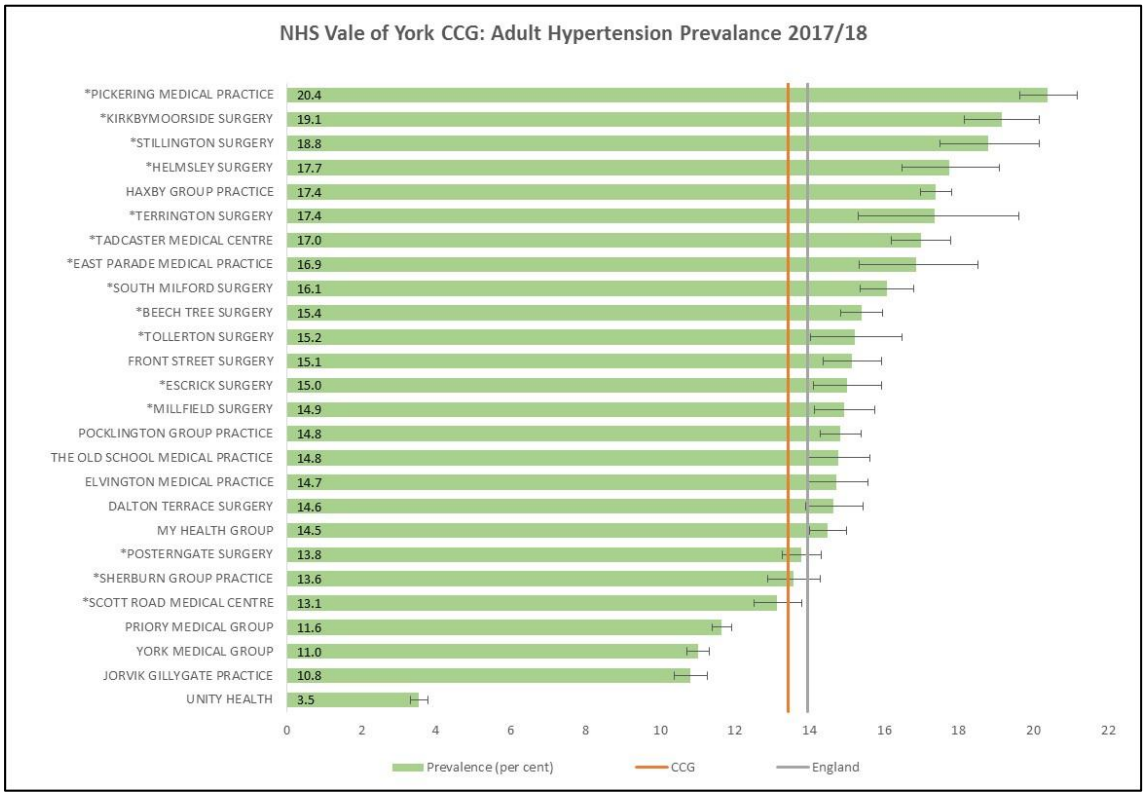
Source: NHS Digital

Disease prevalence by general practice

The following charts use the NHS Quality and Outcomes Framework prevalence data for 2017/18. These are expressed as crude percentages, without taking account of variation in the populations between general practices. Differences such as the proportion of elderly patients, ethnicity and levels of deprivation may affect crude prevalence rates. The charts are presented in order of recorded prevalence, from highest to lowest, within the CCG. Practices within North Yorkshire are indicated by an asterisk (*).

Hypertension

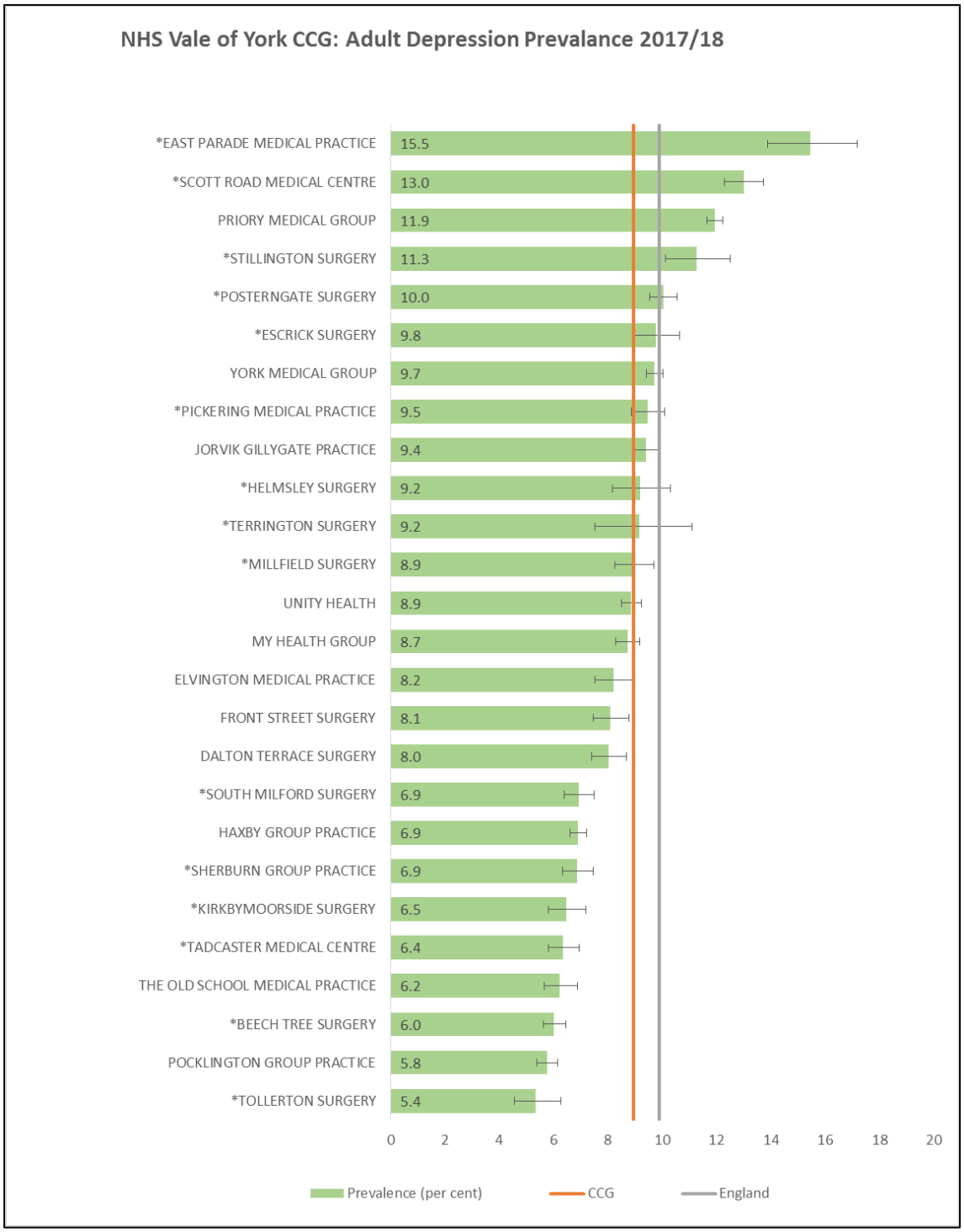
In VoY CCG, there are 47,900 people with known hypertension and prevalence is lower than England. Fourteen general practices have rates significantly higher than England, whilst five have significantly lower rates, seven practices have significantly similar prevalence to England.



Source: NHS Digital

Depression

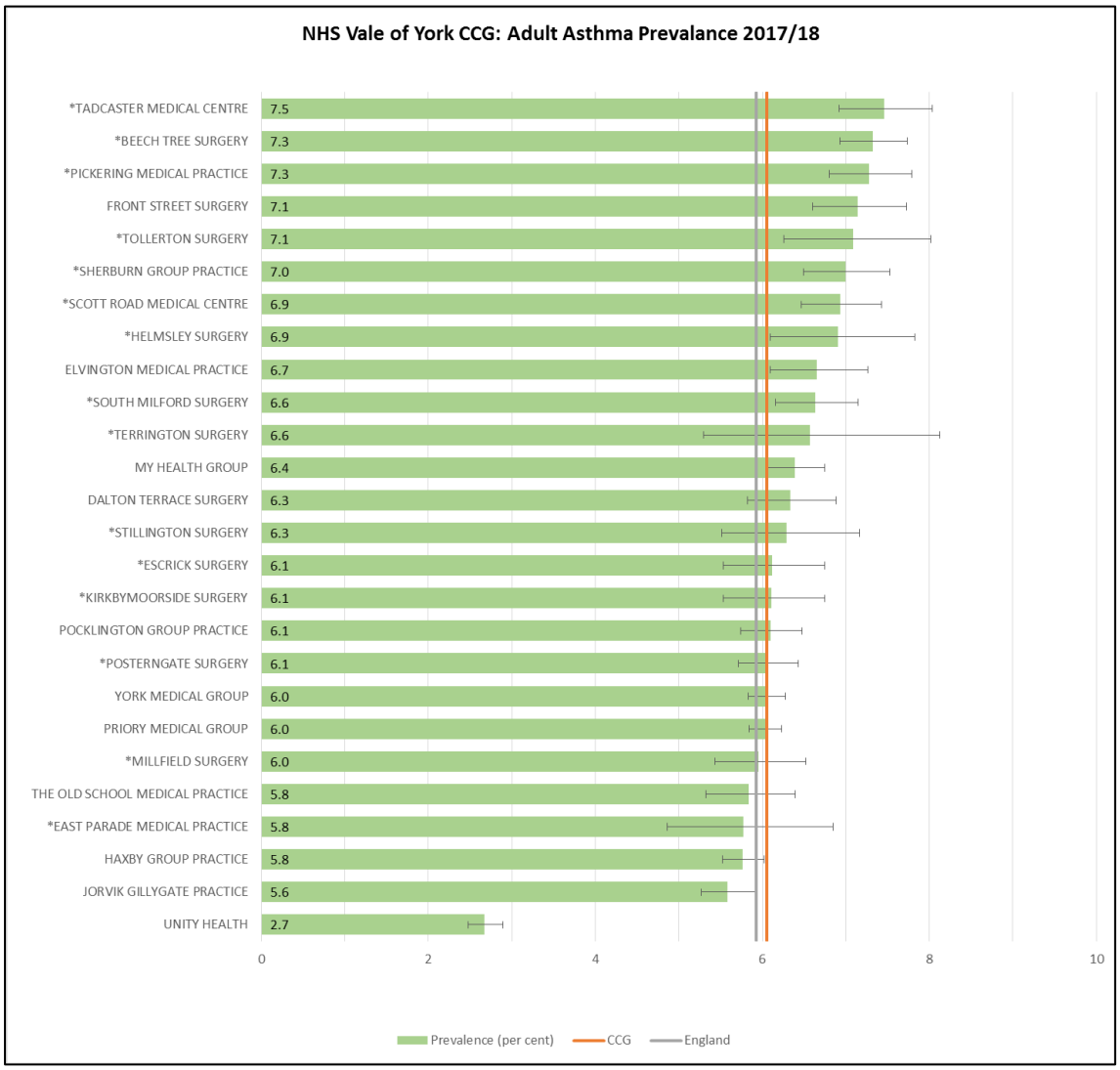
There are more than 26,300 people with a record of depression in VoY CCG, with a lower rate than seen in England. Four practices have prevalence rates which are significantly higher than England, while 15 practices have significantly lower rates.



Source: NHS Digital

Asthma

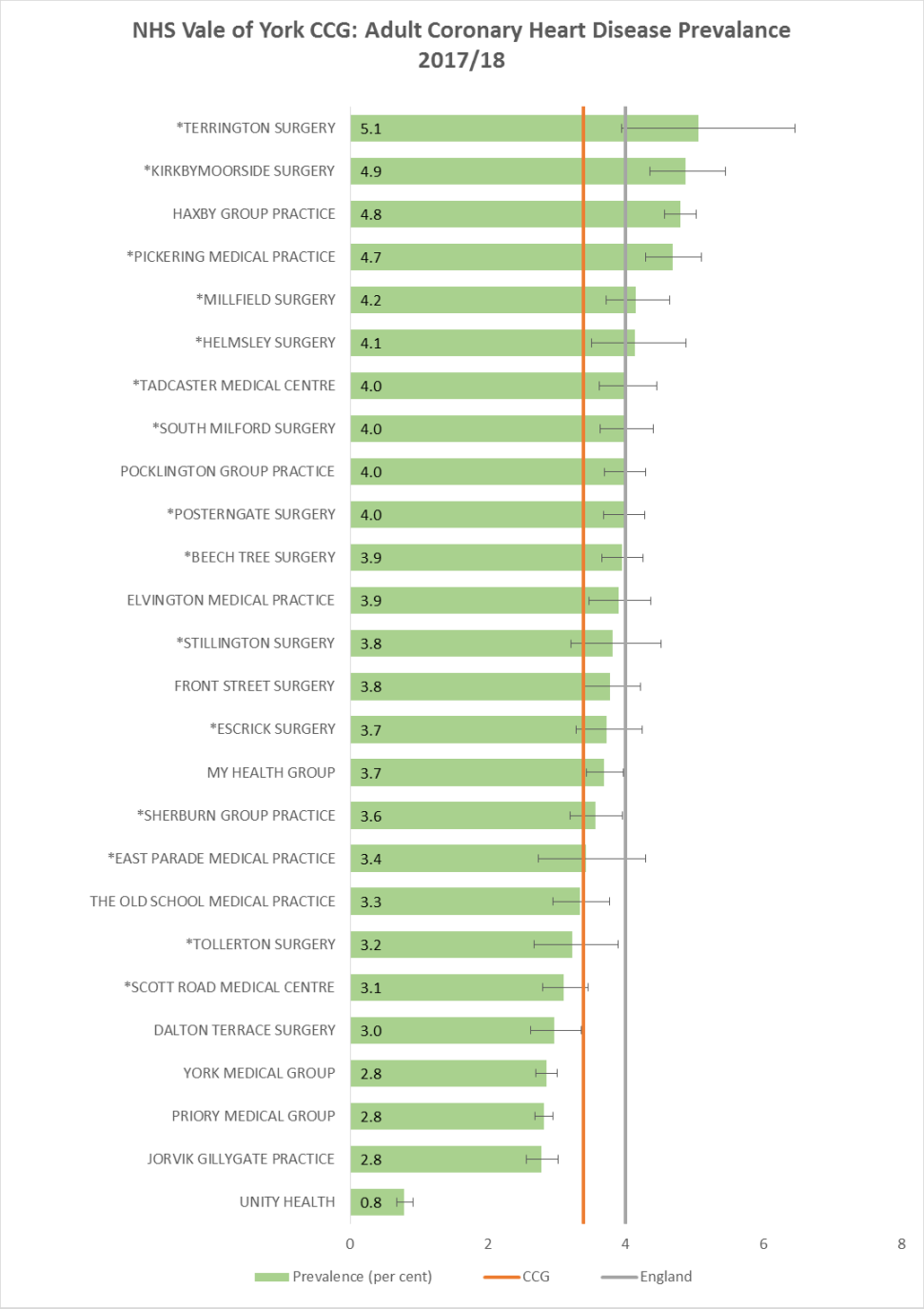
In VoY CCG, asthma prevalence is higher than England. There are over 21,600 people on asthma registers in VoY CCG. There are ten practices that have asthma prevalence rates which are significantly higher than England, 15 practices are similar and one practice is significantly lower compare to England.



Source: NHS Digital

Coronary heart disease

Coronary heart disease (CHD) prevalence is lower in VoY CCG compared with England and there are nearly 12,100 people with diagnosed CHD. Three of the 26 general practices have prevalence rates significantly higher than England.



Source: NHS Digital

Consideration can be given to variation which may be due to modifiable risk factors within the population, differences in record keeping, variation in health care and access to services. NHS RightCare produces a range of intelligence products to help local health economies identify and address health inequality.

Furthermore, the NHS Health Check is a health check-up for adults in England aged 40-74, designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As individuals age they have a higher risk of developing one of these conditions and an NHS Health Check helps find ways to lower this risk. The NHS Health Check report for North Yorkshire highlights performance of health checks across North Yorkshire and can be found on Data North Yorkshire.

Hospital admissions

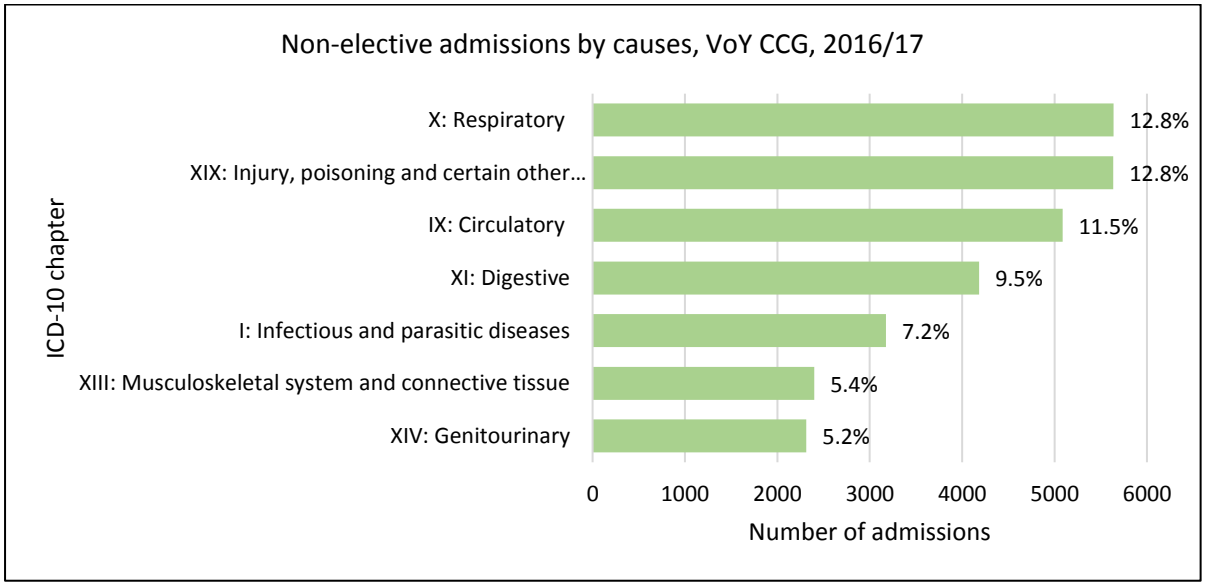
In 2016/17, there were just over 40,000 hospital admissions of which 72,675 (62.2%) were elective admissions and 44,163 (37.8%) were non-elective admissions. In total, there were 158 providers, with York Teaching Hospitals NHS Foundation Trust being the main provider.

Hospital admissions by provider, VoY CCG, 2016/17

Provider	Proportion of elective admissions	Proportion of non-elective admissions	Proportion of all admissions
York Teaching Hospitals NHS Foundation Trust	81.4%	89.9%	84.6%
Leeds Teaching Hospitals NHS Trust	4.8%	2.3%	3.9%
Mid Yorkshire Hospitals NHS Trust	2.6%	2.7%	2.6%
Ramsay Healthcare UK Operations Ltd	2.6%		1.6%
Hull and East Yorkshire Hospitals NHS trust	2.0%	1.0%	1.7%
Harrogate & District NHS Foundation Trust	1.6%		1.2%
Remaining providers	5.0%	4.1%	4.4%

Source: Public Health England SHAPE atlas

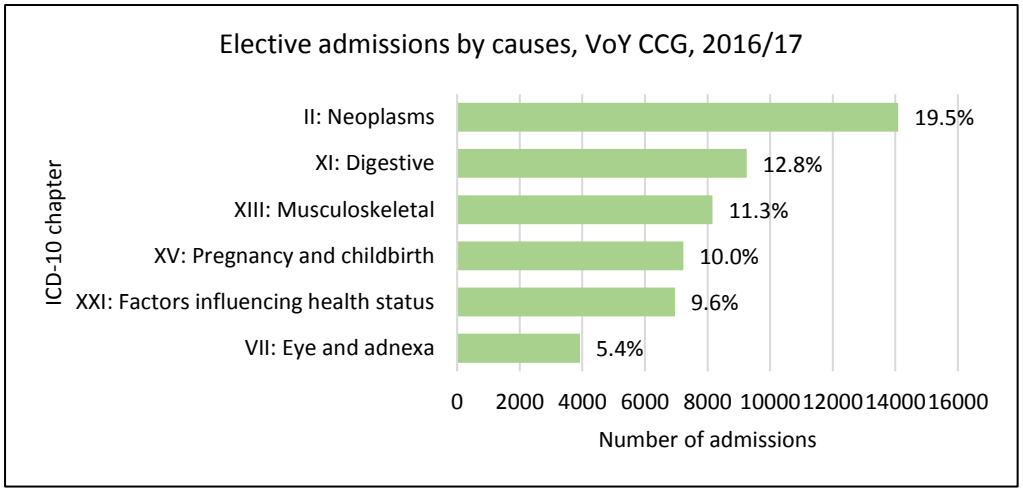
The main reasons for non-elective admissions are shown below for causes which contributed towards more than 5% of non-elective admissions. Respiratory diseases and injuries & poisoning are the most common reasons for non-elective admission followed by circulatory and digestive diseases.



Source: Public Health England SHAPE atlas

Within *chapter XIX: Injury, poisoning and certain other consequences of external causes*, the main reasons for admission are: poisoning by non-opioid drugs; fracture of femur; open wound of head; complications of procedures not elsewhere classified; and fracture of lower leg. This suggests drug overdose (accidental or otherwise) and falls may contribute importantly to local emergency admissions.

The main reasons for elective admission are similarly shown for causes which contributed towards more than 5% of elective admissions. Neoplasms represent the highest percentage of elective admissions, followed by digestive diseases and musculoskeletal problems.

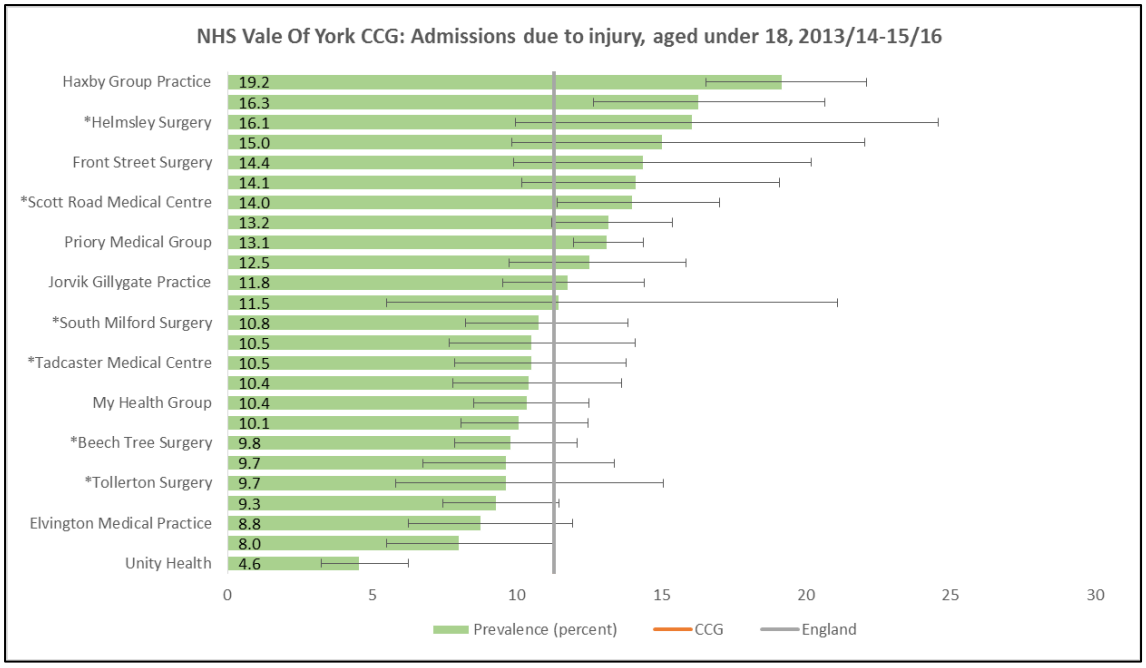


Source: Public Health England SHAPE atlas

For *chapter XXI: Factors influencing health status*, the leading reasons for admission are: liveborn infants according to place of birth (35% of admissions in this chapter); supervision of normal pregnancy (14%); follow-up examination after treatment for malignant neoplasm; follow-up examination after treatment for conditions other than cancer; and need for other prophylactic measures.

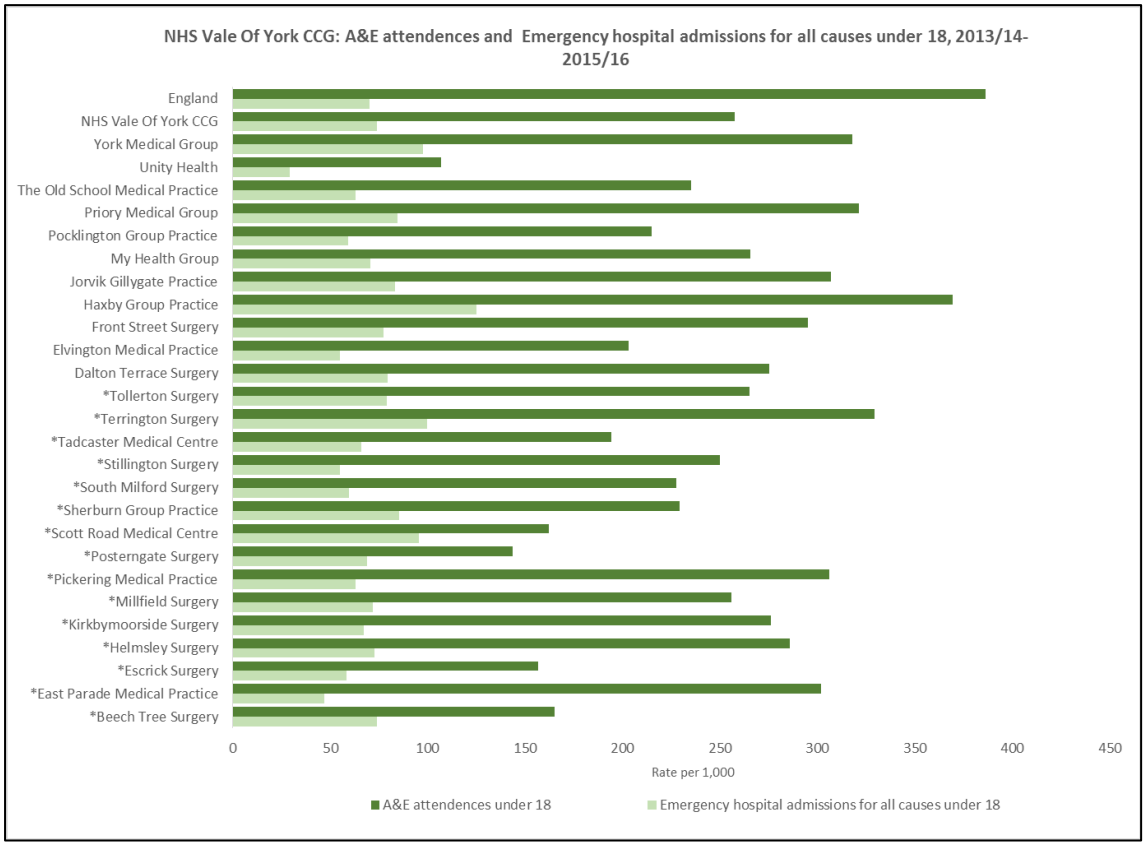
Under 18 hospital admissions

VoY CCG has the second highest rate of admissions due to injury for those under 18 compared to other CCGs in North Yorkshire. The rate is similar to the England average. Over half of practices in AWC CCG have higher rates than the England and CCG average.



Source: National General Practice Profiles, PHE

VoY CCG has the lowest rate of emergency hospital admissions for all causes under 18 when compared to other CCGs in North Yorkshire; however the rate is higher than the England average. Similarly VoY CCG has the lowest of A&E attendance under 18 and this is lower than the England average.



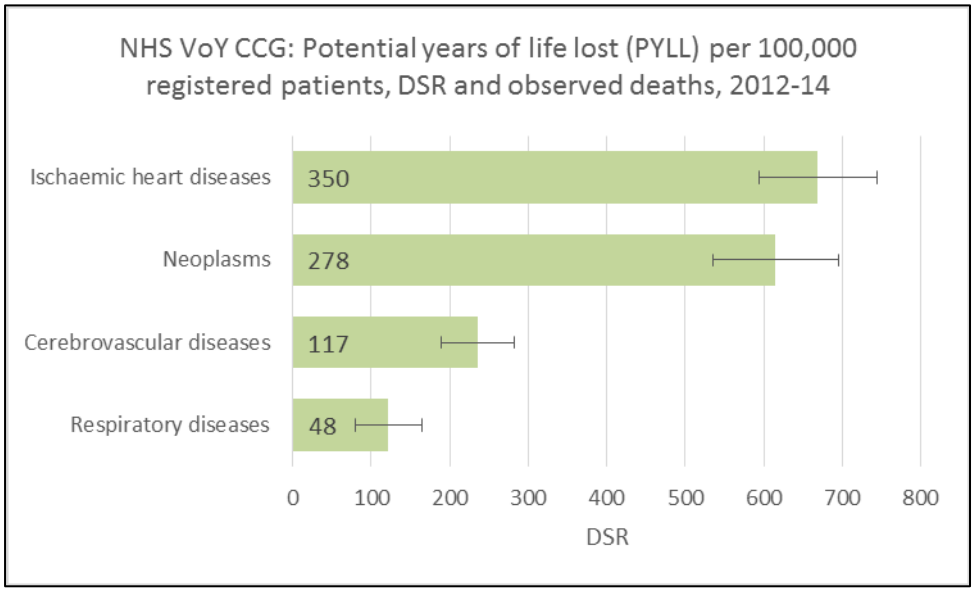
Source: National General Practice Profiles, PHE

Public Health England produces a summary health profile for VoY CCG (Appendix 2). This compares more than 50 indicators with national data and highlights those which are significantly different from England. This can be used to help inform topics which might be considered for focused improvement work. In particular, it highlights the following as being significantly worse than England:

- Emergency admissions in under 5s (Crude rate per 1,000)
- Binge drinking adults (%)
- Emergency hospital admissions for Myocardial Infarction (heart attack) (SAR)
- Elective hospital admissions for hip replacement (SAR)
- Elective hospital admissions for knee replacement (SAR)
- Deaths from coronary heart disease, all ages (SMR)
- Deaths from stroke, all ages (SMR)

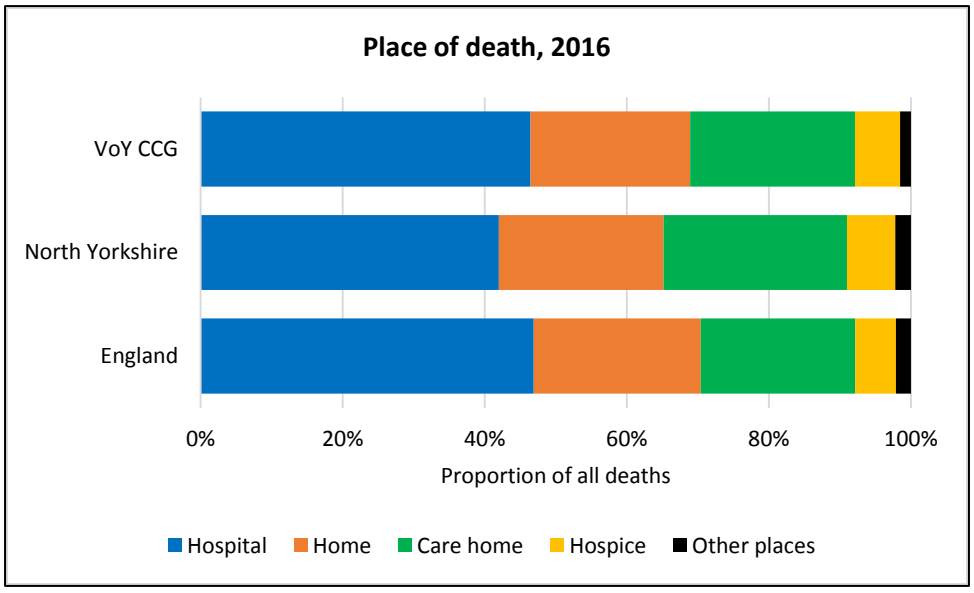
Mortality

The chart below shows the directly standardised potential years of life lost (PYLL) per 100,000 registered patients and the number of observed deaths by conditions. The condition with the highest DSR (668.7) and observed deaths (350) is Ischaemic heart diseases.



Source: HSCIC

Within VoY CCG, 46.5% of deaths occurred in hospital, 23.2% in care homes, 22.5% at home, 6.4% in hospices and 1.5% elsewhere. Compared with England, VoY CCG has a similar profile to England.



Additional mortality data available in the JSNA 2018 District Profiles.

References

1. Public Health England. Local Health
2. Public Health England. National General Practice Profiles
3. Data.gov.uk
4. NHS Digital. QOF 2017/18
5. SHAPE (registration required)
6. NHS Digital. CCG outcomes tool
7. ONS. Clinical commissioning group population estimates
8. ONS. Population projections - clinical commissioning groups
9. Public Health England. End of Life Care Profiles

Contributors:

Judith Yung, Public Health Intelligence Analyst

Emel Perry, Public Health Intelligence Analyst

Wendy Rice, Public Health Intelligence Analyst

Sharon Draper, Data Officer

Katie Wilkinson, Data Officer

Leon Green, Senior Public Health Intelligence Specialist

Contact:

nypublichealth@northyorks.gov.uk

January 2019

Appendix 1

LSOA	Ward	District	Index of Multiple Deprivation (IMD) National Rank (where 1 is most deprived)	Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10% of LSOAs)
Selby 005C	Selby West	Selby	2,057	1
York 018B	Westfield	York	3,490	2
York 009D	Clifton	York	3,735	2
York 009C	Clifton	York	4,591	2
York 018F	Westfield	York	5,303	2
York 013F	Guildhall	York	6,357	2
Selby 005E	Selby East	Selby	6,430	2

Appendix 2 - VoY CCG health profile summary

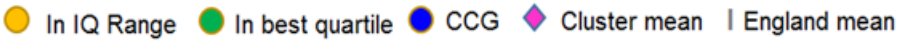
Selection: E38000188 - NHS Vale of York CCG

Indicators	*Selection value*	*England value*	*England worst*	*Summary chart*	*England best*
Low Birth Weight of term babies (%)	2.3	2.8	5		1.7
Child Development at age 5 (%)	64.4	60.4	42.2		74.3
GCSE Achievement (5A*-C inc. Eng & Maths) (%)	60.5	56.6	40.2		75.4
Unemployment (%)	0.8	1.8	4.8		0.5
Long Term Unemployment (Rate/1,000 working age population)	1.3	3.7	14.4		0.5
General Health - bad or very bad (%)	4.2	5.5	9.5		2.8
General Health - very bad (%)	0.9	1.2	2.2		0.6
Limiting long term illness or disability (%)	15.8	17.6	25.6		11.2
Overcrowding (%)	5.4	8.7	34.9		2.7
Provision of 1 hour or more unpaid care per week (%)	9.8	10.2	13		6.5
Provision of 50 hours or more unpaid care per week (%)	1.9	2.4	4		1.3
Pensioners living alone (%)	30.4	31.5	45.2		25.7
Deliveries to teenage mothers (%)	1	1.1	2.3		0.2
Emergency admissions in under 5s (Crude rate per 1000)	178.9	149.2	269.8		65.3
A&E attendances in under 5s (Crude rate per 1000)	372.9	551.6	1719.5		221
Admissions for injuries in under 5s (Crude rate per 10,000)	140.3	138.8	280.3		77.7
Admissions for injuries in under 15s (Crude rate per 10,000)	102.9	110.1	183.9		65.2
Admissions for injuries in 15 - 24 year olds (Crude rate per 10,000)	108.2	137	238.6		53.9
Occasional smoker (modelled prevalence, age 15) (%)	4.9	4	5.3		1.2
Regular smoker (modelled prevalence, age 15) (%)	9.5	8.7	12.7		3.2
Obese adults (%)	24.6	24.1	30.9		14.5
Binge drinking adults (%)	28.8	20	34.5		7.5
Healthy eating adults (%)	28.2	28.7	19.4		46.5
Obese Children (Reception Year) (%)	8.1	9.3	13.8		5.3
Children with excess weight (Reception Year) (%)	21	22.2	27.2		14.6
Obese Children (Year 6) (%)	15.6	19.3	27.1		9.8
Children with excess weight (Year 6) (%)	29.6	33.6	42.9		21.7
Emergency hospital admissions for all causes (SAR)	92.8	100	152.5		68.2
Emergency hospital admissions for CHD (SAR)	96.5	100	270.9		59.4
Emergency hospital admissions for stroke (SAR)	93.1	100	160.1		76.8
Emergency hospital admissions for Myocardial Infarction (heart attack) (SAR)	112	100	280.2		53.8
Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) (SAR)	78	100	233.4		43.2
Incidence of all cancer (SIR)	97.2	100	118.7		84.5
Incidence of breast cancer (SIR)	95.5	100	119.3		76.4
Incidence of colorectal cancer (SIR)	103.8	100	120.3		76.6
Incidence of lung cancer (SIR)	83.6	100	191.6		57
Incidence of prostate cancer (SIR)	100.5	100	147.4		64.3
Hospital stays for self harm (SAR)	96.3	100	308.4		28.7
Hospital stays for alcohol related harm (SAR)	87.5	100	182.5		57.7
Emergency hospital admissions for hip fracture in 65+ (SAR)	95.9	100	123.3		72.6
Elective hospital admissions for hip replacement (SAR)	123.5	100	140.9		32.7
Elective hospital admissions for knee replacement (SAR)	106.5	100	149.4		36.4
Life expectancy at birth for males, 2011- 2015 (years)	80	79.4	73.9		82.4
Life expectancy at birth for females, 2011- 2015 (years)	83.6	83.1	78.8		86
Deaths from all causes, all ages (SMR)	96.2	100	147.9		75.5
Deaths from all causes, under 65 years (SMR)	91.7	100	179.1		69.3
Deaths from all causes, under 75 years (SMR)	91.6	100	177		72.7
Deaths from all cancer, all ages (SMR)	95.9	100	127.9		78.3
Deaths from all cancer, under 75 years (SMR)	96.5	100	136.5		76.4
Deaths from circulatory disease, all ages (SMR)	102.8	100	153.5		73.1
Deaths from circulatory disease, under 75 years (SMR)	91.3	100	230.1		61.5
Deaths from coronary heart disease, all ages (SMR)	105	100	176.8		66.3
Deaths from coronary heart disease, under 75 years (SMR)	91.2	100	245.4		50.8
Deaths from stroke, all ages (SMR)	109.4	100	174.5		67.3
Deaths from respiratory diseases, all ages (SMR)	95.2	100	177.9		70.5

● *significantly worse* ● *significantly better* ● *not significantly different from average*

Appendix 3

VoY CCG Outcomes Framework



Indicator Name	Value		Spine chart	
1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare - Male (2014)	1,936	↓	1325	3902
1.2 Under 75 mortality rates from cardiovascular disease (2016)	58.8	↑	39.7	151.2
1.3 Completion of cardiac rehabilitation following an admission for coronary heart disease (2013/14)	47.7	↑	0	75.4
1.4 Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes (2015/16)	197.9	↓	52.3	280.2
1.5 Mortality within 30 days of hospital admission for stroke (2016/17)	0.95	↑	0.29	1.62
1.6 Under 75 mortality rates from respiratory disease (2016)	25.1	↑	15.1	88.6
1.7 Under 75 mortality rates from liver disease (2016)	13.9	↑	7.1	41.4
1.8 Emergency admissions for alcohol related liver disease (2017 - 2017 (Jan - Dec))	12.3	↓	7.2	79.3
1.9 Under 75 mortality rates from cancer (2016)	119	↑	77	307
1.10 One-year survival from all cancers (Diagnosed 2015)	71.6	↑	67	77.4
1.11 One-year survival from breast, lung and colorectal cancers (Diagnosed 2011)	70.3	↑	62.1	76.2
1.12 People with Serious Mental Illness (SMI) who have received the complete list of physical checks (2014/15)	29.1	↓	17.5	52.4
1.14 Maternal smoking at delivery (2017/18 Q3)	7.43	↓	1.62	27.85
1.15 Breast feeding prevalence at 6 - 8 weeks (2015/16 Q1)	No Data		0	82.5
1.17 Record of stage of cancer at diagnosis (2016)	84.6	↑	66.1	86.8
1.18 Percentage of cancers detected at stage 1 and 2 (2016)	53.4	↓	39.4	60.4
1.19 Record of lung cancer stage at decision to treat (2016)	95.5	↑	74.5	99.2
1.20 Mortality from breast cancer in females (2014 - 2016)	33.3	↑	22.1	48
1.21 All-cause mortality – 12 months following a first emergency admission to hospital for heart failure in people aged 16 and over (April 2013 to March 2016)	103.5	↓	75.6	119.7
1.22 Hip fracture: incidence (2017 - 2017 (Jan - Dec))	445	↑	64	626
1.23 Smoking rates in people with serious mental illness (SMI) (2014/15)	36.7		27.2	55
1.24 Referrals to cardiac rehabilitation within 5 days of an admission for coronary heart disease (2014/15)	2.80	↓	0	41.9
1.25 Neonatal mortality and stillbirths (2016)	3.80	↓	2	13.3
1.26 Low birth weight full-term babies (2016)	2.40	↑	1.3	5.2
CCG Outcomes Indicator Set- domain 2				
2.1 Health-related quality of life for people with long-term conditions (2016/17)	0.75	↓	0.64	0.82
2.2 Proportion of people who are feeling supported to manage their condition (2016/17)	69.3	↑	52.1	74.2
2.3 The percentage of people with Chronic Obstructive Pulmonary Disease (COPD) and Medical Research Council (MRC) Dyspnoea Scale >=3, identified on GP systems, referred to a pulmonary rehabilitation (2014/15)	11.7	↑	3.8	68.5
2.4 Percentage of people with diabetes who have received nine care processes (2016/17)	50.5	↓	17.7	86.9
2.5 People with diabetes diagnosed less than a year referred to structured education (2014/15)	82.0	↑	41.7	93.2
2.6 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (2017 - 2017 (Jan - Dec))	790	↑	177	1390
2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2017 - 2017 (Jan - Dec))	253	↑	40	647
2.8 Complications associated with diabetes (2015/16)	117.1	↑	62.3	278.8
2.9 Access to community mental health services by people from Black and Minority Ethnic (BME) groups (2014/15)	1,134	↑	658	5283
2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups (2015/16)	351	↑	295	13013
2.11a Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable recovery following completion of treatment (2015 - 2015 (Jan - Dec))	43.9	↓	18.7	60.5
2.11b Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable improvement following completion of treatment (2015 - 2015 (Jan - Dec))	61.0	↓	33.6	79.8
2.11c Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicator a reliable deterioration following completion of treatment (2015 - 2015 (Jan - Dec))	5.70	↓	3.4	11.3
2.15 Health-related quality of life for carers, aged 18 and above (2016/17)	0.82	↑	0.73	0.85
2.16 Health-related quality of life for people with a long-term mental health condition (2016/17)	0.56	↓	0.34	0.68

CCG Outcomes Indicator Set- domain 3				
3.1 Emergency admissions for acute conditions that should not usually require hospital admission (2017 - 2017 (Jan - Dec))	1,396	↑	225	2115
3.2 Emergency readmissions within 30 days of discharge from hospital (2011/12)	10.9	↓	8.9	14.5
3.3 Elective Hip replacement (Primary) procedures - patient reported outcomes measures (PROMS) (2015/16)	0.44	↑	0.35	0.52
3.3 Elective knee replacement (Primary) procedures - patient reported outcomes measures (PROMS) (2015/16)	0.32	↑	0.19	0.39
3.3 Elective groin hernia procedures - patient reported outcomes measures (PROMS) (2015/16)	0.09	↑	0.04	0.15
3.3 Elective varicose veins procedures - patient reported outcomes measures (PROMS) (2015/16)	No Data		0	0.15
3.4 Emergency admissions for children with lower respiratory tract infections (2017 - 2017 (Jan - Dec))	707	↑	39	838
3.5 People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital (2016/17)	59.3	↓	17.6	85.1
3.6 People who have had an acute stroke who receive thrombolysis (2016/17)	11.40	↑	0	27.6
3.7 People with stroke who are discharged from hospital with a joint health and social care plan (2016/17)	91.9	↑	34.3	100
3.8 People who have a follow-up assessment between 4 and 8 months after initial admission for stroke (2016/17)	31.40	↓	0	96.1
3.9 People who have had an acute stroke who spend 90% or more of their stay on a stroke unit (2016/17)	88.1	↓	57.7	97.9
3.10.i Hip fracture: proportion of patients recovering to their previous levels of mobility/walking ability at 30 days (2015)	35.3	↑	0	88.9
3.10.ii Hip fracture: proportion of patients recovering to their previous levels of mobility/walking ability at 120 days (2016)	50.3	↓	41.1	92.9
3.11 Hip fracture: collaborative orthogeriatric care (2016)	99.4	↑	55.1	100
3.12 Hip fracture: timely surgery (2016)	75.1	↓	40.1	90.6
3.13 Hip fracture: multifactorial falls risk assessment (2016)	100.0	✖	73.9	100
3.14 Alcohol-specific hospital admissions (2017 - 2017 (Jan - Dec))	96.0	↓	33.9	322.6
3.15 Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (2015 - 2017(Jan - Dec))	96.8	↑	41.9	198.2
3.16 Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over (2014/15)	108.4	↑	20.9	317.5
3.17 Percentage of adults in contact with secondary mental health services in employment (2016 - 2017 (Dec - Dec))	16.00	⇑	0	24
3.18 Hip fracture: care process composite indicator (2016)	72.3	↓	25.5	87.9

CCG Outcomes Indicator Set- domain 4				
4.1 Patient experience of GP out-of-hours services (2014/15)	63.4	↓	49	85.3
4.2 Patient experience of hospital care (2015/16)	80.0	↑	68.3	83.5
4.5 Responsiveness to Inpatients personal needs (2015/16)	73.0	↑	60.1	78
CCG Outcomes Indicator Set- domain 5				
5.3 Incidence of Healthcare Associated Infection (HCAI) – Methicillin-resistant Staphylococcus aureus (MRSA) (April 2013 - April 2018)	10.61		2.23	19.83
5.4 Incidence of Healthcare Associated Infection (HCAI) – C. difficile (April 2013 - April 2018)	129.9		46	234

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Item Number: 8

Name of Presenter: Michelle Carrington

Meeting of the Governing Body **Date of meeting: 2 January 2020**	NHS Vale of York Clinical Commissioning Group

Report Title – Quality and Patient Experience Report

Purpose of Report *(Select from list)*
To Receive

Reason for Report

To provide the Governing Body with a highlight update on progress regarding recent quality and safety activities across healthcare services commissioned by the CCG.

A more detailed report has been discussed at the Quality of Patient Experience Committee (QPEC) in December 2019.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks	**Risk Rating**
☐Financial ☐Legal ☒Primary Care ☒Equalities	

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

Recommendations

The Governing Body is requested to:

- Accept this update on the quality and safety information and activity for commissioned services.

- Agree whether they are satisfied they are sighted on the current quality and safety concerns and assured that proposed actions are appropriate to manage effectively any quality and safety issues or risks.

Decision Requested (for Decision Log)

N/A

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington Chief Nurse	Paula Middlebrook Deputy Chief Nurse

Vale of York
Clinical Commissioning Group

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

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1. PURPOSE OF THE REPORT

The purpose of this report is to provide the Governing Body with a highlight update on progress regarding recent quality and safety activities across healthcare services commissioned by the CCG.

A more detailed report has been discussed at the Quality of Patient Experience Committee (QPEC) in December 2019.

2. QUALITY IN PRIMARY CARE

2.1 Health Navigator

The offer for the Health Navigator service has now been rolled out to all GPs within Vale of York. We are actively working to engage clinicians, encourage referral of appropriate patients and hope to be able to evaluate the services impact on primary care consumption in due course.

2.2 Social Prescribing

Patient engagement has started within Selby Town Primary Care Network relating to social prescribing. This information helps to understand what the public understand by social prescribing and will feed into the development and promotion of social prescribing services in the Selby area.

2.3 Primary Care Focussed discussion for QPEC

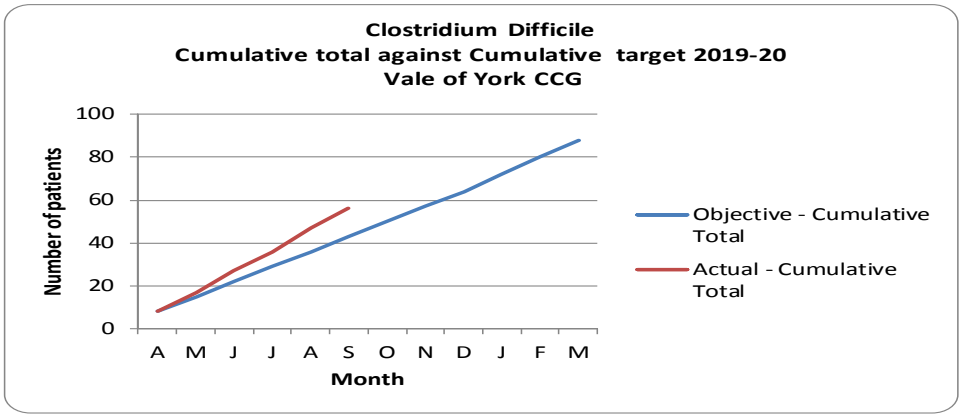
The Quality and Patient Experience Committee is increasing its frequency of meetings to monthly with effect from December 2019. This will provide the opportunity for a more focussed presentation and discussion regarding differing services.

Primary Care will be the focus of the first ‘deep dive’ and provide the opportunity to share the range of developments that are happening within primary care, how quality is monitored and focus upon risks and issues.

3. INFECTION PREVENTION & CONTROL (IPC) UPDATE QUARTER 2

3.1 Clostridium *difficile (C-Diff)*

The CCG have 56 attributed cases reported at the end of Quarter 2(see chart below). This is 13 cases over the end of Quarter 2 objective. Eighteen cases have been agreed as lapses in care, 11 cases are York Teaching Hospital NHS FT (YTHFT) attributable cases (Please see YTHFT below). Sixteen cases are awaiting review.



YTHFT have a yearend objective of a maximum 61 cases. At the end of Quarter 2 the trust have breached their yearend objective by 14 cases due to the outbreak at the Scarborough site. Nineteen cases are awaiting review and 32 cases have been agreed as lapses in care at the HCAI review group due to:

- Antibiotic prescribing not in line with guidelines, including longer course than recommended and not reviewed appropriately
- Environmental issues, contaminated commodes and raised toilet seats.
- Cross contamination from patient to patient.
- Delay in sampling.
- Hand Hygiene compliance.

Overuse of antibiotics can be a factor placing patients at risk of developing C-Diff. The trust has therefore commenced an antibiotic audit from 1 October 19. A back to basics IPC audit has commenced across the Trust to identify areas of good practice and those requiring improvement.

The issues specific to the Scarborough site have been reported to QPEC and Governing Body in full previously.

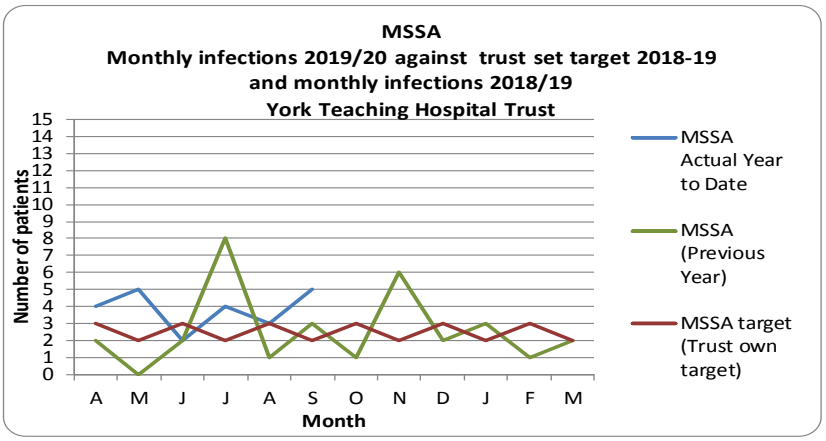
Progress against actions are being monitored through the newly formed Quality Improvement Board.

3.2 Methicillin-resistant Staphylococcus aureus Blood Stream Infections (MRSA BSI)

Four CCG reportable cases of MRSA BSI have been reported up to the end of Quarter 2 against a Zero tolerance objective. Three of the cases are primary care attributed i.e. have been detected within 48hrs of admission. One case is a YTHFT attributed case. Two of the cases have been determined as avoidable following the multidisciplinary post infection review. In both cases intravenous access was an attributing factor in determining the cases as avoidable.

3.3 Methicillin-susceptible Staphylococcus aureus Blood Stream Infections (MSSA BSI)

YTHFT have reported an increase of 7 cases at the end of Quarter 2 2019/20 compared to the same period in 2018/19 (Chart two below).



At the end of July the Trust had reported an increase Staphylococcus aureus blood stream infections up to the end of July 19. They have reported that a number of these infections are related to IV cannulas and lines. There is some evidence that staff are not recognising signs of phlebitis (inflamed vein) and that the Visual Infusion Phlebitis score (VIP score) may not be accurate. Aseptic Non Touch Technique (ANTT) training has a good uptake by nursing staff but low numbers of medical staff. Previously utilised cannulas introduced were not well received by staff, therefore these have been replaced by a different product and roll out has been completed with the addition of a cannula insertion pack to reduce risk of infection. The September intake of Doctors has been targeted to ensure they receive ANTT training to reduce the risk of infection.

4. SERIOUS INCIDENTS (SIs)

4.1 York Teaching Hospital Foundation Trust (YTHFT)

Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

YTHFT have declared 3 Never Events over the last 3 months these are:

- York Hospital theatres (VoY patient) whereby a Femoral nerve block was inserted on the wrong leg. This was recognised prior to surgical intervention. Initial enquiries suggest that all checks appeared to have taken place appropriately. The investigation to determine root case and any learning is ongoing.

- Scarborough Hospital site, one concerning a medication incident and the second due to a retained guidewire. The investigation reports are yet to be finalised. Both patients were from the Scarbough CCG area.

  Completed Investigation reports will be reviewed as normal for Quality assurance in North Yorkshire Collaborative SI group.

4.2 YTHFT SI Quality Review

The CCG is working with YTHFT regarding the quality of Serious Incident investigations, timeliness and how the trust and the CCG gain assurance that lessons are being learnt. This will be a subgroup of the Quality Improvement Board.

4.3 Tees Esk and Wear Valleys (TEWV) NHS FT SI Quality Review

The total number of SIs reported by TEWV for all CCGs has increased over the last year. This has impacted upon the Trust's ability to investigate incidents in a timely way with fewer than 25% of investigations being completed within the National Framework timescales.

TEWV has established a Family Liaison Officer to support families through the investigations and keep them up to date with progress / timescales etc.

Assurance has been requested concerning the mapping of learning from events and recurrent themes. Improvement work to address this is on-going within TEWV.

Progress will be discussed further at the January 2020 North Yorkshire Collaborative SI group and subsequently at the CCG / provider Quality sub contract meeting.

5. QUALITY ASSURANCE FROM PROVIDERS

Following changes in personnel within the Quality and Nursing team, a full review has been undertaken by the team in order to ensure that lead individuals are identified for ensuring quality assurance of each commissioned provider.

Only exceptions are highlighted within this report.

5.1 Tees, Esk and Wear Valleys Trust (TEWV)

The Quality meeting has continued to meet bi-monthly.

A review of the Quality Assurance approach to TEWV is underway. Positive discussions are taking place which includes

- Opportunities for the CCG to attend Trust internal quality meetings / forums / service user forums
- A revamp of the formal CCG / Trust Quality sub contract meeting to develop a schedule of topics / service areas where there will be a presentation / deep dive in order to have more meaningful discussions and understanding.

5.2 The Retreat

A Clinical Quality visit is scheduled for January 2019. This will aim to gain further assurance and updates following the outcomes of their CQC visit in July 2019.

5.3 York Teaching Hospital Foundation Trust (YTHFT)

Following the Risk Summit held in August 2019, NHSE/I convened a Quality Improvement Board (QIB) in November with system partners (YHFT, CQC, North Yorkshire CCGs, Vale of York CCG and NHSE/I) to discuss progress on actions and address issues around quality and safety and performance (particularly ED performance).

The CCG has held weekly internal meetings to ensure actions are being progressed and this was reported into the QIB.

Of particular concern are:

- the significant number of 12 hour trolley breaches, mainly at Scarborough Hospital
- the growing backlog of patients waiting for planned surgery
- Infection controls issues
- The staffing concerns raised by the CQC in Coronary Care Unit and Medical Wards in Scarborough
- Quality of discharges.

The decision was taken that the QIB would be led by the Chief Nurses across the system using the existing Quality & Safety Group (the sub contract management group between Scarborough and Ryedale, Vale of York, East Riding CCGs and YHFT) as the vehicle for improvement. The terms of reference were agreed. This first meeting took place on the 13th December.

5.4 Hepatitis B vaccinations for people with Chronic Kidney Disease

People with chronic kidney disease are at increased risk of developing Hepatitis B infection because during dialysis they are repeatedly exposed to donor's blood and body fluids.

In March 2018 NHSE wrote to both Primary Care and Secondary Care Trusts informing them that the responsibility for provision of Hepatitis B vaccinations was transferring from Primary care to Secondary care renal services from July 2019.

As the main provider for renal medicine / dialysis across York, Scarborough and Harrogate, YTHFT have informed the CCG that they are unable to meet this need due to the additional resource that is required in clinic capacity and personnel to deliver the service.

Local GPs have stopped providing the vaccinations due to the NHSE notification that they are no longer commissioned to provide it.

A risk has therefore developed for people who may not have commenced or completed their course of vaccinations.

Dialogue is taking place between the CCG, Trust and Primary Care representatives to try and deliver a short term response to the identified risk, whilst a longer term proposal for delivery to the service is established.

6. SCREENING AND IMMUNISATIONS UPDATE

Influenza (Flu) Immunisations

YTHFT District Nurses have offered to vaccinate certain cohorts of eligible patients with a planned to completion by 7th December 2019.

Last year supply of the vaccine for the over 65 cohort was disrupted, however this year there have been no issues with that particular vaccine.

Uptake in the over 65s cohort is above what it was at this time last year in all practices with the CCG average currently standing at 70.5%. (The national target is 75%).

Some supplies of the quadrivalent vaccine for the under 65s at risk patients have been disrupted this year depending on the manufacturer the practice has ordered from, which will have affected overall uptake for the CCG. The Screening and Immunisation Team (SIT) are monitoring this.

Supplies of the Fluenz nasal vaccination were initially disrupted but this is now resolved. This may have affected uptake and the SIT are monitoring this.
The MHRA have provided an instruction again this year for practices to share vaccines which may help.

7. PATIENT EXPERIENCE UPDATE

7.1 Vale of York CCG Complaints

14 complaints were registered in the CCG during September and October 2019.

100% of the complaints were acknowledged within 3 days (in accordance with the NHS complaint procedure).

100% of the closed complaints were responded to within allocated timescales (usually 30 working days). The on-going complaint's initial target date has been extended to allow more time for the investigation.

Specialty/Area	No. of complaints	Outcome after investigation
Adult Mental Health	1	Not upheld
Continuing Healthcare	4	2 partially upheld 1 upheld 1 not upheld
Patient Transport Service	5	3 upheld 2 not upheld
Referral Issue	1	On-going
Repeat prescribing	2	Not upheld
Wheelchair	1	Not upheld

7.2 Parliamentary & Health Service Ombudsman (PHSO)

The PHSO is the second and final stage of the NHS complaints procedure for complainants who remain unhappy with the NHS organisation's attempts to resolve their complaint.

One complaint, about the CCG's Health Optimisation Policy (BMI/smoking thresholds for elective surgery) has been referred to the PHSO. A copy of the complaint file has been provided and we are waiting to hear whether they are investigating further.

8. ENGAGEMENT UPDATE– DECEMBER 2019

The following table summarises how we are developing, monitoring and improving services in partnership with our community. This includes the difference public involvement activity has made.

Date	The impact of engagement
14 Oct	**Carers training at Pocklington Patient Participation Group:** The East Riding Carers advisory group wanted help to raise awareness of and signposting for carers in GP practices. We supported David, who shared his story about being multiple

	carer Pocklington Participation Group. As a result the practice is looking at how it can provide more information about local support and services for carers.
21 Oct	**All Age Learning Disabilities Strategy:** Members of the CCG attended the launch of the All Age Learning Disabilities Strategy for York. It aims to set out the Partnership's four priority areas in including education/life-long learning and employment, independent living, participating in society and being as healthy as possible. This strategy is the opportunity to help make York a fully inclusive City for people with learning disabilities and their families/carers. It has been coproduced by people with learning disabilities and their families/carers, together with the voluntary sector, education, health and social care. Click here to view the document.
22 Oct	**Healthwatch Assembly:** Giving feedback and letting people know how their views have made a difference is really important. At the Healthwatch Assembly we gave an update on how their views had shaped the CCG's engagement principles and strategy. Feedback was also provided about action that had been taken from a recent Healthwatch report into the experiences of the LGBT community in accessing healthcare. Click here to view the Healthwatch presentation and click here to view how the public shaped our engagement principles.
29 Oct	**Work with our LGBT+ community:** Healthwatch York produced a report about LGBT+ experience of accessing health and social care and the barriers they face. This report highlights that a quarter of the participants said they had experienced barriers to accessing health and social care services. As a result in October 2019 we invited in Yorkshire MESMAC to deliver two training sessions. Over 45 people including staff, Healthwatch, GPs and health professionals. We adopted the rainbow badges - an initiative that gives staff a way to show that we are open, non-judgemental and inclusive towards our colleagues, partners and our population who may identify as LGBT+. We are working with a local GP to review the transgender pathway and improve experience for patients, as well as looking at rolling out training at our Protected Learning Time events in 2020.
5 Nov	**Wheelchair user forum:** The aim of the meeting was to provide an update about services and personal wheelchair budgets, and to give attendees the opportunity to give feedback to the providers of services. 28 people attended including service users, staff, clinicians, voluntary organisations, NRS Healthcare and commissioners. Listening directly to feedback from services users was very powerful. Following a very rich discussion commissioners and providers have committed to working together to provide feedback on a number of key themes that were raised at the meeting. This includes reviews of equipment, clarity around personal health budgets, provision of community assessments and ensuring users get the right equipment first time. You can read what was said, and how providers and commissioners will respond to feedback by clicking here.

6, 13 and 21 Nov	**Work with our carers:** During November we attended several carers groups to provide feedback on areas of health that they wanted to know more about. Discussions included wheelchair services, repeat prescription changes and access to GPs. The new York Carers Strategy was launched and there is a commitment to how we can support carers to be healthy and well. On 21 November we supported carers rights day.
26 Nov	**Selby Posterngate Patient Participation Group:** We attended the PPG to gather feedback about 'social prescribing'. This information helped us to understand what the public understand by social prescribing and will feed into the development and promotion of social prescribing services in the Selby area.

8.1 Patient story update:

As part of commitment to ensuring patient, carer and public voice is heard within the organisation, a patient story is presented as a regular item at the start of each Quality and Patient Experience Committee (QPEC). These are subsequently presented at Governing Body. Below is a table to illustrate stories that have been presented and how this has influenced the work of the CCG.

Date	Patient story theme	Medium	Impact: Influencing our work
Dec 2017	Parent carer and special schools services.	Video	The CCG has continued to work with partners to improve the transition pathway for SEND children. We now have a designated post focusing on children and young people. An update was presented at Governing Body in April 2019.
Feb 2018	Safeguarding children: Engaging with looked after children.	Person and video	The safeguarding team ensures that the voice of the young person is heard throughout their work.
April 2018	Continuing Health Care (CHC): Experience of the CHC process	Person	The CCG continued to meet the carer and his mother to monitor their experience of the care system. Feedback on the 'patient voice' was presented to the CHC nursing team at a full team meeting.
June 2018	Tommy Whitelaw – thinking of care from the perspective of the cared for and their families.	Video clip	Staff took part in a 'what matters to me' exercise to encourage looking at services from the point of view of the patient and their family

Aug 2018	Caring for someone with a mental health condition	Person	The carer continues to be a critical friend to the CCG attending forums and presenting at the governing body to raise awareness of the support needed for carers and the cared for.
Oct 2018	End of Life Care (EOLC) story	Passage read out	The new EOLC strategy and people's charter was developed and launched in 2019, built on the involvement of the public, patients and their families, professionals and partners. EOLC has been a designated topic at three of the protected learning time for primary care events.
Dec 2018	Experience of mental health services: A mother talks about her personal experience as an adult and for her children	Reading of story	Mental Health remains a CCG priority and is reflected in the 2019-20 commissioning intentions. Joint work on the Local Transformation Plan, with involvement of children and their families, provides details of work of the whole local system of support around the well- being of children and young people.
Feb 2019	Two stories relating to opiate prescribing	Reading	Engagement work continues with primary care to look at reducing opiate prescribing.
Apr 2019	Care home story: Partnership working - how the support from the CCG is helping improve care of residents	Care home manager – in person	We continue to work with care homes to focus on deteriorating residents and those at risk of falls. Engagement sessions take place with carers and some work has been carried out with a domiciliary care agency and families.
June 2019	Providing co-ordinated and anticipatory care for frail and vulnerable patients in the north locality: an integrated care approach and its benefits	Gill Barrett, North PCN gave her story in person	Gill presented at Governing Body in September and the Governing Body noted the holistic person-centred approach and emphasised opportunities for replication across the patch. Coordinated care for EOLC patients was the keynote speech at the October Protected Learning Time.

Oct 2019	New approaches to inclusive engagement with new/expectant mothers and their families to gather feedback to improve and develop maternity services.	Video of members of the Maternity Voices Partnership (MVP)	Feedback from over 500 survey results and open group session in a child friendly location (where mums, dads and families attended) is being analysed and will be presented to the maternity services in January 2020. This will help to develop services based on patient feedback.
Dec 2019	Raising awareness of support and signposting for carers in primary care	Video of Karen, a carer	To be shown.

A full patient story action plan is available on the CCG website.

9. QUALITY IN CARE HOMES AND DOMICILIARY CARE

Work continues to support improvements in care homes and domiciliary care. Priorities are identified primarily through the framework for Enhanced Health in Care Homes Guidance (2016).

Engagement and communication with key stakeholders takes place through the following:

- Partners in Care Forum meets bimonthly and invites are extended to all Care Homes and Domiciliary Providers across the Vale of York.

- Weekly Partners in Care Bulletin is circulated and monthly registered managers network supported by CCG.

9.1 Smiles Matter Quality Improvement (QI) Project

Following a recent publication of a CQC report ‘Smiles Matter’ a QI project focussing on the issue of oral health in care homes is ongoing. A patient/staff experience survey was completed which highlighted some areas of good practice relating to mouth care for residents, and some areas where care home staff can be supported better to help improve outcomes for their residents. Training sessions will commence in the New Year, and subsequently aim to demonstrate improvement in staff knowledge and patient care.

9.2 Recognition and Responding to Deteriorating Residents

Since the project began, 10 homes and 1 care agency have engaged in training covering nearly 600 residents and nearly 400 staff trained. 6 New homes have engaged with the potential of training a further 250+ staff covering 350 residents.

Feedback has been positive with care home managers commenting that it has given staff more confidence in communicating with other health professionals and has led to a more structured and comprehensive approach to observing and responding to deterioration in their residents.

Work continues with a number of GPs to support them in the delivery of care to a cohort of care homes.

Approval to extend accessibility to OT, Physiotherapy, dietetics and SALT teams by care home managers is awaited from the Community Services Manager.

The Senior Quality Lead recently presented findings from the identification of deteriorating residents work into the domiciliary care setting at the Q Community national Event in London in November. There have also been presentations at the Academic Health Science Network and the Yorkshire Quality and Safety research group conference.

A second local conference as a follow up to one held in May 2018 was delivered on November 26th 2019. This showcased achievements and learning from improvement projects, related work and aimed to launch spread of the work to a wider regional audience. Feedback was extremely positive.

Plans to present the evaluation when complete to members of the Primary Care Networks will be identified and encouragement for adoption and spread supported.

9.3 React to Red

Support to care homes and domiciliary care staff implement this programme of work to reduce the incidence of pressure ulcers continues to ensure sustainability of results.

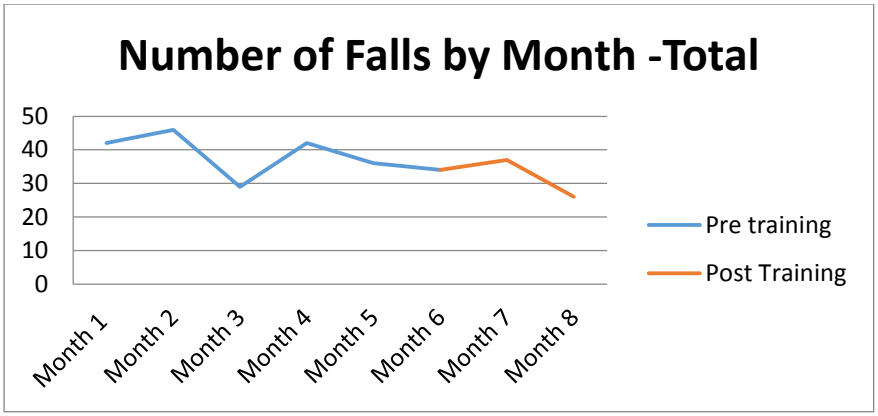
9.4 React to Falls Prevention

There are 31 participating care homes (out of 82)

438 care staff have received training, out of those trained only 38% have received previous falls training.

Feedback is positive with recognition given to the training approach adopted by the team.

Early data suggests that the training has had a positive impact upon a reduction in falls.



(NB data from 8 care homes that have sent consistent, regular figures)

9.5 Trusted Transfer Pathway Joint implementation with SRCCG

The Trusted Transfer of Care Document (Hospital passport) is implemented in care homes, with full recognition that trusted transfer should work for both transfer into and out of hospital to ensure continuity of personalised care and safety. Issues raised by care homes from transfer out of hospital are being raised and taken forward within the Complex Discharge Steering Group at YTHFT.

9.6 Care Home Capacity Tracker

The Care Home capacity tracker is an electronic mechanism for care homes to maintain a 'live update of their available capacity', which in turn assists with the identification of potential placements and reduced lengths of stay for people in hospital for people who need to transfer to a care home (either temporarily or permanently)

93% of Nursing and Residential homes and identified Residential Learning Disability homes in scope are registered on the Capacity tracker in VOY CCG. There are 4 in scope homes not using the tracker, 2 of which have recently opened, 1 of which has had on-going management changes and 1 which has a new CQC profile following takeover (so needs a new account creating)

63% of registered homes have updated within the recommended 7 days as of writing, and 77% within the last 14 days. 3 homes are not currently updating the tracker due to the home being suspended from new admissions.

The CCG has led the roll out of the Capacity Tracker as an identified NHSE/I priority to help reduce Delayed Transfers of Care, however in order to ensure sustainability of the development a joint approach needs to be taken forward with the Local Authority. The CCG is working positively with North Yorkshire County Council, however we have been unable to agree a joint approach with City of York Council. Further discussions are therefore required in order to progress.

10. RESEARCH AND DEVELOPMENT

A key focus of the Long Term Plan is research and innovation to drive future outcomes and improvement. This acknowledges that patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery.

The CCG is working with Primary Colleagues to support the increase in research activity.

10.1 National Institute for Health Research (NIHR) – Clinical Research Network Yorkshire & Humber – CCG Portfolio Research Activity

The following table provides an overview of research activity across the CCG. This compares positively against other CCGs within Yorkshire and Humber.

CCG	No. Practices	No. Practices Recruiting	% Practices Recruiting	No. Studies	Recruitment	Population	Recruitment per Million
NHS Vale of York CCG	26	18	69%	12	196	359,602	545

(NIHR Open Data Platform data cut 18/12/19)

10.2 Recruitment to NIHR Portfolio Research Studies within the NHS VoY CCG 01.04.19 – 22.11.19 by Practice

The following table demonstrates the positive activity being undertaken across practices within the CCG.

ODS	Site Name	No. Studies	Recruitment
B82021	DALTON TERRACE SURGERY	1	1
B82026	HAXBY GROUP PRACTICE	1	3
B82047	UNITY HEALTH	1	3
B82064	TOLLERTON SURGERY	1	1
B82068	HELMSLEY SURGERY	1	1
B82081	ELVINGTON MEDICAL PRACTICE	1	1
B82100	FRONT STREET SURGERY	1	1
B82105	TADCASTER MEDICAL CENTRE	1	1
B82031	SHERBURN GROUP PRACTICE	2	8
B82041	BEECH TREE SURGERY	2	2
B82074	POSTERNGATE SURGERY	2	5
B82097	SCOTT ROAD MEDICAL CENTRE	2	2
B82005	PRIORY MEDICAL GROUP	3	3

B82080	MY HEALTH GROUP	3	16
B82002	MILLFIELD SURGERY	4	12
B82033	PICKERING MEDICAL PRACTICE	5	27
B82098	JORVIK GILLYGATE PRACTICE	6	24

(NIHR Open Data Platform data cut 22/11/19)

Dr David Hartley at Jorvik Gillgate practice is stepping down from his role as research lead to concentrate on his new PCN Clinical Directors role. The new lead will be Dr Francesco Palumbo.

In addition to NIHR portfolio research, four of our General Practices undertake Commercial Research run either by their own staff or by local research company LH Clinical Research Limited.

10.3 New research studies in General Practice

The following are new research studies that are being taken forward within our CCG area:

- ACCESS study – Evaluation of patient access to medical test results service in general practice**.**
- OWL - Testing the short-term effectiveness of Online Weight loss programmes.
- An investigation of skill mix in primary care - online survey for Practice Managers
- MODS - Multi-Morbidity in Older Adults with Depression

10.4 Pickering Medical Practice Research Open Evening – 22nd October 2019

The practice welcomed members of the public, some of which had participated in research, along to their research open evening on 22nd October. The evening was supported by the VoY CCG R&D Manager, the NIHR Clinical Research Network: Yorkshire and Humber, Cancer Research UK, Join Dementia Research, the University of York Mental Health Research Team and the University of Newcastle's RURALLY research team. Members of the public were engaged in the subject and keen to discuss their participation in research. This was a successful evening, celebrating research and collaboration.

10.5 Research Partnership Group – update

The Research Partnership Group met in November and continued the topic of Smoking and Pregnancy. The Speciality Registrar in Public Health, City of York Council provided an update regarding the monetary incentive proposal for women who are pregnant and smoke. This research project will be discussed with maternity services at YTHFT in order to progress it.

The next Joint Strategic Needs Assessment Meeting (JSNA) topic for discussion is 'Over half the adults in York are overweight / obese' and will be led by YTHFT who have research ideas in mind that they want to explore further with the group.

11. CHILDREN AND YOUNG PEOPLE

11.1 Special School Nursing and Community Children's Nursing Transformation Plan

Previous reports to both QPEC and Governing Body have detailed the challenges of implementing a transformation plan for children and Young People jointly with York Teaching Hospitals NHS FT (YTHFT).

Positive discussions are now taking place following new Executive and Care Group Leadership, and a meeting with the Care Group responsible at YTHFT is scheduled for January 2020 to develop a work plan to take this forward. As is outlined later in this report, this work is fundamental to ensuring compliance with the Children and Families Act 2014.

This will be further supported by the appointment of a Head of Nursing for Child Health for YTHFT which is currently out to recruitment.

The risks however due to the existing delay in this work progressing are now included within the CCG's risk register.

11.2 Community Paediatric Continence Service

The team at YTHFT are consulting with the CCG on the implementation of the new community paediatric continence service. Emerging issues include responsible commissioner anomalies including children from other CCGs who are accessing the service without any commissioning arrangements in place. The senior quality lead for children and young people has met with the relevant Commissioner's and is supporting YTHFT with the transfer of these children back to their own area. Challenges include patients registered with CCGs where there is no established service.

Work is ongoing to agree with the trust the service level agreement describing the standards, quality and Key performance indicators expected.

11.3 End of Life care and support for children & young people

A new national service specification to improve palliative and end of life care for children and young people is under development. The Yorkshire & Humber Children's Palliative Care Network (YHCPN) have completed a project and developed an options appraisal and recommendations to NHSE to deliver against the new specification.

From a range of options considered the preferred recommendation includes:

- Two central specialised children's palliative care teams (funded by Specialised Commissioning, NHSE)

- Rapid response 24/7 community children's nursing provision (funded by CCGs)

For Vale of York, children and young people requiring end of life care at home have been historically low although it is not clear if this is due to the choice not being available. The local community children nursing service report they can provide some 'ad hoc' support, however this is not consistent and affects wider service provision. Children's continuing care is an option but there is limited availability of providers who can meet the health care needs at short notice so is not always successful.

Local intelligence suggests that:

Fraser et al (2011) suggested there are 144 children and young people with life limiting conditions across the Vale of York. This data is currently being reviewed and early indications are reportedly suggesting the prevalence is much higher.

The number of expected deaths for children and young people with life limiting conditions across York and North Yorkshire was 66 from 2013 – 2016 (CDOP data) which is currently not disaggregated between the CCGS.

Recent data (November 2019) submitted by our local children's hospice (Martin House) in Boston Spa reports that 37 children and young people (from Vale of York) with complex and life threatening conditions were supported over 518 nights by their service last year. This does not include bereavement support for families, including siblings.

The CCG contributions to Martin House have remained unchanged in at least seven years and are considerably small in finance terms.

Whilst this information suggests a gap in service provision for this group of patients and their families, it is important to note that there are no known complaints, feedback or stories reported to the CCG flagging a negative impact.

Additional NHSE funding for hospices and children's end of life care

NHSE recently announced additional finance support which includes:

- NHSE will provide match funding up to 7million (nationally) to CCGs investing in local children's and palliative care services
- Non recurrent additional funding up to 25 million for 2019/20 for both Adult and Children and Young people's hospices

The CCG has submitted an expression of interest to NHSE proposing additional investment (with match funding) in children & young people's palliative care to develop access to 24/7 end of life support for those who wish to die at home and their families. Thus achieving compliance with the new national service specification.

The CCG will also consider a more equitable split of the CCG grant funding between the adult and children's hospice. Meetings are scheduled with each of the hospices

to consider an appropriate split and consideration of the return of investment, recognising that a proportion of the funding will be to assist in provider resilience.

11.4 Joint Area SEND Inspection

To measure compliance with the various duties enacted by the Children and Families Act 2014 OfSted and CQC undertake joint area inspections of all children's SEND support; SEND support is available to all those children and young people up to the age of 25, who have needs that potentially adversely affect their educational attainment and life and employment opportunities. The inspection considers how effectively the local area:

- Identifies SEND
- Supports children and young people up to 25 with SEND and their families
- Improves outcomes for those with SEND

Themes of leadership, collaboration and joint planning underpin the effectiveness of the local arrangements.

The inspection reviews education, social care and health arrangements, both strategic and operational, and provides a commentary on strengths and areas for development. A written statement of action may be required where the inspection concludes there are areas of significant weakness; around half of all inspections now receive a written statement.

The SEND inspection for City of York (CYC) took place 9 – 13th December. Verbal feedback at high level has been received.

11.5 Children and Young People's Mental Health

The CCG continues to monitor the additional investment into service during 2019/2020. The Q2 monitoring report indicates a more rapid pathway from initial referral through the triage call and into the initial comprehensive assessment. TEWV and the CCG are discussing the priorities for investment in 2020/2021 and beyond, with a likely focus on increasing the level of resource into direct therapy work.

There is also work on developing the whole pathway commissioning approach across the CCG, TEWV, local authority and third sector partners, with a stakeholder workshop planned for January 2020 to scope the priorities for work in 2020. This is an exciting development, which is planned to bring all support together into a single pathway to ensure that children and young people have access to advice and support at every level of need.

Work with colleagues across North Yorkshire, including TEWV and the LMC has resulted in a draft protocol for health checks for children and young people with eating disorders: under the protocol, primary care will provide a detailed health analysis at point of referral, and once accepted by the clinic, TEWV will have responsibility for ordering and interpreting health check data whilst the young person

remains on caseload. The protocol is being discussed with the LMC and General Practice, and subject to comments, is set for introduction in January 2020.

12. ADULT MENTAL HEALTH

Improving Access to Psychological Therapies (IAPT) - Access and Recovery.

A Contract Performance Notice had previously been issued to TEWV for IAPT, however this has now been withdrawn as the access target has been achieved consistently from August to October and is now on track to deliver for 2019/20. The CCG will continue to closely monitor IAPT performance through the usual contract mechanisms going forward

13. RECOMMENDATIONS

Governing Body is requested to receive this report as assurance :

- of the work and activity on-going to ensure safe and quality services
- that the CCG is sighted upon key risk areas and that appropriate action is being taken to address the issues identified.

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Item Number: 9

Name of Presenter: Christine Pearson

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Learning Disability Mortality Review Annual Report 2018-19

Purpose of Report *(Select from list)*
To Receive

Reason for Report

The Learning Disability Mortality Review (LeDeR) Annual Report summarises the implementation and progress of the LeDeR programme in 2018-19. The report was received at the Quality and Patient Experience Committee on 12 December.

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

Risk Rating

Emerging Risks

None

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

Recommendations

Request that the Governing Body receive the report for assurance.

Decision Requested (for Decision Log)

Report received.

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse	Christine Pearson Designated Nurse Safeguarding Adults

Learning Disability Mortality Review

Annual Report

2018 - 2019

Authors and contributors:

Allison Brown Specialist Practitioner for LeDeR and Local Area Contact for Harrogate and Rural District CCG and Hambleton; Richmondshire and Whitby CCG.

Olwen Fisher Designated Professionals for Safeguarding Adults; LeDeR Project Lead; and Secondary Contact for North Yorkshire and York CCGs

Christine Pearson Designated Professionals for Safeguarding Adults and Local Area Contact for Scarborough and Ryedale CCG and Vale of York CCG

Heather Wilson Project Administrator; and Secondary Contact for North Yorkshire and York CCGs

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1.0 Introduction

1.1 This is the first annual report for the Learning Disability Mortality Review (LeDeR) programme compiled on behalf of Harrogate and Rural District (HaRD) CCG; Hambleton, Richmondshire; and Whitby (HRW) CCG; Scarborough and Ryedale (SCR) CCG; and Vale of York (VOY) CCG.

1.2 The report describes the national context of the programme; the local arrangements now in place; and the work undertaken to deliver the programme across the North Yorkshire and York area.

1.3 Most importantly the report includes the findings and learning from completed reviews; the key achievements so far; and the challenges and opportunities for the programme in 2019/20.

2.0 National Context

2.1 The LeDeR programme was established as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with a learning disability (CIPOLD). CIPOLD reported that some people with learning disabilities were dying sooner than they should. Some of the reasons for this were related to the standard of health and social care they received.

2.2 The LeDeR programme is run by the University of Bristol. It has been commissioned as the first programme of its kind by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

2.3 The LeDeR programme was set up to contribute to improvements in the quality of health and social care for people with learning disabilities in England. It does so by supporting local areas to carry out local reviews of deaths of people with learning disabilities. Through an agreed local review process, it aims to firmly embed the responsibility for conducting the reviews and implementing any recommendations and plans of action, into the hands of regional and local services.

2.3 The main purpose of the LeDeR review of a death of a person with learning disabilities is to:

- Identify any potentially avoidable factors that may have contributed to the person's death and
- Develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

2.4 In January 2018 the role of Local Area Contact for the programme was transferred from the NHS England project team to the CCG Designated Nurses for Safeguarding Adults.

3.0 Key Achievements in establishing the programme 2018/19

- ✓ Specialist Practitioner for the LeDeR Programme employed from the 1st October 2018 for two days per week on a one year fixed term contract. The role is hosted by HaRD CCG and funded by money from NHS England.

- ✓ A LeDeR Steering Group has been established across the four CCGs.

- ✓ Training has been delivered to build up the pool of reviewers and develop reviewers to achieve competence in the role.

- ✓ A database of LeDeR reviewers has been established with pen portrait of individuals to assist with the allocation of appropriate reviews.

- ✓ Continued development of a support system for reviewers in order to retain and recruit further reviewers and to contribute to their professional development and continued engagement with the programme.

- ✓ A system of quality assurance for completed reviews developed through the CCG Serious Incident Panel which ensures that appropriate scrutiny and extraction of learning and actions are formally recorded and agreed.

- ✓ Identification and implementation of links with other appropriate mortality review processes. (Child Death Overview Panel, Structured Judgement Reviews), and associated processes (Safeguarding Enquiry, Police Investigation, Coroners Process, Serious Incident Process).

- ✓ Raised awareness of the programme leading to an increase in referrals of deaths across the partnership including GPs; Local Authorities; and the Coroner's Office.

- ✓ Development of a GP `Myth Busters` briefing in conjunction with local GPs and the Nurse Consultant Safeguarding Children and Vulnerable Adults for Primary Care. This has been shared with NHS England as good practice.

- ✓ Awareness of LeDeR included in the GPs Protected Learning workshops in addition to inclusion in the annual programme of Safeguarding 'Hot Topic' events that have been attended by over 200 GP Practice staff.

- ✓ Valuable contribution of the GP Learning Disabilities Lead to increase GP knowledge regarding the LeDeR Programme.

- ✓ Established links with local Advocacy and Self-Advocacy Groups.

- ✓ Established links with care providers and partnership forums

4.0 Specialist Practitioner - LeDeR Programme

4.1 In Spring 2018 NHS England allocated funding across CCGs areas to support the development of the LeDeR Programme. The CCGs used the funding to employ a Specialist Practitioner for the programme on a fixed term contract for 2 days per week (end date 30th September 2019). Key deliverables for the role were agreed:-

- To be responsible, in conjunction with the Designated Nurses for Safeguarding Adults, and the Executive Nurse for NHS Harrogate and Rural District CCG, for the development and implementation of the LeDeR Review Programme as defined by NHS England and the Bristol University LeDeR Programme.
- To take the lead role in the recruitment, training, support, and activity of multi-agency LeDeR Reviewers, to ensure high quality LeDeR reviews identifying potential lessons to be learned as defined by the Bristol University LeDeR Programme.
- To take a lead role in the development and implementation of the LeDeR Review process and Strategic/Steering Group across NHS Scarborough and Ryedale CCG; NHS Harrogate and Rural District CCG; NHS Hambleton, Richmondshire and Whitby CCG; and NHS Vale of York CCG.
- To develop the sustainability of the programme and embed the principles across the multi-agency partnership.

4.2 The key deliverables have been achieved and it is hoped that future bids in 2019-20 for funding to continue the post with a focus on different objectives will be successful.

5.0 CCG Local Steering Group

5.1 As directed by the LeDeR guidance a sub-regional North Yorkshire and York LeDeR Steering Group has been established, utilising the existing North Yorkshire Transforming Care Partnership (TCP) footprint. The group provides oversight, support and governance to the local delivery of the programme. The Steering Group operates within the North Yorkshire CCGs Constitution and aligns with relevant CCG policies and procedures.

5.2 As part of the wider Transforming Care agenda, the group reports directly to the North Yorkshire Transforming Care Partnership via the Executive Lead Nurse.

5.3 The Group has an Information Sharing Agreement and a Privacy Impact Assessment to support working together and to enable appropriate sharing of information for the purpose of achieving good quality reviews.

5.4 Meetings are held bi-monthly with membership made up from the partners and relevant stakeholders from across the health and social care economy.

5.5 A Communications Strategy is in development to enable information and learning from both the national and local programme to be disseminated and embedded across networks.

6.0 Regional Steering Group

The regional steering group meeting is held on a quarterly basis and chaired by the Director of Nursing - NHS England - North (Yorkshire & the Humber). It is attended by the Regional Coordinator and the Local Area Contacts from each CCG. Speakup Self-Advocacy and Inclusion North provide the voice for people with a learning disability at the regional meeting. The meeting offers the opportunity to hear updates from the regional and national team; share information, best practice and challenges from across the region.

7.0 LeDeR methodology including changes to the Programme

7.1 The LeDeR review process is described on the LeDeR website at: http://www.bristol.ac.uk/sps/leder/. All deaths of people with learning disabilities aged 4 years and over in England are notified centrally and reviewed locally. The Local Area Contacts (LAC) are informed of referrals into the system; allocating these to a suitable LeDeR reviewer; supporting the reviewer through the process; conducting a preliminary quality assurance appraisal of the completed report prior to submission to the CCG Serious Incident Panel for scrutiny and final approval.

7.2 Allocation and completion of reviews for HaRD and HRW CCGs has used the methodology described in 7.1.

7.3 For the VOY and SCR CCGs a panel approach has been adopted for completion of reviews following a successful six month trial (October 2018 to April 2019). The multi-agency panel meets on a monthly basis and members are a cross-section from health and social care services with specialist knowledge of learning disabilities and review processes. All members have completed reviewer training. The reviews completed using this process are then submitted to the CCG Serious Incident Panel for scrutiny and final approval.

7.4 Both methods recognise families and carers as key contributors to reviews and prioritise their involvement throughout the process.

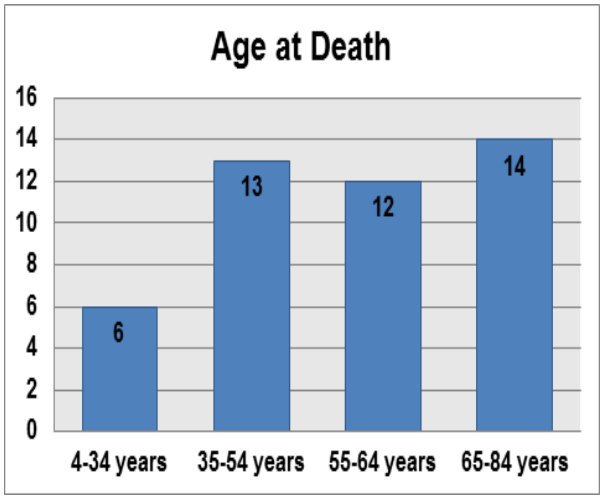
7.5 A process of ‘Rapid Review’ was proposed as a potential methodology for review of cases that were 60 working days or over from notification. This was due to the recognition of increasing number of cases nationally that were not allocated to a reviewer. A review may be suitable for this process if the death was not unexpected and there were no apparent complications or concerns. Locally further work took place supported by the Nurse Consultant for Safeguarding for Primary Care and one of the Lead GPs for Learning Disabilities to refine a template to gather relevant information from GP records for the ‘Rapid Review’. Thus far this approach has only been used in cases for HaRD and HRW CCGs.

7.6 From October 2018 the well-established statutory Child Death Review process was accepted as the primary review process for children with a learning disability; consequently it is not necessary for a separate LeDeR review to be completed; however it is still crucial that any learning is shared through the LeDeR programme network in the usual way.

8.0 Programme Statistics

8.1 The figures in tables 8.1.1 to 8.1.3 are reported from the total number of deaths (age 4 years and over) reported to the programme between April 1st 2018 and 31st March 2019 (n = 45). Where possible we have compared local data to the national statistics reported in LeDeR Annual Report 2018 published May 2019 by University of Bristol Norah Fry Centre for Disability Studies.

8.1.1 Age at death



Nationally the mean age at death for people with learning disabilities age over 4 years was 59 years. For males it was 60 years; for females 59 years

Locally the average age at death for people with a learning disability was 54 years. For males it was 55 years; for females 54 years.

The figures appear to show that locally people with learning disabilities are dying 5 years younger on average than nationally.

It is important to remember that comparisons with the general population are indicative but not directly comparable: deaths of people with learning disabilities are notified from the age of 4 years, while general population data also includes information about children aged 0-3 years.

In addition, as is shown in the national picture, more people who died at a younger age had profound and multiple learning disabilities and some of these would have complex medical conditions or genetic conditions that may make an earlier death likely.

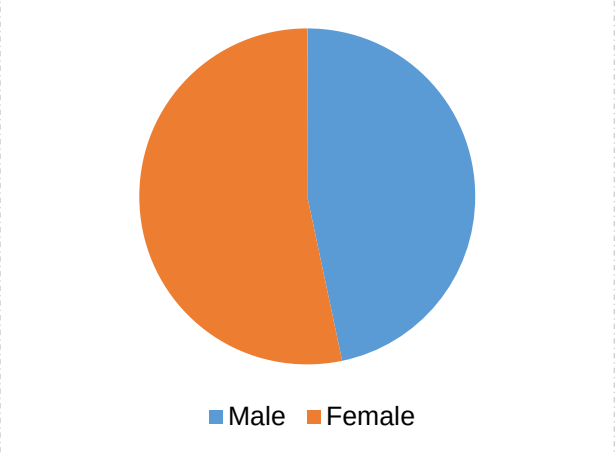
8.1.2 Place of Death

Place of death	Hospital	Usual place of residence	Residential/Nursing Home/Hospice that was not usual place of residence
Total	28	10	7
Local %	62%	22%	16%
National %	62%	n/a	n/a

The percentage of people with learning disabilities dying in hospital nationally was 62%; in the general population it is 46%; locally hospital also represents the place of death for 62% of those reported. Deaths in hospital were mostly attributable to acute infections that needed specialist interventions.

We hope that in 2019/20 where death is expected we will see people with a learning disability having choice and more supported planning around the place where they are looked after at the end of their life.

8.1.3 Gender



Nationally over half of deaths (58%) that reported the person's gender were males and 42% were females. Locally the person's gender was recorded in all cases and reports as 53% females and 47% males. We do not have the statistics to know whether this is reflective of the gender split in people with a learning disability in our local populations.

8

8.2 Reported deaths per CCG area and progress of completions of reviews.

The table and narrative below illustrates the number of reported deaths per CCG area and the progress of those reviews for the financial year 1st April 2018 – 31st March 2019.

CCG	Notified (between April 1st 18-March 31st 19)
HaRD + HRW	15
VOY + SCR	30
Total	45

Across North Yorkshire and York CCGs there were five reviews that were fully completed and approved within that period.

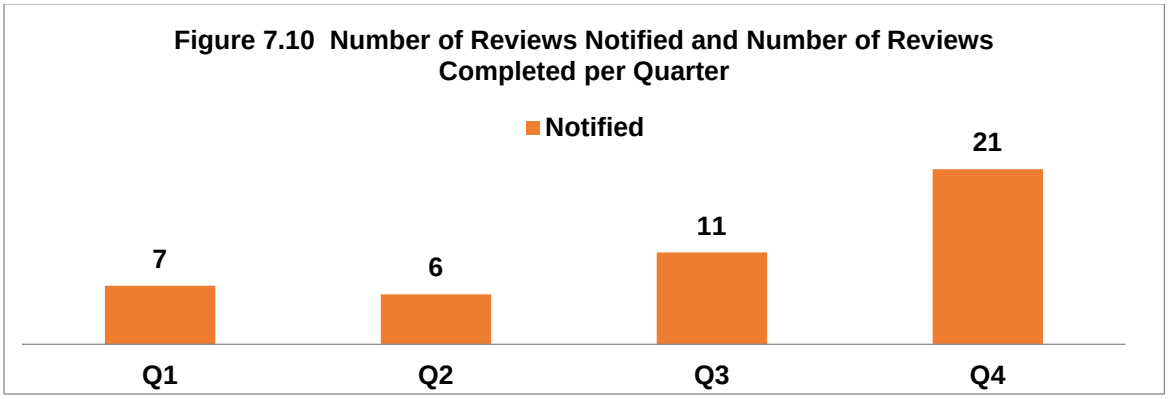
The higher number of deaths reported in VOY + SCR CCG area is considered to be reflective of the population size and the focus of panel members who have been active in searching for and reporting deaths.
The low number of completed reviews (11%) is disappointing but reflects the national picture (26%) whereby reviews remain unallocated due to a lack of reviewers and an initial prioritised focus on establishing the programme and governance structure across the four CCGs.

It is anticipated that with an increased investment in the programme in 2019/20 the percentage of reviews completed within the target timeframe (i.e. within six months of being reported) will be significantly more achievable.

8.3 Number of notifications per quarter (between April 1st 2018-March 31st 2019).

The table below reflects the number of deaths reported per quarter.

Figure 7.10 Number of Reviews Notified and Number of Reviews Completed per Quarter



The higher numbers in Q3 and Q4 are likely to be indicative of increased respiratory infections in the winter months; however they are also reflective of the increased awareness of the reporting of deaths.

8.4 Data reported below is taken from reviews that were notified, completed and approved (n=12) in York and North Yorkshire between April 1st 2018 - October 8th 2019. The dates have been extended beyond the financial year in order that the learning can be shared more proactively.

8.4.1 Cause of death

Due to the low numbers of completed reviews we are only reporting on the medical conditions most frequently cited in Part I of the Medical Certificate of Cause of Death which was: pneumonia (34%) and aspiration pneumonia (25%).

These are higher than the nationally reported cases in 2018 of pneumonia (25%) and aspiration pneumonia (16%).

Nationally pneumonia and aspiration pneumonia were causes of death more frequently reported in people with severe or profound and multiple learning disabilities.

Locally pneumonia and aspiration pneumonia were causes of death mostly in people with mild or moderate learning disabilities.

There are expressed concerns about the accuracy of the coding of the underlying causes of death in people with learning disabilities, nationally and internationally (LeDeR Annual Report 2018). These are the under-reporting that a person had learning disabilities when it was relevant to the cause of death, and erroneously listing a learning disability or an associated condition as an underlying cause of death, for example Downs Syndrome.

A number of completed reviews have 'Downs Syndrome' or 'Learning Disability' listed as the 'Other significant conditions contributing to death but not related to the disease or condition causing it'.

None of the completed reviews indicate Learning Disability or Downs Syndrome as the cause of death.

It is hoped that an increased awareness of the causes of death shared across the health and social care economy and increased investment in the learning into action programme both nationally and locally will lead to a more active approach being taken to reduce preventable conditions, for example – increasing the uptake of the influenza vaccination and health screening for people with a learning disability.
Increasing the offer and uptake of Annual Health Checks and development of a Health Action Plan will be essential to achieving this.

8.4.2 Indicators of the quality of care provided

At the end of their review, having considered all of the evidence available to them, reviewers are requested to provide an overall assessment of the quality of care provided to the person.The following are the possible gradings:

1) This was excellent care (it exceeded expected good practice).
2) This was good care (it met expected good practice).
3) This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's wellbeing).
4) Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.
5) Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.
6) Care fell far short of expected good practice and this contributed to the cause of death.

Local data reflects the national picture that the person who died had received care which met, or exceeded, good practice (83 %).

There were no cases locally where it was considered that care fell short of good practice that significantly impacted on wellbeing or directly contributed to death as opposed to 8% where this occurred nationally.

9. Local Learning

9.1 The LeDeR programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

9.2 The following are key examples of identified best practice reported in one or more reviews:

- ✓ Good communication between the learning disability hospital liaison nurses; the learning disability community teams; and the care providers which supported a better hospital experience for people

- ✓ Good team working demonstrated across primary and secondary care with advice and support for the care staff from the District Nurses and the Tissue Viability Nurse.

- ✓ Multiple examples of person centred care which provided a good quality of life.

- ✓ There was a high level of positive response by the care provider which supported an individual to achieve his personal goals.

9.3 Under the Equality Act 2010, organisations have a legal duty to make changes in their approach or provision to ensure that services are as accessible to people with disabilities as they are for everybody else. These changes are called reasonable adjustments.

The provision of reasonable adjustments often requires just a small amount of increased thought and planning on behalf of someone with a learning disability, which can then make the difference as to whether an intervention is successful or not.

Examples of reasonable adjustments are:

- ✓ information and letters provided in an easy read format
- ✓ reserved parking spaces when attending health appointments
- ✓ timing of appointments so person does not become anxious or distressed by waiting
- ✓ the provision of a side-room on a hospital ward to reduce the distress caused by the noise and disturbance from the busy main ward

9.4 Where the person who died has family members who have been involved in their care and support the family member is contacted to inform them of the review process and to ask them if they would like to be involved. Family members were represented in just over 40% of the completed reviews, often providing the person's story from childhood to older age through various struggles and challenges and changes in health; education; and social care provision. Reviewers have listened and recorded stories of historical abuse; and acknowledge the often ongoing adverse effects of multiple changes in care provision; and multiple changes of support staff. No family members in the twelve completed reviews have raised concerns to reviewers in relation to either the care of the person or the death of the person.

9.5 Care providers were represented in 100% of completed reviews. A small number of care providers raised concerns to the reviewer about the treatment of the person they were supporting in some parts of the health service. When these were looked at more closely in the review they were found to be mainly due to poor communication between the health team and the support staff.

9.6 There were no delays in care and treatment that had an adverse effect, no processes or problems with organisational systems and processes that led to a poor standard of care, or gaps in service provision that may have contributed to a person's death reported in the twelve completed reviews.

10.0 Recommendations made by reviewers for local action

The following are highlighted as recommendations from the completed reviews:

- The importance of using appropriate advocates. The Mental Capacity Act 2005 introduced Independent Mental Capacity Advocates (IMCA). It is important to use these services appropriately rather than presume family or friends can adequately fulfil the role.

- The consistent use of hospital passports in order to ensure that patients have their passport when they are admitted to hospital from their care facility.

- The importance of following correct DNA/CPR (do not attempt cardio-pulmonary resuscitation) processes. Forms should be completed clearly and should include discussion with person if they have capacity; and family member or an advocate if they lack capacity.

- End of Life Plans. People with a learning disability are not consistently offered the opportunity to develop an end of life plan.

- Identification of a Learning Disability on all medical records. For good communication and information, it would be beneficial if all medical records indicate that the patient was on the Learning Disability register including the GP summary.

- Documentation must adhere to standards for medicines management (NICE 2015 - Medicines management in care homes – Quality Standard 6: Covert Medicine Administration) and the Mental Capacity Act 2005. Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.

The recommendations are agreed and recorded and their progress into action is monitored by the local CCG LeDeR Steering Group.

11.0 Current National Position

11.1 The NHS long-term plan.

The NHS long-term plan was published in January 2019; with a stated commitment to continue to fund the LeDeR programme. It stated: *Across the NHS, we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives.* The plan went further in saying*: Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people* and *the whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing.*

11.2 Learning Disabilities Mortality Review (LeDeR) – Learning into Action network developed. Practical resources have been developed based on learning from completed reviews that could be usefully shared nationally to prevent replication, increase impact and help share good practice - however they haven't yet been located in one central searchable resource. The new Learning Disability Mortality network has been developed to meet this need.

11.3 The LeDeR Annual Report 2018 was published in May 2019. http://www.bristol.ac.uk/news/2019/may/leder-report.html referenced in the narrative report above.

11.4 Learning Disability Mortality Review (LeDeR) Programme: Action from Learning Report published in May 2019 https://www.england.nhs.uk/publication/leder-action-from-learning/ This is the first report translating learning into action carried out between 2018 and 2019. National projects to improve practice include: sepsis and the deteriorating patient; constipation; dysphagia; cancer; and the Mental Capacity Act.

11.5 From June 2019 NHS England will be investing a further £5 million nationally to ensure reviews of deaths are completed within six months of notification. There will also be an increase in transparency, with local reports to NHS public board meetings and greater detail published at a national level about each areas performance in completing reviews.

11.6 The Department of Health and Social Care (DHSC) extended its consultation on the proposal to introduce mandatory learning disability and autism training for health and care staff. The recommendation to make this training compulsory was originally recommended in the 2017 LeDeR Annual Report, which was published in May 2018. The DHSC consultation closed on Friday, April 26th. The response from the DHSC is still awaited.

11.7 The NHS Operational Planning and Contracting Guidance 2019/20 now include four deliverables in relation to the LeDeR programme:

- ✓ CCGs are a member of Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- ✓ There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- ✓ CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
- ✓ An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

The publication of this annual report provides evidence and assurance that these deliverables are being achieved in the North Yorkshire and York CCGs.

12.0 Summary

In 2018/19 the North Yorkshire and York CCGs have made significant progress in establishing the LeDeR programme. The achievements listed in the report show the combined commitment to making a difference to people with learning disabilities, their families and care providers to ensure that any learning points at individual level are shared widely across the health and social care economy and taken forward as appropriate into relevant service improvements.

The local team maintain strong links with the regional and national team in order to ensure that the progress made with the national action from learning projects is translated across local services.

13.0 Challenges for 2019/20

- Building capacity for reviewers within the local system is an ongoing challenge but is vital in order to sustain the programme. Some of this will be achieved through the allocation of additional funding from NHS England.

- Appropriate engagement from partner organisations in nominating and supporting LeDeR Reviewers is also required for the LeDeR programme to be successful.

- Continued attendance and engagement with the LeDeR Steering Group is vital to translate learning into action and share the learning across the system.

- Further raising of awareness within Primary and Secondary care in addition to establishing closer links with the local Coroner to influence the quality of information on death certificates of people with learning disabilities.

14.0 Acknowledgements

On behalf of the CCGs the local LeDeR team would like to acknowledge and pay tribute to the lives and deaths of the people who are in this report. They are sadly missed by those who supported them with love and care. We have met with some incredible care providers and amazing families and pass on our sincere condolences to them whilst also thanking them for the contributions they have made to making improvements in our systems.

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Item Number: 11

Name of Presenter: Abigail Combes

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Audit Committee Terms of Reference

Purpose of Report *(Select from list)*
To Ratify

Reason for Report

The Audit Committee undertook its annual review of the attached terms of reference at its meeting on 28 November 2019 and approved them for ratification by the Governing Body.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☒Legal
☐Primary Care
☐Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

N/A

Recommendations

The Governing Body is asked to ratify the Audit Committee Terms of Reference.

Decision Requested (for Decision Log)

The Governing Body ratified the Audit Committee Terms of Reference

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

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

NHS
Vale of York
Clinical Commissioning Group

AUDIT COMMITTEE

Terms of Reference

1 Introduction

The Audit Committee (the Committee) is established in accordance with NHS Vale of York Clinical Commissioning Group's constitution.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the constitution.

2 Membership

The Committee shall be appointed by the Clinical Commissioning Group as set out in the Clinical Commissioning Group's constitution and may include individuals who are not on the Governing Body. It shall consist of not less than three members including the following:

- Lay Member with the lead role in governance
- Lay member acting as Deputy Chair
- Secondary care clinician

The Lay Member on the Governing Body with a lead role in overseeing key elements of governance will chair the Audit Committee.

The Chair of the Governing Body will not be a member of the Committee.

3 Attendance

In addition to the members of the Committee the Chief Finance Officer (or nominated deputy), Accountable Officer (or nominated deputy), the respective appointed external and internal auditors, and anybody requested by the Chair will normally attend meetings.

The Executive Director of Quality and Nursing (or nominated deputy) will attend where requested by the Committee.

At least once a year the Committee should meet privately, separately with the external and internal auditors.

Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Audit Committee.

The Accountable Officer will normally attend and will discuss, at least annually with the Committee, the process for assurance that supports the annual governance statement.

Any other directors (or similar) may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Chair of the Governing Body may also be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

4 Secretary

The secretary will be responsible for supporting the Chair in the management of the Committee's business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

5 Quorum

A quorum shall be two members.

6 Frequency and Notice of Meetings

A minimum of five meetings will be held a year as set out in the Audit Committee Timetable. The Chair will agree dates and the secretary will give a minimum of 10 working days' notice of meetings.

The external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary

7 Remit and Responsibilities of the Committee

The Committee shall critically review the Clinical Commissioning Group's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

The duties of the Committee will be driven by the priorities identified by the Clinical Commissioning Group, and the associated risks. It will operate to a programme of business, agreed by the Clinical Commissioning Group that will be flexible to new and emerging priorities and risks.

As part of its integrated approach, the Committee will have effective relationships with other committees (for example, the Quality and Patient Experience Committee and Finance and Performance Committee) so that it understands processes and linkages. The distinct roles of these committees should, however, remain.

The key duty of the Audit Committee will be to provide and report assurance to the Governing Body on broadly the following areas:

Integrated Governance, Risk Management and Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control and the management of conflicts of interest across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

Its work will dovetail with that of the Quality and Patient Experience Committee, through which the Clinical Commissioning Group seeks assurance that robust clinical quality is in place.

Its work will also dovetail with that of the Finance and Performance Committee, through which the Clinical Commissioning Group seeks assurance that robust finance and performance is in place.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Clinical Commissioning Group.
- The management of Information Governance within the Clinical Commissioning Group.
- The policies, procedures and strategies for all work related to cyber security within the Clinical Commissioning Group.
- The underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in the NHS Counter Fraud Authority's counter fraud standards for commissioners.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching

systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Clinical Commissioning Group. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Clinical Commissioning Group.
- An annual review of the effectiveness of internal audit.
- Drawing the Committee's attention to best practice, national guidance and other relevant documents, as appropriate.

External Audit
The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the performance and independence of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Clinical Commissioning Group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions
The Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.
These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators / inspectors (for example, the Care Quality Commission and NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include clinical governance, risk management or quality committees that are established. In reviewing work on clinical governance and issues around clinical risk and management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit and quality assurance function.

Counter Fraud
The Committee shall satisfy itself that the Clinical Commissioning Group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

Management
The Committee shall request and review reports and positive assurances from officers, directors and managers on the overall arrangements for governance, risk management internal control and quality.

The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group's financial performance.

The Committee shall ensure that the systems for financial reporting to the Clinical Commissioning Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Clinical Commissioning Group.

The Committee shall review the annual report and financial statements before submission to the Governing Body and the Clinical Commissioning Group, focusing particularly on :

- The wording in the governance statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

Auditor Panel Provisions

The Committee will act as the CCG's Auditor Panel. It will formally record when it is acting as Auditor Panel. To be quorate, two lay members must be present. In the event of a dispute, the Chair has the casting vote.

The role of the Auditor Panel is to advise the Governing Body on the selection and appointment of the external auditor. The main tasks are to:

- Agree and oversee a robust process for selecting the external auditors in line with the organisation's normal procurement rules at least once every five years.
- Make a recommendation to the Governing Body as to the appointment.
- Advise on the purchase of 'non-audit services' from the auditor. This includes the approval of any policy on the purchase of 'non-audit services'.
- Ensure that any conflicts of interest for members and attendees at the auditor panel or external auditor, are dealt with effectively. For example, if non-statutory audit services work is awarded to the external auditor, ensure that the auditor's independence is maintained.
- Advise the Governing Body on the maintenance of an independent relationship with the appointed external auditor and that communications are professional.
- Advise the Governing Body on any decision as to the removal or resignation of the external auditor.
- Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.

8 Relationship with the Governing Body

The minutes of the Committee meetings shall be formally recorded by the secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure or executive action.

The Committee will report to the Governing Body at least annually on its work in support of the annual governance statement, specifically commenting on the fitness for purpose of the assurance framework, risk management arrangements in the organisation, and financial and governance arrangements.

9 Policy and Best Practice

The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of the group and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

10 Raising Concerns (Whistleblowing)

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about the possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

The Freedom to Speak Up Guardian is the Executive Director of Quality and Nursing.

11 Conduct of the Committee

The Committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice, including Nolan's seven principles of public life.

The Committee will review, at least annually, its own performance, membership and terms of reference. Any resulting changes to the terms of reference or membership will be approved by the Governing Body.

12 Review of Committee Effectiveness

The Committee shall undertake a review of its effectiveness at least annually. The Committee shall be subject to any review of Vale of York Clinical Commissioning Group committees as required.

Author	Abigail Combes Head of Legal and Governance
Reviewing Committee (including date)	Audit Committee 28 November 2019
Approved by (including date)	Governing Body
Version Number	5.0
Review Date :	November 2020

Author	Abigail Combes Head of Legal and Governance
Reviewing Committee (including date)	Audit Committee 23 May 2018
Approved by (including date)	Governing Body 05 July 2018
Version Number	4.0
Review Date :	July 2019

Author	Rachael Simmons Corporate Services Manager
Reviewing Committee (including date)	Audit Committee 23 May 2018
Approved by (including date)	Governing Body
Version Number	3.2
Review Date :	May 2018

Update by	Helena Nowell, Strategy and Assurance Manager
Date	20 September 2016
Committee Approval (including date)	Audit Committee 28 September 2016
Approved by (including date)	Council of Representatives 20 October 2016
Approved by (including date)	Governing Body 01 December 2016
Version Number	3.1
Review Date :	01 December 2017

Update by	Lynette Smith, Head of Corporate Assurance and Strategy
Date	27 August 2015
Committee Approval (including date)	Audit Committee 08 September 2015
Approved by (including date)	Governing Body 01 October 2015
Version Number	3.0

Author	Lynette Smith, Head of Integrated Governance
Committee Approved (including date)	Audit Committee 10 December 2014
Approved by (including date	Governing Body 05 February 2015
Issue Date	05 February 2015
Review Date	December 2016
Version Number	2.0 – December 2014

Item Number: 12

Name of Presenter: Simon Bell

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Financial Performance Report Month 8

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 2019/20 as at the end of November 2019.

To provide details and assurance around the actions being taken.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Recommendations

The Governing Body is asked to note the financial performance to date and the associated actions.

Decision Requested (for Decision Log)

The Governing Body is asked to note the report.

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

Annexes (please list)
Appendix 1 – Finance Dashboard
Appendix 2 – Running Cost Dashboard

Finance and Contracting Performance Report – Executive Summary

April 2019 to October 2019

Month 7 2019/20

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

IMPROVEMENTS IN PERFORMANCE

Issue	Improvement	Action Required
Primary Care QIPP	£642k of the Primary Care QIPP target of £700k has now been delivered with an additional £23k identified.	Continue to identify opportunities to deliver the remaining £35k slippage to deliver the full £700k.
Patient Transport	The trading position has been reviewed and the forecast has been subsequently reduced based upon current activity.	Continue to monitor the contract.
Primary Care – Other GP services	Slippage of £221k against the additional roles budget has been forecast in Month 8.	Continue discussions with PCNs and update forecast accordingly.
Running Costs	After a full review of running costs, the vacancy factor still to be identified within running costs has reduced from £245k in Month 7 to £66k in Month 8 representing a significant improvement.	Review costs each month and update the required vacancy factor accordingly.

Financial Performance Headlines

DETERIORATION IN PERFORMANCE

Issue	Deterioration	Action Required
MH Out of Contract Placements (MHOOC)	The MHOOC forecast outturn has deteriorated by £305k from Month 7. This is as a result of a number of new packages which have been backdated to the beginning of the year.	Work with the MH team to understand why there has been a delay on funding these packages.
Prescribing	The prescribing position has deteriorated from Month 7 by £193k.	An in-depth review of the movement between Month 7 and Month 8 is being undertaken to understand why the prescribing position has worsened.
Reserves	Non recurrent recovery actions of £2.2m are included within the forecast outturn to offset worsening performance in other areas.	Continue to review and manage contracts and expenditure. Review and confirm all CHC cases currently at various stages of legal challenge to identify requirement for contingency.

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. In year mitigations – The CCG has identified and quantified several risks to the financial position including slippage on QIPP and the increased activity at Ramsay. A set of in-year mitigations was agreed at Executive Committee on 18th September. The forecast financial position at Month 8 includes these risks and mitigations. As well as reporting the value of identified risks and delivery of mitigations to Finance Committee they will also be reported to Executive Committee on a fortnightly basis. Work on managing risk and realising mitigations is part of daily work in the CCG.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				2019-20 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	7.1	0.5	G
In-year total expenditure does not exceed total allocation (Programme and Running costs)					492.6	511.4	(18.8)	R
Better Payment Practice Code (Value)	95.00%	99.71%	4.71%	G	95.00%	>95.00%	0.00%	G
Better Payment Practice Code (Number)	95.00%	97.20%	2.20%	G	95.00%	>95.00%	0.00%	G
CCG cash draw dow n does not exceed maximum cash draw dow n					511.2	511.4	(0.2)	R

- 'In-year total expenditure does not exceed total allocation' – outturn expenditure is forecast to be £18.8m higher than the CCG's in-year allocation, but is in line with the CCG plan.

- 'CCG cash drawdown does not exceed Maximum Cash Drawdown' – this is currently showing as red on the RAG due to non-cash items (depreciation and provisions) which are included within expenditure but excluded from the Maximum Cash Drawdown.

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				2019-20 Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	4.8	4.7	0.1	G	7.1	7.1	(0.0)	G
Programme spend within plan	336.2	337.3	(1.1)	G	504.4	504.4	0.0	G
Actual position is within plan (In-year)	(12.6)	(13.6)	(1.1)	G	(18.8)	(18.8)	(0.0)	G
Actual position is within plan (Cumulative)					(81.3)	(81.3)	0.0	G
Risk adjusted deficit					(18.8)	(18.8)	0.0	G
Cash balance at month end is within 1.25% of monthly draw down (£000)	467	38	429	G				
QIPP delivery	8.8	7.2	(1.6)	R	14.7	11.2	(3.5)	R

- 'QIPP delivery' Year to Date (YTD) and Forecast Outturn (FOT) – the shortfall relates to prescribing indicative budgets (YTD £744k, FOT £1.0m) and System Recovery Schemes (YTD £1.1m, FOT £2.7m). These variances are detailed as deteriorations in performance on slide 3, and in more detail in the financial performance report narrative.

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Detailed Narrative

Report produced: December 2019

Financial Period: April 2019 to November 2019 (Month 8)

1. Month 8 Supporting Narrative

The year to date plan at Month 8 was a deficit of £12.6m; however the actual deficit is £13.6m, £1.0m worse than planned. This is explained in further detail in the table below.

QIPP delivery at Month 8 is £7.2m against a year to date plan target of £8.8m, £1.6m worse than plan. The difference relates primarily to slippage on prescribing schemes and system recovery plans. The forecasts relating to these schemes have been updated to reflect anticipated in year shortfalls – see section 7 for more details.

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
Reserves	(£1.66m)	This relates wholly to the System Recovery Schemes. Year to date delivery of these schemes is now reflected in the York Teaching Hospital Acute line.
Primary Care Prescribing	(£1.50m)	This variance includes slippage on QIPP schemes (£744k), Category M price increases from August (£332k) and NCSO charges (£294k).
Continuing Care	£1.00m	The reported position is based on information from the iQA system. A £1.5m contingency has been provided in plan for high cost packages, and this has not been utilised in the year to date position resulting in a £1.0m underspend.
Ramsay	(£0.49m)	The year to date position is based on the Month 7 flex position. Activity in April to September was higher than plan however October has seen a reduction in activity.
Other Services	(£0.44m)	The CCG has agreed and paid a settlement to NHS Property Services for 2017/18 and 2018/19 invoices. This creates an in-year pressure of £381k, but represents a significant write off of outstanding bills and means the CCG has no on-going financial liability for Bootham Park Hospital estate from 1st April 2019.
Other Mental Health	£0.41m	This variance is due to phasing of Transforming Care Partnership packages.
Other Acute Contracts	£0.33m	Several of the CCG's smaller acute contracts have had lower activity than plan including Harrogate

		(£161k) and Mid Yorkshire (£171k).
York Teaching Hospital NHS Foundation Trust	£0.32m	The year to date delivery of System Recovery Schemes is now reflected on this line, as these schemes relate to reduced planned care costs at YTHFT.
Other variances	£0.98m	
Total impact on YTD	**(£1.06m)**	

2. Forecast Outturn Supporting Narrative

The forecast outturn of £18.8m deficit is in line with plan, however within this position there are several variances which are explained in further detail in the following table.

The forecast outturn includes QIPP delivery of £11.2m, which is a shortfall of £3.4m against the CCG's plan of £14.7m. This variance relates to System Recovery Schemes (£2.7m) and Prescribing (£1.0m).

Forecast in-year financial position – variance analysis

Description	Value	Commentary / Actions
Contingency	£2.44m	The CCG's contingency has now been released in full to offset the reduced delivery of the System Recovery Schemes.
Reserves	(£1.68m)	This variance relates to the £3.7m planned System Recovery Schemes – forecast delivery of these schemes is now reflected in the York Teaching Hospital Acute line. This is offset by further recovery actions of £2.19m.
Primary Care Prescribing	(£2.18m)	The Prescribing forecast now includes £1.0m slippage on QIPP schemes. It also includes £665k relating to the nationally notified Category M price adjustment and £441k of NCSO, which it is assumed will be managed by CCGs and therefore has been included in the forecast position.
Continuing Care	£0.72m	The forecast position is based on information from the iQA system. A £1.5m contingency has been provided in plan for high cost packages. There has been no expenditure incurred against this from April to November, and the forecast now assumes that there will be a £750k underspend against this contingency.
York Teaching Hospital NHS Foundation Trust	£0.72m	The forecast delivery of System Recovery Schemes is now reflected on this line, as the majority of schemes relate to reduced planned care costs at YTHFT.
Out of Contract Placements	(£0.55m)	This worsening forecast position is due to the full year effect of a number of new out of contract packages which have been backdated to the beginning of the year.
Other Acute Contracts	£0.50m	Several of the CCG's smaller acute contracts have had lower activity than plan so far in 2019/20 and this pattern is extrapolated in the CCG's forecast. This includes £259k with Mid Yorkshire, £244k with

		Harrogate and £176k with Leeds.
Other Services	(£0.46m)	The CCG has agreed a position with the NHS Property Services arbitration team for the settlement of 2017/18 and 2018/19 invoices as described in the year to date variances.
Ramsay	(£0.43m)	Activity at Ramsay has been higher than plan for April to September and without additional action the forecast is an £730k overspend. The forecast position assumes that Ramsay spend is managed within the contract value for December to March.
Other variances	£0.92m	
Total impact on forecast	**£0.00m**	

3. Gap and Key Delivery Challenges

In the Month 8 non-ISFE submission, the CCG did not report any additional risks to delivery of the forecast outturn.

4. Allocations

The allocation as at Month 8 is as follows:

Description	Recurrent / Non-recurrent	Category	Value
Total allocation at Month 7			£428.86m
GPFV – Practice Resilience – STP Funding	Non-recurrent	Core	£0.01m
GPFV – Primary Care Networks – STP Funding	Non-recurrent	Core	£0.24m
Charge Exempt Overseas Visitor Adjustment	Non-recurrent	Core	(£0.33m)
LeDeR Funding 2019/20	Non-recurrent	Core	£0.04m
Winter Funding for York and Scarborough system	Non-recurrent	Core	£1.30m
Total allocation at Month 8			**£430.12m**

5. Underlying position

The underlying position reported at Month 8 is a deficit of £23.8m; this is detailed in the table below.

Description	Value
Planned in-year deficit	**(£18.84m)**
Adjust for non-recurrent items in plan -	
Equipment and wheelchairs non-recurrent prior year payment	£0.20m
Deferred PIB payments	£0.60m
Repayment of 2016/17 system support	£0.33m
Primary Care slippage – non-recurrent QIPP	(£0.60m)
Other non-recurrent items in plan	£0.19m
Underlying position in financial plan	(£18.13m)
Recurrent impact of System Recovery Scheme under delivery	(£3.37m)
Recurrent impact of QIPP under delivery	(£1.00m)
Recurrent overspends in forecast outturn	(£1.70m)
FYE of QIPP and investments	£0.40m
Reported underlying position	**(£23.79m)**

6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 30 November 2019. The CCG's Maximum Cash Drawdown as determined by NHS England has been updated in November for the expected value of depreciation. The CCG is showing a difference of £0.2m due to non-cash items (depreciation and provisions) which are included within expenditure but excluded from the Maximum Cash Drawdown.

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

7. QIPP programme

		Year to Date			Forecast Outturn				
Area	Scheme	Plan	Actual	Variance	Plan	Delivered	Forecast	FOT Variance	Comments
Acute Commissioning	Anti-Coagulation Monitoring - move to Primary Care	20	20	0	30	30	30	0	Full year effect, delivered in 2019-20
	Biosimilar drugs (FYE)	2,060	2,060	0	2,384	2,384	2,384	0	Delivered in full through acute contract
	Cost reductions in contract	1,653	1,653	0	2,970	2,970	2,970	0	Delivered in full through acute contract
Complex Care	CHC Packages (FYE)	1,252	1,331	79	1,401	1,443	1,443	42	Delivered in full
	MH Out of Contract Packages (FYE)	226	215	(11)	237	224	224	(13)	Delivered in full
	Review of CHC Packages	635	469	(166)	1,377	469	1,247	(129)	Forecast is based on a detailed package by package savings report and will continue to be monitored throughout the year.
	Fast track post (investment)	(32)	(32)	0	(48)	(32)	(48)	0	
	MH Out of Contract Packages	0	93	93	0	93	168	168	No specific line in plan relating to MH OOC but packages continue to be reviewed. This offsets the forecast shortfall in CHC to deliver the full level of planned savings across complex care.
Prescribing	Prescribing schemes	927	183	(744)	2,008	183	1,004	(1,004)	Prescribing Indicative Budgets 2 has been rolled out from September 2019 with Primary Care Networks. The forecast delivery ofthis scheme assumes delivery over the second half of the financial year and therefore £1.0m slippage against the plan value.
Primary Care	Primary Care investment slippage	400	619	219	600	642	700	100	The forecast delivery now includes an additional £100k slippage following Executive Committee approval of non recurrent mitigations to manage emerging in year pressures. £642k of slippage has been delivered, which includes £198k in relation to GP Framework additional roles.
System Recovery Schemes	Independent Sector	556	0	(556)	1,000	0	0	(1,000)	The forecast delivery of System Recovery schems has been reviewed and agreed by system partners. The overall forecast delivery across the system is £3.2m against a plan value of £11.2m. This results in a £0.8m shortfall, of which £2.7m impacts the CCGs financial position.
	Cardiology prescribing - DOAC switch	389	0	(389)	700	0	0	(700)	
	Decommissioning non obstetric ultrasounds (YHS)	123	0	(123)	370	0	0	(370)	
	PTS - decommission saloon cars / tighten criteria	83	51	(33)	250	51	76	(174)	
	Management costs	100	0	(100)	180	0	0	(180)	
	Other acute cost reductions (YTHFT)	407	513	106	1,220	513	982	(238)	
		8,799	**7,175**	**(1,624)**	**14,679**	**8,970**	**11,181**	**(3,498)**	
	Performance against plan		**82%**			**61%**	**76%**		
	Delivery as a percentage of in-year allocation				**3.0%**	**1.8%**	**2.3%**		

Appendix 1 – Finance dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioned Services																		
Acute Services																		
York Teaching Hospital NHS FT	145,135	144,819	316	127,032	126,747	285	18,103	18,073	31	217,212	216,491	721	217,212	216,415	797	0	76	(76)
Yorkshire Ambulance Service NHS Trust	9,511	9,511	(0)	8,322	8,322	(0)	1,189	1,189	(0)	14,267	14,267	(0)	14,267	14,267	(0)	0	0	0
Leeds Teaching Hospitals NHS Trust	5,679	5,562	117	4,978	4,882	96	701	680	20	8,497	8,321	176	8,497	8,331	166	0	(10)	10
Hull and East Yorkshire Hospitals NHS Trust	2,235	2,353	(118)	1,954	2,094	(141)	281	259	22	3,320	3,487	(167)	3,320	3,545	(225)	0	(58)	58
Harrogate and District NHS FT	1,699	1,538	161	1,479	1,310	169	220	228	(8)	2,552	2,308	244	2,552	2,258	295	0	51	(51)
Mid Yorkshire Hospitals NHS Trust	1,425	1,254	171	1,247	1,113	134	178	141	37	2,119	1,860	259	2,119	1,886	232	0	(26)	26
South Tees NHS FT	948	948	(0)	829	829	(0)	118	118	(0)	1,422	1,422	0	1,422	1,422	0	0	0	0
North Lincolnshire & Goole Hospitals NHS Trust	248	271	(23)	217	213	4	31	58	(27)	369	404	(35)	369	319	50	0	85	(85)
Sheffield Teaching Hospitals NHS FT	195	171	24	171	147	24	24	25	(0)	293	269	24	293	269	24	0	0	(0)
Non-Contracted Activity	3,599	3,651	(53)	3,149	3,129	20	450	522	(72)	5,398	5,479	(80)	5,398	5,379	20	0	100	(100)
Other Acute Commissioning	899	728	171	778	600	178	121	127	(7)	1,382	1,264	117	1,382	1,275	106	0	(11)	11
Ramsay	3,226	3,713	(487)	2,827	3,333	(505)	398	380	18	4,820	5,246	(426)	4,820	5,246	(427)	0	(0)	0
Nuffield Health	2,393	2,162	231	2,098	1,941	157	296	221	74	3,574	3,232	342	3,574	3,310	264	0	(78)	78
Other Private Providers	944	790	153	826	723	103	118	68	50	1,415	1,185	230	1,415	1,269	147	0	(83)	83
Sub Total	**178,135**	**177,473**	**662**	**155,907**	**155,383**	**524**	**22,229**	**22,091**	**138**	**266,639**	**265,236**	**1,403**	**266,639**	**265,191**	**1,448**	**0**	**45**	**(45)**
Mental Health Services																		
Tees, Esk and Wear Valleys NHS FT	29,381	29,391	(10)	25,708	25,718	(10)	3,673	3,673	(0)	44,028	44,038	(10)	44,028	44,038	(10)	0	0	0
Out of Contract Placements	4,902	5,134	(232)	4,289	4,376	(87)	613	757	(145)	7,353	7,901	(549)	7,353	7,596	(244)	0	305	(305)
SRBI	810	989	(179)	709	847	(138)	101	142	(41)	1,215	1,427	(211)	1,215	1,424	(208)	0	3	(3)
Non-Contracted Activity - MH	305	209	96	267	157	110	38	52	(14)	458	362	96	458	347	110	0	14	(14)
Other Mental Health	739	334	405	647	481	166	92	(147)	239	1,109	1,154	(46)	1,109	1,141	(32)	0	14	(14)
Sub Total	**36,137**	**36,056**	**81**	**31,620**	**31,578**	**42**	**4,517**	**4,478**	**39**	**54,163**	**54,882**	**(719)**	**54,163**	**54,546**	**(383)**	**0**	**336**	**(336)**
Community Services																		
York Teaching Hospital NHS FT - Community	12,750	12,750	0	11,156	11,156	0	1,594	1,594	0	19,125	19,125	0	19,125	19,125	0	0	0	0
York Teaching Hospital NHS FT - MSK	1,557	1,557	(0)	1,363	1,363	(0)	195	195	(0)	2,336	2,336	(0)	2,336	2,336	(0)	0	0	0
Harrogate and District NHS FT - Community	1,936	1,951	(15)	1,694	1,735	(40)	242	216	26	2,905	2,882	22	2,905	2,884	21	0	(1)	1
Humber NHS FT - Community	1,437	1,438	(1)	1,258	1,258	(1)	180	180	(0)	2,156	2,157	(1)	2,156	2,157	(1)	0	0	0
Hospices	998	995	2	873	871	2	125	124	0	1,497	1,493	3	1,497	1,494	3	0	(0)	0
Longer Term Conditions	188	184	4	165	171	(7)	24	13	11	282	279	3	282	290	(8)	0	(11)	11
Other Community	1,737	1,887	(150)	1,521	1,649	(127)	216	238	(22)	2,592	2,850	(257)	2,592	2,733	(140)	0	117	(117)
Sub total	**20,604**	**20,763**	**(159)**	**18,030**	**18,203**	**(173)**	**2,574**	**2,560**	**14**	**30,893**	**31,122**	**(229)**	**30,893**	**31,018**	**(125)**	**0**	**105**	**(105)**

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			FOT Previous Month			FOT Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Other Services																		
Continuing Care	18,206	17,206	1,000	15,992	15,069	923	2,214	2,137	77	26,885	26,167	718	26,885	26,029	855	0	138	(138)
CHC Clinical Team	833	788	44	729	691	38	104	98	6	1,303	1,272	31	1,303	1,271	32	0	1	(1)
Funded Nursing Care	2,701	2,540	161	2,364	2,324	39	338	216	122	4,052	3,783	269	4,052	4,032	20	0	(249)	249
Patient Transport - Yorkshire	1,489	1,396	94	1,303	1,314	(11)	186	82	104	2,234	2,094	140	2,234	2,254	(20)	0	(160)	160
Voluntary Sector / Section 256	373	365	9	327	319	8	47	46	1	560	547	13	560	547	13	0	0	0
Non-NHS Treatment	415	420	(6)	363	363	(0)	52	57	(5)	622	632	(10)	622	628	(6)	0	4	(4)
NHS 111	708	706	2	619	618	1	88	88	0	1,061	1,059	3	1,061	1,059	3	0	0	0
Better Care Fund	7,534	7,537	(3)	6,599	6,601	(3)	935	936	(0)	11,275	11,280	(5)	11,275	11,280	(5)	0	0	0
Other Services	472	916	(444)	413	828	(415)	59	88	(29)	708	1,172	(464)	708	1,141	(433)	0	30	(30)
Sub total	**32,731**	**31,874**	**857**	**28,708**	**28,127**	**581**	**4,023**	**3,748**	**276**	**48,701**	**48,006**	**695**	**48,701**	**48,241**	**460**	**0**	**(235)**	**235**
Primary Care																		
Primary Care Prescribing	32,225	33,726	(1,501)	28,257	29,216	(959)	3,968	4,510	(541)	47,319	49,501	(2,182)	47,319	49,309	(1,990)	0	193	(193)
Other Prescribing	1,518	1,361	158	1,154	1,140	14	365	221	144	1,978	2,079	(102)	1,978	2,121	(143)	0	(42)	42
Local Enhanced Services	1,551	1,454	97	1,378	1,289	90	173	165	8	2,242	2,120	122	2,242	2,124	118	0	(4)	4
Oxygen	248	256	(9)	217	225	(8)	31	32	(1)	371	385	(13)	371	385	(14)	0	(1)	1
Primary Care IT	611	530	81	535	518	17	76	12	64	917	778	139	917	861	57	0	(83)	83
Out of Hours	2,165	2,177	(12)	1,894	1,904	(10)	271	273	(3)	3,247	3,372	(125)	3,247	3,380	(133)	0	(8)	8
Other Primary Care	1,809	1,900	(91)	1,439	1,487	(48)	370	413	(43)	2,713	2,947	(234)	2,466	2,431	35	247	516	(269)
Sub Total	**40,127**	**41,404**	**(1,277)**	**34,873**	**35,777**	**(904)**	**5,254**	**5,627**	**(373)**	**58,787**	**61,181**	**(2,394)**	**58,540**	**60,610**	**(2,070)**	**247**	**572**	**(325)**
Primary Care Commissioning	**30,135**	**29,879**	**256**	**26,302**	**26,019**	**283**	**3,832**	**3,860**	**(28)**	**45,265**	**44,899**	**366**	**45,265**	**44,963**	**302**	**0**	**(64)**	**64**
Trading Position	**337,869**	**337,449**	**420**	**295,440**	**295,087**	**353**	**42,429**	**42,362**	**67**	**504,449**	**505,326**	**(877)**	**504,202**	**504,569**	**(367)**	**247**	**757**	**(510)**
Prior Year Balances	0	(117)	117	0	(103)	103	0	(14)	14	0	(117)	117	0	(103)	103	0	(14)	14
Reserves	(1,658)	0	(1,658)	(1,142)	0	(1,142)	(516)	0	(516)	(2,508)	(825)	(1,683)	(3,515)	(1,336)	(2,179)	1,007	511	496
Contingency	0	0	0	0	0	0	0	0	0	2,443	0	2,443	2,443	0	2,443	0	0	0
Unallocated QIPP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reserves	**(1,658)**	**(117)**	**(1,541)**	**(1,142)**	**(103)**	**(1,039)**	**(516)**	**(14)**	**(502)**	**(65)**	**(942)**	**877**	**(1,072)**	**(1,439)**	**367**	**1,007**	**497**	**510**
Programme Financial Position	**336,211**	**337,332**	**(1,121)**	**294,298**	**294,984**	**(686)**	**41,914**	**42,348**	**(435)**	**504,384**	**504,384**	**0**	**503,130**	**503,130**	**0**	**1,254**	**1,254**	**(0)**
In Year Surplus / (Deficit)	(12,566)	0	(12,566)	(10,995)	0	(10,995)	(1,571)	0	(1,571)	(18,849)	0	(18,849)	(18,849)	0	(18,849)	0	0	0
In Year Programme Financial Position	**323,645**	**337,332**	**(13,687)**	**283,302**	**294,984**	**(11,682)**	**40,343**	**42,348**	**(2,005)**	**485,535**	**504,384**	**(18,849)**	**484,281**	**503,130**	**(18,849)**	**1,254**	**1,254**	**(0)**
Running Costs	**4,783**	**4,725**	**59**	**4,243**	**4,201**	**42**	**540**	**524**	**17**	**7,052**	**7,052**	**(0)**	**7,052**	**7,052**	**(0)**	**0**	**0**	**0**
Total In Year Financial Position	**328,428**	**342,057**	**(13,629)**	**287,545**	**299,185**	**(11,640)**	**40,883**	**42,872**	**(1,989)**	**492,587**	**511,436**	**(18,849)**	**491,333**	**510,182**	**(18,849)**	**1,254**	**1,254**	**(0)**
Brought Forward (Deficit)	(41,647)	0	(41,647)	(36,441)	0	(36,441)	(5,206)	0	(5,206)	(62,471)	0	(62,471)	(62,471)	0	(62,471)	0	0	0
Cumulative Financial Position	**286,781**	**342,057**	**(55,276)**	**251,104**	**299,185**	**(48,081)**	**35,677**	**42,872**	**(7,195)**	**430,116**	**511,436**	**(81,320)**	**428,862**	**510,182**	**(81,320)**	**1,254**	**1,254**	**(0)**

Appendix 2 – Running costs dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
Directorate	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**	**Budget £000**	**Actual £000**	**Variance £000**
Joint Commissioning	124	74	50	109	67	42	16	7	8	197	132	65	197	154	43	0	(22)	22
Chief Executive / Board Office	775	676	99	678	595	83	97	81	16	1,162	1,016	146	1,162	1,050	112	0	(34)	34
Planned Care	674	650	24	596	585	11	78	66	12	986	957	29	986	968	17	0	(12)	12
Communication and Engagement	186	153	33	162	133	29	24	20	4	284	266	18	284	278	6	0	(12)	12
Contract Management	571	529	42	500	463	36	71	65	6	856	786	70	856	797	59	0	(11)	11
Corporate Governance	660	611	49	589	544	45	70	66	4	937	893	43	937	898	39	0	(4)	4
Finance	892	848	44	793	757	37	99	91	8	1,291	1,246	44	1,291	1,268	23	0	(22)	22
Medicines Management	84	81	3	74	73	1	11	9	2	126	115	11	126	126	0	0	(11)	11
Quality & Nursing	512	493	19	458	445	13	54	48	6	726	697	29	726	718	8	0	(21)	21
Risk (SI team)	21	20	1	18	17	1	3	3	(1)	31	27	5	31	30	1	0	(3)	3
RSS	214	219	(6)	187	182	5	27	37	(11)	320	332	(11)	320	335	(14)	0	(3)	3
Primary Care	454	370	84	414	341	74	40	30	10	711	653	58	711	676	35	0	(23)	23
Reserves	(383)	0	(383)	(335)	0	(335)	(48)	0	(48)	(575)	(67)	(508)	(575)	(245)	(330)	0	178	(178)
Overall Position	**4,783**	**4,725**	**59**	**4,243**	**4,201**	**42**	**540**	**524**	**17**	**7,052**	**7,052**	**(0)**	**7,052**	**7,052**	**(0)**	**0**	**0**	**(0)**

Item Number: 13

Name of Presenter: Caroline Alexander

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Integrated Performance Report Month 7 2019/20

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

Reason for Report

This document provides a triangulated overview of CCG performance across all NHS Constitutional targets which identifies the causes of current performance levels and the work being undertaken by CCG partners across a number of different forums and working groups in the local Vale and Scarborough and Ryedale system and wider Humber, Coast and Vale Care Partnership to drive performance improvement.

The report captures validated data for Month 7 (October 2019)

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☒Equalities

Risk Rating

Emerging Risks

Impact Assessments Please confirm below that the impact assessments have been approved and outline any risks/issues identified. ☐ Quality Impact Assessment ☐ Equality Impact Assessment ☐ Data Protection Impact Assessment ☐ Sustainability Impact Assessment **Risks/Issues identified from impact assessments: N/A**
Recommendations
Decision Requested (for Decision Log)

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam, Accountable Officer	Caroline Alexander, Assistant Director of Performance and Delivery

Vale of York CCG
Integrated Performance Report

Validated data to October 2019, Month 7 2019/20

Produced December 2019

NHS
Vale of York
Clinical Commissioning Group

Contents

- **Planned Care:**
  - Diagnostics
  - Referral to Treatment (RTT)
  - % of children waiting 18 weeks or less for a wheelchair
  - Cancer
- **Unplanned and Out of Hospital Care:**
  - Emergency Department – York Teaching Hospital NHS Foundation Trust
  - Yorkshire Ambulance Service (YAS)
  - NHS 111 – Yorkshire and Humber
  - GP Out of Hours – Northern Doctors
  - Primary Care Access
  - Delayed Transfers of Care (DTOCs)
- **Mental Health:**
  - Improving Access to Psychological Therapies (IAPT)
  - Early Intervention in Psychosis (EIP)
  - Dementia Diagnosis
  - Children and Young People's (CYP) Mental Health Services Access Rate
  - Children and Adolescent Mental Health Services (CAMHS) Referral to Treatment (RTT)
  - Children and Young People's (CYP) Eating Disorders
  - Autism Assessments
  - Annual Health Checks for people with Severe Mental Illness (SMI)
- **Complex Care:**
  - Continuing Healthcare (CHC)
  - Personal Health Budgets (PHBs)
- **NHS Oversight Framework 2019/20**
- **Clinical Standards Review 2019**
- **Acronyms**

Performance Headlines

1. On 13th December, NHS England confirmed that there will no longer be a requirement for a separate assessment of CCG performance against the six clinical priority areas – cancer, mental health, maternity, learning disabilities, diabetes, and dementia. The independent panels have now been stood down to enable greater focus on the delivery of the NHS Long-Term Plan.

2. Winter and System Resilience – headlines:

- **ECS 4 hr performance** was 75.7% November and 77% as at 13/12/19

This makes YTHFT ranking 66/123 providers nationally and 20/44 regionally

- **ED attendances all types** increased in November 2019 as compared to Nov 2018 as follows:

+12% York ED and +8% SGH ED
+12% paediatrics across both sites

- **Ambulance handovers** performance has further deteriorated this is the critical trigger for NHSE/I regional winter escalation
- **Quality Improvement Board** has been established to support mitigation of risks at SGH site
- Further system resilience work to develop the escalation response across partners and consider how to develop a **'full capacity plan'**
- **Winter reporting daily 7/7** has started and escalation framework refreshed to support all partners in escalating if one partner reaches opel 3
- **Winter funding** has been confirmed from NHSE/I to support access and care delivery
- All system resilience actions in the **winter resilience plan** are being progressed
- The **HCRB single workplan** will be finalised in January 2020
- **DTOCs** – the CCG has supported work as a system to streamline reporting as a system and this has freed up clinical time in recording information. Further work to finalise reporting based on new system will be complete by early January and support the HCRB 'interface' work group in monitoring the impact of work around improving discharge

3. Additional funding from NHSE/I to support elective care and diagnostics capacity of £319,000 has been received and is now being mobilised. NEIST have supported the development of refreshed recovery plans for diagnostics which will be incorporated into performance improvement plans and trajectories in January.

4. Cancer:

- 62D performance stable at 75.9% but noted that 54% of all 62 day breaches are due to delays in diagnostics and 31% due to inconclusive diagnostics (Rapid Diagnostics Centre pilot now rolling out)
- 2WW above target at 93.2% but noted 7% increase YTD in fast track referrals from same period 2018/19 (pressure of screening

5. Mental health: improvements in IAPT and EIP at target but noted increase in referrals to both services and for autism assessments.

Performance and Programme Overview
Planned Care

Areas Covered:

- Diagnostics
- Referral to Treatment (RTT)
- % of children waiting 18 weeks or less for a wheelchair
- Cancer

Content:

- Summary dashboard
- Narrative
- Supporting data

NHS
Vale of York
Clinical Commissioning Group

Vale of York CCG Performance Summary Dashboard – Planned Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Previous 3 Quarters			Current QTD	Previous Financial Year	Current Financial YTD
																		2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2018/19	2019/20
Planned Care																							
133a	E.B.4		Diagnostics	Diagnostics: % waiting >6 weeks	≤1%	7.3%	11.0%	11.1%	8.6%	8.2%	12.7%	13.7%	11.7%	12.2%	18.6%	17.4%	17.9%	9.4%	12.7%	16.0%	17.9%	6.5%	14.9%
129b		Y	RTT	RTT: Total incomplete pathways (waiting list)	<16,544 at March 2020	17,019	16,831	16,490	16,987	17,143	17,344	18,021	17,849	17,996	18,300	18,792	18,738	-	-	-	-	-	-
129a	E.B.3		RTT	RTT incomplete pathways: % within 18 weeks	≥92%	84.4%	84.1%	84.0%	84.3%	83.3%	81.6%	81.9%	80.5%	79.7%	79.1%	78.4%	77.7%	83.9%	81.3%	79.1%	77.7%	84.8%	79.8%
129c	E.B.18		RTT	RTT: incomplete pathways 52 week breaches	0	6	8	10	7	9	7	4	9	3	1	3	1	26	20	7	1	87	28
			RTT	RTT Completed Admitted pathways: % within 18 weeks	-	63.6%	64.5%	60.6%	63.3%	65.2%	65.1%	64.8%	63.7%	64.5%	64.5%	62.2%	58.5%	63.0%	64.5%	63.7%	58.5%	64.4%	63.2%
			RTT	RTT Completed Non-Admitted pathways: % within 18 weeks	-	89.6%	89.5%	89.5%	90.4%	90.5%	90.9%	89.4%	88.4%	87.7%	88.1%	87.4%	87.7%	90.1%	89.6%	87.7%	87.7%	90.5%	88.5%
	E.O.1		RTT	% of children waiting 18 weeks or less for a wheelchair	≥92%	Quarterly indicator												88.9%	81.8%	90.9%	-	95.1%	84.1%
	E.B.6		Cancer	Cancer: 2WW	≥93%	91.2%	95.9%	86.5%	96.1%	90.7%	88.9%	84.9%	81.7%	88.8%	94.3%	93.6%	96.5%	91.0%	85.3%	92.1%	96.5%	91.6%	89.9%
	E.B.7		Cancer	Cancer: 2WW (breast symptoms)	≥93%	92.2%	88.6%	91.1%	93.1%	82.0%	81.3%	86.1%	92.8%	95.0%	97.3%	97.4%	98.0%	88.8%	86.2%	96.7%	98.0%	93.0%	92.3%
	E.B.8		Cancer	Cancer: 31 day first treatment	≥96%	97.4%	94.6%	94.9%	97.3%	95.4%	95.4%	96.3%	97.9%	96.1%	97.8%	95.5%	95.3%	95.8%	96.6%	96.4%	95.3%	96.8%	96.3%
	E.B.9		Cancer	Cancer: 31 day subsequent treatment - surgery	≥94%	96.4%	85.2%	88.6%	100.0%	90.2%	92.1%	88.6%	90.6%	89.7%	88.9%	96.9%	88.9%	92.0%	90.4%	91.6%	88.9%	93.6%	90.6%
	E.B.10		Cancer	Cancer: 31 day subsequent treatment - drug	≥98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	100.0%	98.8%	100.0%	99.8%
	E.B.11		Cancer	Cancer: 31 day subsequent treatment - radiotherapy	≥94%	100.0%	97.4%	98.0%	98.0%	96.7%	100.0%	98.1%	98.0%	100.0%	100.0%	92.3%	90.7%	97.5%	98.8%	97.5%	90.7%	98.8%	96.7%
122b	E.B.12	Y	Cancer	Cancer: 62 day GP referral	≥85%	76.8%	78.0%	83.2%	77.8%	82.8%	80.2%	77.9%	84.2%	82.1%	82.4%	76.0%	75.9%	81.4%	80.8%	80.1%	75.9%	78.3%	79.7%
	E.B.13		Cancer	Cancer: 62 day Screening referral	≥90%	75.0%	80.0%	100.0%	76.9%	80.0%	100.0%	88.9%	88.9%	100.0%	90.9%	94.1%	84.6%	86.2%	92.0%	93.9%	84.6%	87.7%	92.0%
	E.B.14		Cancer	Cancer: 62 day Status upgrade	-	0.0%	100.0%	100.0%	100.0%	33.3%	100.0%	100.0%	75.0%	60.0%	75.0%	100.0%	100.0%	77.8%	88.9%	77.8%	100.0%	83.3%	84.8%

Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Diagnostics	No – 82.1% against >99% target	Vale of York performance deteriorated slightly in October to 82.1% down from 82.6% in September, equating to 760 patients waiting over 6 weeks from a cohort of 4,249. YTHFT performance saw a slight improvement from 82.4% in September to 83.3% in October. At a Trust level, pressures remain in Endoscopy, Echo CT and Non-Obstetric Ultrasound. The endoscopy backlog is reducing now the new unit is open.	Recovery plans have been created in YTHFT for all modalities not achieving the 99% standard and progress against these is being monitored with Care Groups on a weekly basis. The Endoscopy position was impacted by a sustained increase in fast track demand on the service causing routine patients to be displaced to prioritise these clinically urgent patients. The Trust is working with the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services and initial recommendations are being reviewed and will be incorporated into a draft recovery plan.	Review of diagnostics recovery priorities further to NEIST recommendations at system performance group in January 2020. Additional central funding for diagnostics of £209,000 for endoscopy and MRI has been agreed with NHSE/I and now being mobilised.

Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
RTT – Total Waiting List (TWL) and 92% target	No – 77.7% against 92% target but slight decrease in waiting list	The Vale of York CCG waiting list decreased from 18,792 in September to 18,738 in October. The YTHFT waiting list also decreased from 29,771 in September to 29,440 in October. Performance against the 92% target remains low at 77.7% for Vale of York and 75.4% for YTHFT.	System partners are reviewing all TWLs and pressures by specialty and this will inform recovery and productivity plans moving forward as part of operational planning. The HCV has undertaken a stock take of all three acute providers waiting lists and elective care pressures and there are a number of specialties where there are consistently long waits and backlogs for patients due to demand and capacity pressures – these includes head & neck, ENT, urology, gastro and dermatology. Rapid Expert Input (REI) programme which focuses on better management of the triage and referral process at the beginning of the outpatient pathway is now in delivery.	HCV elective network board to consider how to review the most challenged specialties to support improvement.
RTT – 52 week breaches	No	There was 1 breach in T&O at LTHT in October, taking the CCG one above the submitted full year plan of 27.	LTHT is one of the national 'pilot' sites for choice at 26 weeks, and as such has been looking into what available independent sector capacity there is.	Elective care funding has been provided to provide treatment for the longest waiting patients from NHSE/I of £109,000
Children's Wheelchair Waiting Times	No – 90.9% against 92% target	There was just 1 breach of the 18 week target from a cohort of 11 patients, but due to the small number of patients this equated to a failed target this quarter.		

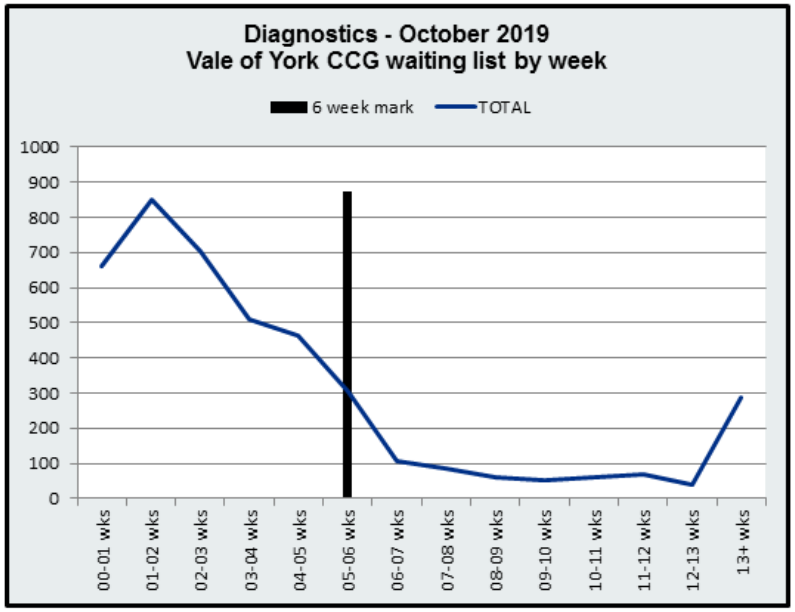
Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Cancer 2WW	Yes – 96.5% against 93% target	Vale of York CCG met the 93% target for the third consecutive month with 96.5% in October, up from 93.6% in September. YTHFT also met target in October with 94%, this is the first time the Trust have met the 93% target since February. YTHFT continues to experience high numbers of Cancer Fast-track referrals and are reporting a 7% increase in FT referrals in Q1 and Q2 2019 compared to 2018-19. Due to this continued rise in referrals, the Trust is undertaking more cancer activity which is impacting on the capacity available for routine outpatient appointments, negatively affecting the Trust's RTT incomplete total waiting list position. The impact of embedding FIT testing in the bowel screening programme on growth in endoscopy activity is being monitored by the screening programme group across Leeds, Harrogate and York. Capacity to delivery this additional activity is limited.	Recovery plans have been developed at YTHFT for any tumour sites not achieving the 14 day standard. Rapid Diagnostic Centre (RDC) for patients with serious non-specific symptoms and Upper GI referrals is being piloted by YHFT in January 2020. Progress towards the April 2020 target to diagnose patients within 28 days continues, with performance of 59.4% in September. Performance is currently being shadow reported as a national target percentage has yet to be set.	

Planned Care

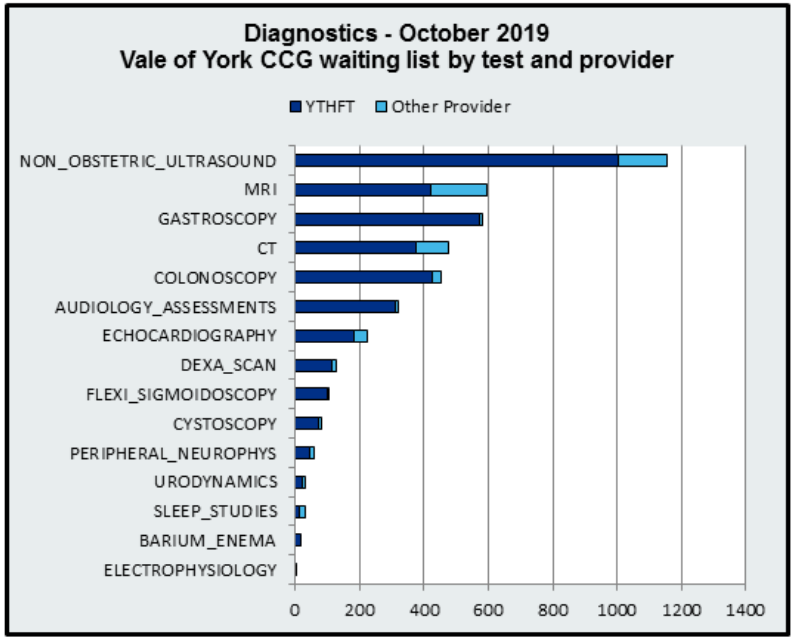
Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Cancer 62 day	No – 75.9% against 85% target	Vale of York CCG performance saw a very slight deterioration in October 2019 to 75.9%, from 76% in September. YTHFT also saw a deterioration from 79.4% in September to 78.9% in October.	Recovery plans have been developed at YTHFT for any tumour sites not achieving the 62 day standard. Progress against these plans is being monitored with care groups on a weekly basis. Weekly 'Cancer Wall' meeting implemented with scrutiny of every diagnosed cancer patient without a treatment plan, to reduce unnecessary delays and mitigate risk. Patients on a 62 day pathway without a diagnosis are also reviewed and plans agreed where required. A revised criterion for prostate diagnosis has been agreed internally, reducing the number of patients who will require an MRI. This will ensure that those who do require an MRI will receive it sooner. Pathways have been reviewed for all the major tumour groups and work is ongoing to embed the timed pathways.	The Cancer Alliance Board is considering priorities for collaborative work to drive up key cancer performance and patient outcomes including survivorship and early staging.

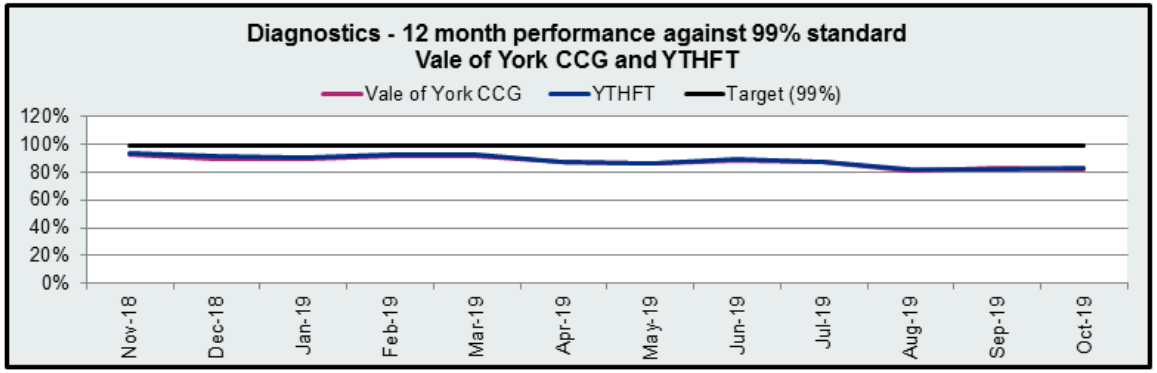
Diagnostics



Diagnostics by Test - Vale of York CCG - October 2019

Diagnostic Test	Total Waiting List	Total >6 weeks	% within 6 weeks (Target ≥99%)	Change from previous month
SLEEP_STUDIES	29	0	100.0%	0.0%
PERIPHERAL_NEUROPHYS	58	0	100.0%	2.8%
BARIUM_ENEMA	17	0	100.0%	0.0%
ELECTROPHYSIOLOGY	1	0	100.0%	0.0%
AUDIOLOGY_ASSESSMENTS	318	1	99.7%	-0.3%
DEXA_SCAN	128	1	99.2%	-0.8%
CT	476	6	98.7%	-0.4%
MRI	594	18	97.0%	-0.6%
CYSTOSCOPY	80	4	95.0%	-2.7%
NON_OBSTETRIC_ULTRASOUND	1,155	99	91.4%	-0.9%
ECHOCARDIOGRAPHY	222	37	83.3%	3.3%
URODYNAMICS	32	7	78.1%	-0.4%
FLEXI_SIGMOIDOSCOPY	105	41	61.0%	12.0%
COLONOSCOPY	451	226	49.9%	-2.6%
GASTROSCOPY	583	320	45.1%	3.6%
Grand Total	**4,249**	**760**	**82.1%**	-0.5%



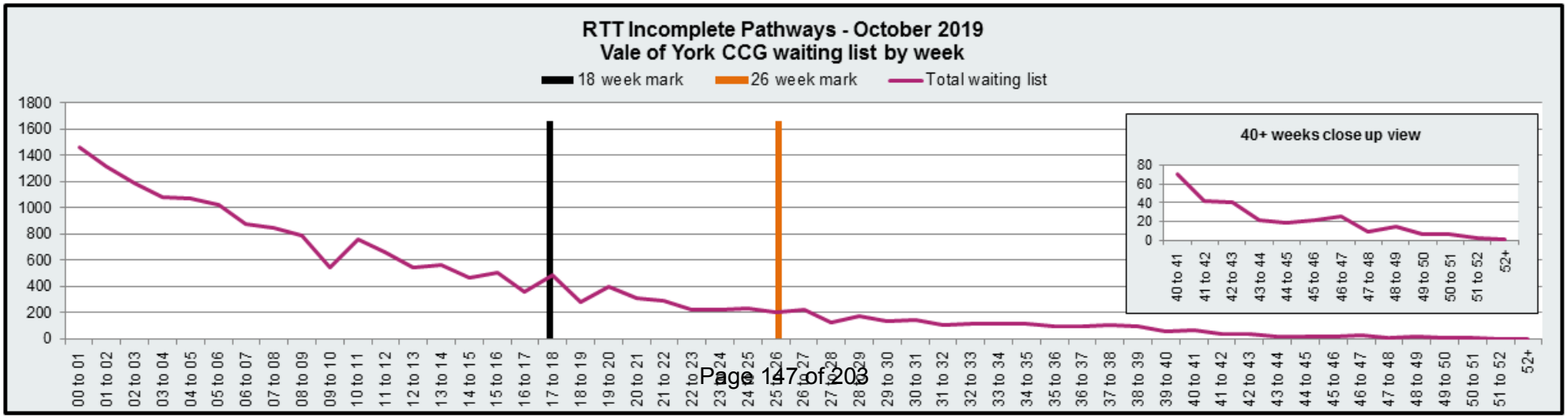


Diagnostics - 2019/20 Plan vs Actual - Vale of York CCG and YTHFT

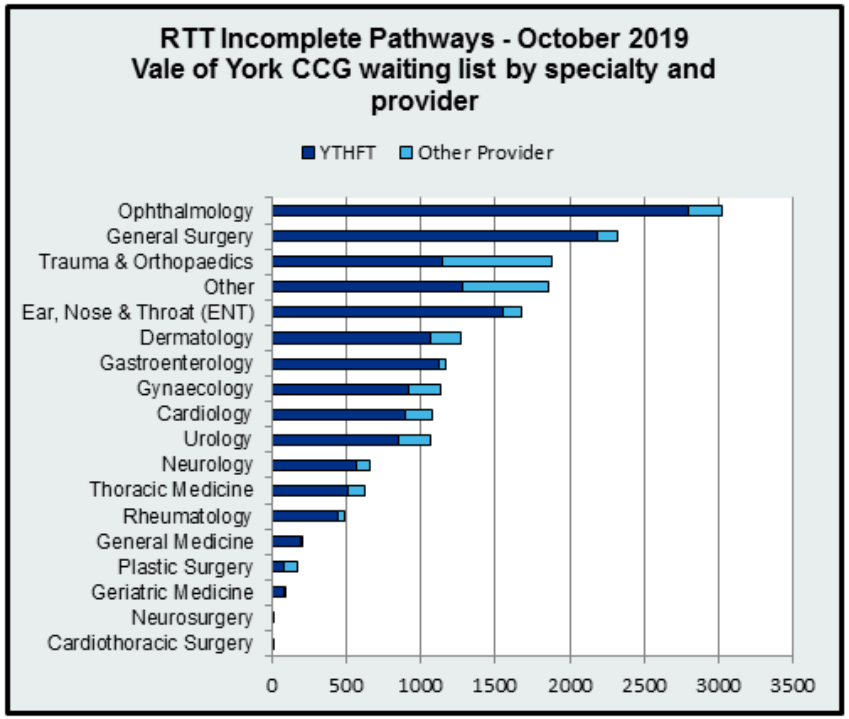
Target ≥99%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	2019/20 Plan	92.0%	92.0%	92.0%	93.0%	93.0%	93.0%	94.0%	94.0%	94.0%	95.0%	95.0%	96.0%
	2019/20 Actual	87.3%	86.3%	88.3%	87.8%	81.4%	82.6%	82.1%	-	-	-	-	-
	Variance	-4.7%	-5.7%	-3.7%	-5.2%	-11.6%	-10.4%	-11.9%	-	-	-	-	-
Target ≥99%		**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**
YTHFT	2019/20 Plan	87.5%	90.0%	91.0%	91.5%	93.0%	94.0%	95.0%	96.0%	97.0%	97.0%	98.0%	99.0%
	2019/20 Actual	87.5%	86.4%	88.9%	87.6%	81.7%	82.4%	83.3%	-	-	-	-	-
	Variance	0.0%	-3.6%	-2.1%	-3.9%	-11.3%	-11.6%	-11.7%	-	-	-	-	-

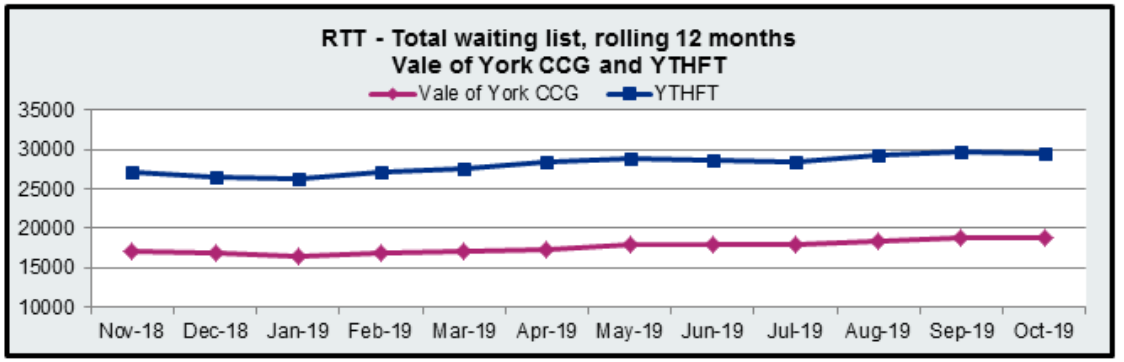
Referral to Treatment (RTT)

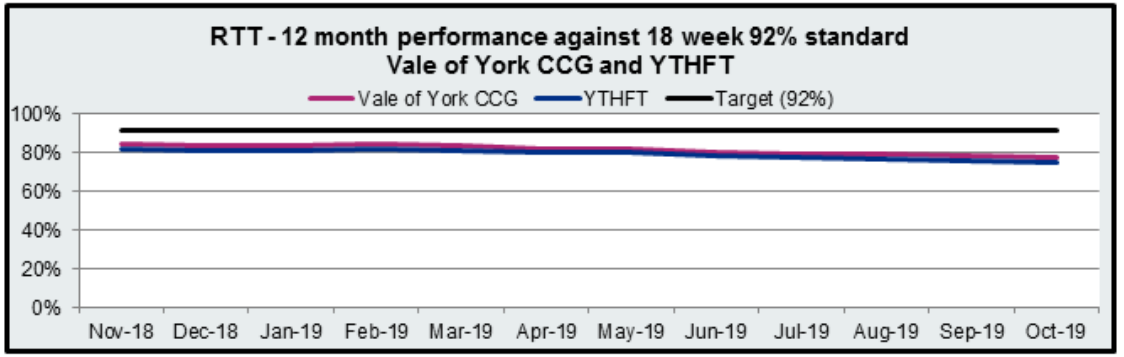
RTT Incomplete Pathways by Specialty - Vale of York CCG - October 2019							
Specialty	**Total Waiting List**	**Total pathways >18 weeks**	**Total pathways >52 weeks**	**% within 18 weeks (Target ≥92%)**	**Change from previous month**	**Median Wait (weeks)**	**92nd percentile (weeks)**
Neurosurgery	20	0	0	100.0%	0.0%	11.3	16.9
General Medicine	203	2	0	99.0%	0.4%	5.3	11.6
Geriatric Medicine	83	1	0	98.8%	0.1%	2.9	13.5
Other	1,853	209	0	88.7%	0.2%	6.7	20.4
Neurology	662	75	0	88.7%	-2.0%	7.9	20.0
Gynaecology	1,133	176	0	84.5%	-0.8%	7.8	23.5
Dermatology	1,271	237	0	81.4%	-1.4%	8.3	24.6
Trauma & Orthopaedics	1,883	360	1	80.9%	-0.2%	9.1	26.4
Ear, Nose & Throat (ENT)	1,672	345	0	79.4%	0.1%	8.4	28.2
Rheumatology	492	103	0	79.1%	0.2%	8.9	24.1
Cardiology	1,074	250	0	76.7%	-1.2%	9.5	26.1
General Surgery	2,323	546	0	76.5%	-0.7%	8.4	29.8
Gastroenterology	1,173	276	0	76.5%	0.4%	9.9	27.8
Urology	1,066	272	0	74.5%	-0.5%	8.2	33.6
Plastic Surgery	171	49	0	71.3%	-2.1%	8.5	32.1
Thoracic Medicine	631	207	0	67.2%	-3.9%	12.3	29.9
Ophthalmology	3,023	1,063	0	64.8%	-1.2%	10.6	36.1
Cardiothoracic Surgery	5	2	0	60.0%	-40.0%	-	-
Grand Total	**18,738**	**4,173**	**1**	**77.7%**	**-0.7%**	**8.6**	**28.9**



Referral to Treatment (RTT)







RTT 52 week breaches - Vale of York CCG

Period	Total breaches	Specialty and Provider
Apr-19	7	1 x T&O at Nuffield York (see narrative slide), 1 x Plastic surgery at St George's University FT, 5 x T&O at LTHT
May-19	4	4 x T&O at LTHT
Jun-19	9	5 x T&O at LTHT, 2 x Urology at YTHFT, 1 x Ophthalmology at YTHFT, 1 x Ophthalmology at Queen Victoria Hospital NHS FT
Jul-19	3	2 x T&O at LTHT, 1 x Ophthalmology at Queen Victoria Hospital NHS FT
Aug-19	1	1 x Urology at YTHFT
Sep-19	3	2 x T&O at LTHT, 1 x General Surgery at YTHFT
Oct-19	1	1 x T&O at LTHT
Nov-19		
Dec-19		
Jan-20		
Feb-20		
Mar-20		
YTD	28	

RTT Total Waiting List - 2019/20 Plan vs Actual - Vale of York CCG and YTHFT

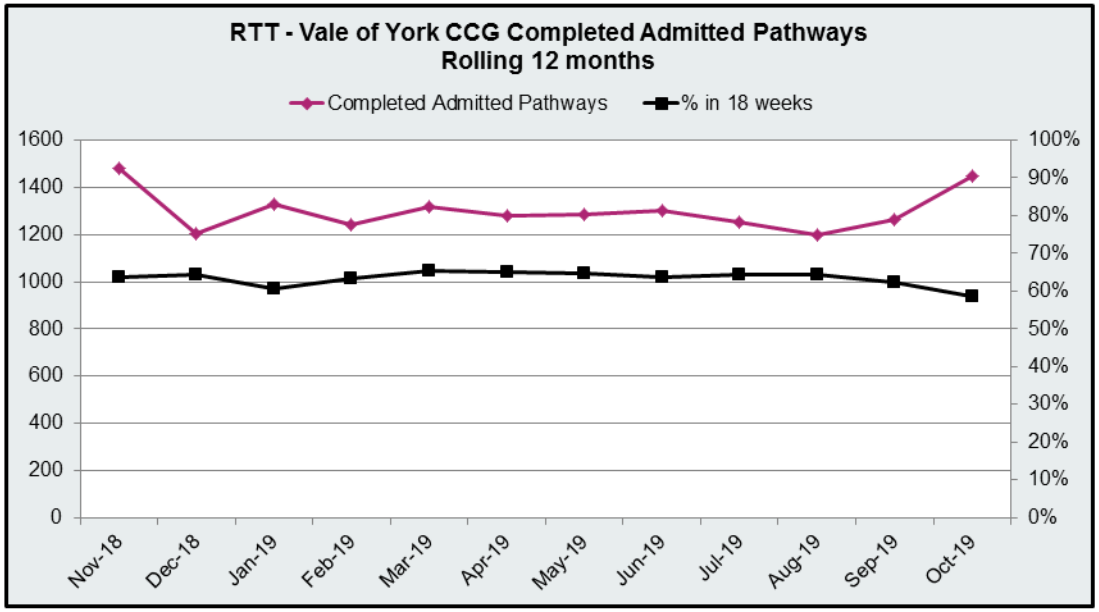
Target <16,544		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	2019/20 Plan	17,464	17,745	18,313	18,899	19,505	20,129	19,622	19,116	18,609	18,103	17,596	17,090
	2019/20 Actual	17,344	18,021	17,849	17,996	18,300	18,792	18,738	-	-	-	-	-
	Variance	- 120	276	-464	-903	-1205	-1337	-884	-	-	-	-	-
Target <26,303		**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**
YTHFT	2019/20 Plan	28,344	28,800	29,722	30,673	31,655	32,668	31,846	31,024	30,202	29,380	28,558	27,736
	2019/20 Actual	28,344	28,809	28,727	28,394	29,252	29,771	29,440	-	-	-	-	-
	Variance	0	9	-995	-2279	-2403	-2897	-2406	-	-	-	-	-

RTT Performance against 92% standard - 2019/20 Plan vs Actual - Vale of York CCG and YTHFT

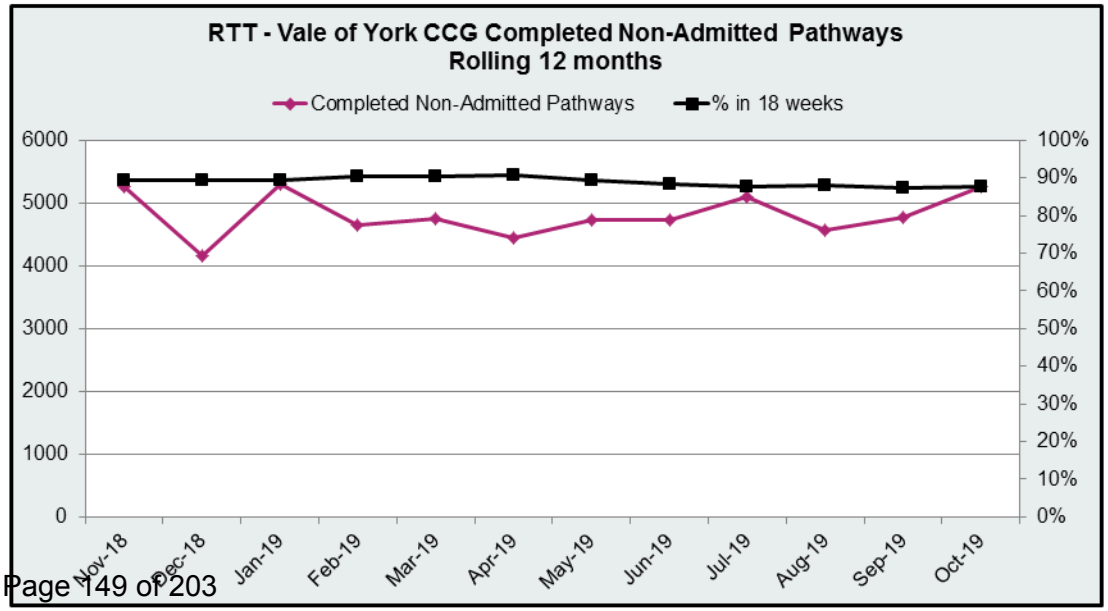
Target ≥92%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	2019/20 Plan	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%
	2019/20 Actual	81.6%	81.9%	80.5%	79.7%	79.1%	78.4%	77.7%	-	-	-	-	-
	Variance	0.3%	0.5%	-0.9%	-1.6%	-2.2%	-2.9%	-3.6%	-	-	-	-	-
Target ≥92%		**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Feb-20**	**Mar-20**
YTHFT	2019/20 Plan	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
	2019/20 Actual	80.0%	80.4%	78.3%	77.4%	76.7%	76.0%	75.4%	-	-	-	-	-
	Variance	0.0%	0.4%	-1.7%	-2.6%	-3.3%	-4.0%	-4.6%	-	-	-	-	-

Referral to Treatment (RTT)

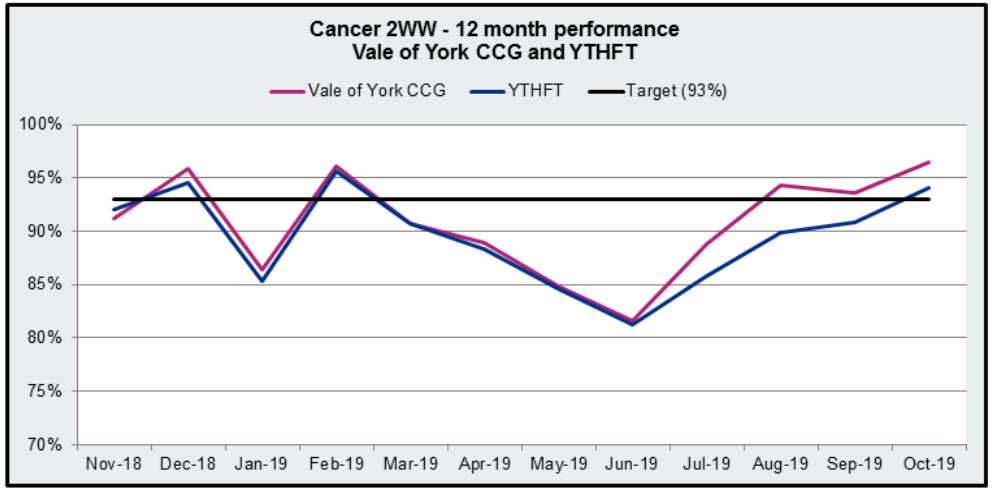
RTT Completed Admitted Pathways by Specialty - Vale of York CCG - October 2019			
Specialty	**Total Completed Admitted Pathways**	**Total pathways >18 weeks**	**% within 18 weeks**
Cardiothoracic Surgery	-	-	-
General Medicine	1	0	100.0%
Thoracic Medicine	3	0	100.0%
Rheumatology	4	0	100.0%
Neurology	1	0	100.0%
Dermatology	10	1	90.0%
Gastroenterology	9	1	88.9%
Other	117	29	75.2%
Neurosurgery	4	1	75.0%
Cardiology	79	20	74.7%
Plastic Surgery	81	26	67.9%
Trauma & Orthopaedics	299	102	65.9%
Urology	104	41	60.6%
Gynaecology	100	44	56.0%
General Surgery	222	107	51.8%
Ophthalmology	317	166	47.6%
Ear, Nose & Throat (ENT)	97	62	36.1%
Geriatric Medicine	1	1	0.0%
Grand Total	**1,449**	**601**	**58.5%**



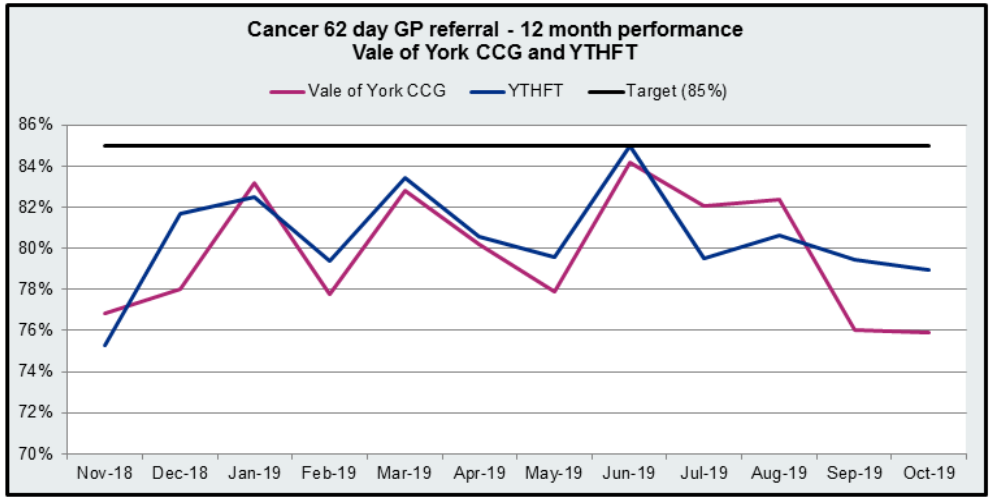
RTT Completed Non-Admitted Pathways by Specialty - Vale of York CCG - October 2019			
Specialty	**Total Completed Admitted Pathways**	**Total pathways >18 weeks**	**% within 18 weeks**
Cardiothoracic Surgery	-	-	-
Geriatric Medicine	98	0	100.0%
General Medicine	95	2	97.9%
Ophthalmology	750	18	97.6%
Urology	318	12	96.2%
Plastic Surgery	44	2	95.5%
Gynaecology	312	23	92.6%
General Surgery	920	69	92.5%
Trauma & Orthopaedics	300	27	91.0%
Other	608	82	86.5%
Ear, Nose & Throat (ENT)	389	57	85.3%
Neurosurgery	6	1	83.3%
Dermatology	439	83	81.1%
Cardiology	231	52	77.5%
Gastroenterology	300	74	75.3%
Neurology	165	45	72.7%
Thoracic Medicine	177	56	68.4%
Rheumatology	110	43	60.9%
Grand Total	**5,262**	**646**	**87.7%**



Cancer Two Week Waits and 62 day GP Referral



Cancer Two Week Waits - Vale of York CCG - October 2019					
Tumour type	Total Treated	Total >2 weeks	% within 2 weeks (Target ≥93%)	Change from previous month	
Acute Leukaemia	-	-	N/A	-	-
Brain/Central Nervous System	-	-	N/A	-	-
Testicular	-	-	N/A	-	-
Haematological malignancies	7	0	100.0%	0.0%	▬
Lung	21	0	100.0%	4.8%	▲
Breast	221	2	99.1%	-0.2%	▼
Lower Gastrointestinal	252	5	98.0%	1.1%	▲
Upper Gastrointestinal	91	2	97.8%	5.3%	▲
Urological (exc Testicular)	135	4	97.0%	7.1%	▲
Head and Neck	143	5	96.5%	1.5%	▲
Skin	202	14	93.1%	5.5%	▲
Gynaecological	93	7	92.5%	0.6%	▲
Other	4	1	75.0%	-25.0%	▼
Children's	2	1	50.0%	-30.0%	▼
Grand Total	**1,171**	**41**	**96.5%**	**2.9%**	▲



Cancer 62 day GP referral - Vale of York CCG - October 2019					
Tumour type	Total Treated	Total >62 days	% within 62 days (Target ≥85%)	Change from previous month	
Brain/Central Nervous System	-	-	N/A	-	-
Acute Leukaemia	-	-	N/A	-	-
Children's	-	-	N/A	-	-
Testicular	-	-	N/A	-	-
Sarcoma	1	0	100.0%	-	-
Breast	17	0	100.0%	0.0%	▬
Haematological malignancies	5	0	100.0%	14.3%	▲
Head and Neck	4	0	100.0%	57.1%	▲
Skin	18	1	94.4%	-5.6%	▼
Upper Gastrointestinal	9	2	77.8%	-22.2%	▼
Gynaecological	9	2	77.8%	2.8%	▲
Urological (exc Testicular)	29	11	62.1%	6.5%	▲
Other	2	1	50.0%	-50.0%	▼
Lower Gastrointestinal	10	6	40.0%	-18.3%	▼
Lung	4	3	25.0%	-58.3%	▼
Grand Total	**108**	**26**	**75.9%**	**-0.1%**	▼

Cancer 2WW - 2019/20 Plan vs Actual - Vale of York CCG and YTHFT													
Target ≥93%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	Plan	93.1%	93.1%	93.0%	93.1%	93.1%	93.0%	93.1%	93.0%	93.0%	93.0%	93.0%	93.0%
	Actual	88.9%	84.9%	81.7%	88.8%	94.3%	93.6%	96.5%	-	-	-	-	-
	Variance	-4.2% ▼	-8.2% ▼	-11.4% ▼	-4.2% ▼	1.2% ▲	0.6% ▲	3.4% ▲	-	-	-	-	-
Target ≥93%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
YTHFT	Plan	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.1%	93.2%	93.1%	93.1%	93.1%
	Actual	88.3%	84.6%	81.3%	85.9%	89.9%	90.9%	94.0%	-	-	-	-	-
	Variance	-4.8% ▼	-8.5% ▼	-11.8% ▼	-7.3% ▼	-3.2% ▼	-2.2% ▼	0.9% ▲	-	-	-	-	-

Cancer 62 day GP Referral - 2019/20 Plan vs Actual - Vale of York CCG and YTHFT													
Target ≥85%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	Plan	80.0%	80.2%	81.0%	81.2%	81.3%	81.8%	82.8%	83.5%	83.9%	84.0%	84.8%	85.0%
	Actual	80.2%	77.9%	84.2%	82.1%	82.4%	76.0%	75.9%	-	-	-	-	-
	Variance	0.2% ▲	-2.3% ▼	3.2% ▲	0.9% ▲	1.0% ▲	-5.8% ▼	-6.9% ▼	-	-	-	-	-
Target ≥85%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Plan	80.1%	80.5%	80.9%	81.1%	81.7%	82.0%	82.4%	83.1%	83.6%	83.8%	84.5%	85.0%
	Actual	80.6%	79.5%	85.0%	79.5%	80.7%	79.4%	78.9%	-	-	-	-	-
	Variance	0.5% ▲	-0.9% ▼	4.1% ▲	-1.5% ▼	-1.1% ▼	-2.6% ▼	-3.5% ▼	-	-	-	-	-

Performance and Programme Overview
Unplanned and Out of Hospital Care

Areas Covered:

- Emergency Department – York Teaching Hospital NHS Foundation Trust
- Yorkshire Ambulance Service (YAS)
- NHS 111 – Yorkshire and Humber
- GP Out of Hours – Northern Doctors
- Primary Care Access
- Delayed Transfers of Care (DTOCs)

Content:

- Summary dashboard
- Narrative
- Supporting data

NHS
Vale of York
Clinical Commissioning Group

Vale of York CCG Performance Summary Dashboard – Unplanned and Out of Hospital Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Previous 3 Quarters 2018/19 Q4	Previous 3 Quarters 2019/20 Q1	Previous 3 Quarters 2019/20 Q2	Current QTD 2019/20 Q3	Previous Financial Year 2018/19	Current Financial YTD 2019/20
Unplanned and Out of Hospital Care																							
127c	E.B.5		A&E*	A&E: % within 4 hours (YTHFT)	≥95%	89.6%	87.6%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.1%	81.3%	78.1%	80.4%	82.4%	81.9%	80.3%	78.1%	87.7%	80.3%
			A&E*	A&E: 12 hour breaches (YTHFT)	0	0	0	17	8	28	24	26	2	0	7	32	16	53	52	39	25	66	116
			YAS	ARP: Category 1 (Life threatening) Mean	00:07:00	00:07:02	00:07:03	00:06:59	00:07:03	00:06:44	00:06:58	00:06:49	00:06:49	00:06:54	00:06:50	00:06:58	00:07:19	-	-	-	-	00:07:21	00:06:57
			YAS	ARP: Category 2 (Emergency) Mean	00:18:00	00:20:29	00:21:03	00:19:49	00:20:02	00:17:40	00:19:40	00:18:38	00:18:46	00:18:17	00:17:04	00:18:26	00:21:50	-	-	-	-	00:20:26	00:18:59
			YAS	ARP: Category 1 (Life threatening) 90th percentile	00:15:00	00:12:13	00:12:15	00:12:08	00:12:05	00:11:28	00:12:06	00:11:56	00:11:56	00:12:11	00:11:53	00:12:02	00:12:31	-	-	-	-	00:12:37	00:12:06
			YAS	ARP: Category 2 (Emergency) 90th percentile	00:40:00	00:42:36	00:44:17	00:41:16	00:41:50	00:35:35	00:40:29	00:38:09	00:38:14	00:37:26	00:34:21	00:37:32	00:45:13	-	-	-	-	00:42:34	00:38:59
			YAS	ARP: Category 3 (Urgent) 90th percentile	02:00:00	01:58:25	02:15:22	01:58:10	01:53:11	01:29:42	01:49:54	01:42:58	01:49:27	01:42:47	01:26:58	01:33:37	02:09:54	-	-	-	-	01:58:44	01:45:22
			YAS	ARP: Category 4 (Less urgent) 90th percentile	03:00:00	03:44:04	03:38:33	03:52:38	03:25:18	03:00:09	03:36:53	03:51:12	04:33:48	04:01:23	02:47:17	02:41:57	02:40:55	-	-	-	-	03:51:57	03:22:22
			NHS 111*	NHS 111: Calls abandoned after 30 seconds	≤5%	1.2%	0.7%	1.6%	1.7%	1.0%	1.2%	1.2%	1.3%	2.3%	1.2%	1.2%	1.5%	1.4%	1.2%	1.6%	1.6%	1.1%	1.4%
			NHS 111*	NHS 111: Calls answered within 60 seconds	≥90%	82.9%	90.2%	81.6%	79.0%	86.1%	91.8%	90.9%	88.7%	84.1%	86.8%	89.0%	81.7%	82.3%	90.5%	86.6%	78.7%	88.1%	86.1%
			GP OOH	GP OOH: Face to face within 2 hours	≥95%	97.3%	94.9%	88.5%	95.9%	94.9%	89.8%	91.8%	95.2%	93.3%	94.6%	93.4%	89.6%	92.8%	92.2%	93.8%	89.6%	95.9%	92.5%
			GP OOH	GP OOH: Face to face within 6 hours	≥95%	99.6%	95.8%	97.4%	96.9%	98.4%	97.2%	96.7%	98.0%	97.0%	97.7%	98.5%	96.8%	97.6%	97.3%	97.7%	96.8%	98.3%	97.4%
			GP OOH	GP OOH: Speak to clinician within 2 hours	≥95%	95.3%	93.2%	95.3%	91.3%	92.5%	88.6%	90.2%	89.2%	90.6%	91.3%	88.3%	90.1%	93.2%	89.3%	90.1%	90.1%	95.0%	89.8%
			GP OOH	GP OOH: Speak to clinician within 2 to 6 hours	≥95%	98.9%	95.6%	97.5%	95.0%	96.1%	93.1%	95.6%	96.0%	94.7%	94.1%	96.5%	93.8%	96.2%	94.9%	95.1%	93.8%	97.7%	94.8%
			GP OOH	GP OOH: Speak to clinician within 6+ hours	≥95%	99.9%	98.7%	99.2%	99.6%	99.6%	98.9%	99.0%	99.0%	98.7%	99.5%	99.5%	99.7%	99.4%	98.9%	99.2%	99.7%	99.6%	99.2%
			GP OOH	GP OOH: Total calls	-	2,960	4,099	3,469	3,001	3,040	3,331	3,302	2,983	2,914	3,167	2,743	2,861	9,510	9,616	8,824	2,861	36,591	21,301
			GP OOH	GP OOH: % of dispositions <2 hours	-	62.3%	62.6%	63.4%	62.7%	62.6%	61.5%	62.1%	61.5%	61.5%	60.5%	63.2%	63.4%	62.9%	61.7%	61.7%	63.4%	60.5%	61.9%
	E.D.16		Primary Care Access	Proportion of the population with access to online consultations	≥75% by March 2020	Data to follow																	
	E.D.17		Primary Care Access	Extended Access appointment utilisation	≥75% by March 2020	Data to follow																	
	E.D.18		Primary Care Access	Proportion 111 can directly book appts into extended access	100% by March 2020	Data to follow																	
			DTOC	DTOC: YTHFT - Acute bed days	-	1,059	1,212	1,093	1,067	1,178	1,456	1,529	1,486	1,346	1,325	1,355	1,215	3,338	4,471	4,026	1,215	13,693	9,712
			DTOC	DTOC: YTHFT - Non-acute bed days	-	358	337	385	295	377	277	303	352	235	362	335	342	1,057	932	932	342	4,182	2,206
			DTOC	DTOC: YTHFT - Total bed days	-	1,417	1,549	1,478	1,362	1,555	1,733	1,832	1,838	1,581	1,687	1,690	1,557	4,395	5,403	4,958	1,557	17,875	11,918
			DTOC	DTOC: TEWV - Total bed days (All non-acute)	-	672	550	557	506	657	673	547	630	454	496	537	647	1,720	1,850	1,487	647	9,591	3,984

*Note that A&E and NHS 111 data is available one month ahead of other data sources which will affect QTD and YTD calculations

Unplanned and Out of Hospital Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
ED 4 hour target	No –% in October against 95% target		✓ Full winter resilience plan for the system ✓ Health & Care Resilience Board single work plan across pre-hospital, in-hospital and interface between organisations/ partners in development ✓ Quality Improvement Board to focus on mitigation of risks from poor ECS performance and target ambulance handovers, corridor care from long trolley waits and impact of bed reductions from infection control ✓ Escalation policy constantly refreshed based on system lessons learnt	There are continuous actions and escalations undertaken by the System Resilience Group which then inform the wider workplan as well as daily escalation responses.
YAS	Yes	Yes		
NHS 111	Yes	Yes		
GP Out of Hours	At or close to target across all	Yes		N/A

Unplanned and Out of Hospital Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Primary Care Access	N/A – targets apply to year end	**Proportion of the population with access to online consultations** Priory Medical Group, Haxby Group, Jorvik Gillygate, Front Street and Tadcaster Medical Practices all have Online Consultations software installed and technically enabled. This represents 5 out of 26 Practices, with a combined list size of 129,050 out of a total Vale of York registered population of 361,626 (35.7%) **Extended Access Appointment Utilisation** Providers of Extended Access (evenings/weekends) appointments are required to report available appointments, number of appointments booked, DNA's, and utilisation on a daily basis. Utilisation is calculated as: (number of appointments booked - DNAs) / available appointments. For the quarter to end June 2019, the average Extended Access appointment utilisation was 89%, up from 70% in March 2019.	The STP continues to fund a Project Manager to assist Practices in deploying the Online Consults software (Engage Consult) and has funded licenses to enable Practices to trial the system for 12 months The CCG plans further engagement with Practices to promote uptake in order to meet the GP Contract Reform target of all patients having access to Online Consults by April 2021. Workforce and GP workload continue to be the main challenges for this service. Providers are consistently meeting national targets but the service may have a greater impact if the number of GP appointments (compared to nurse appointments) could be increased.	

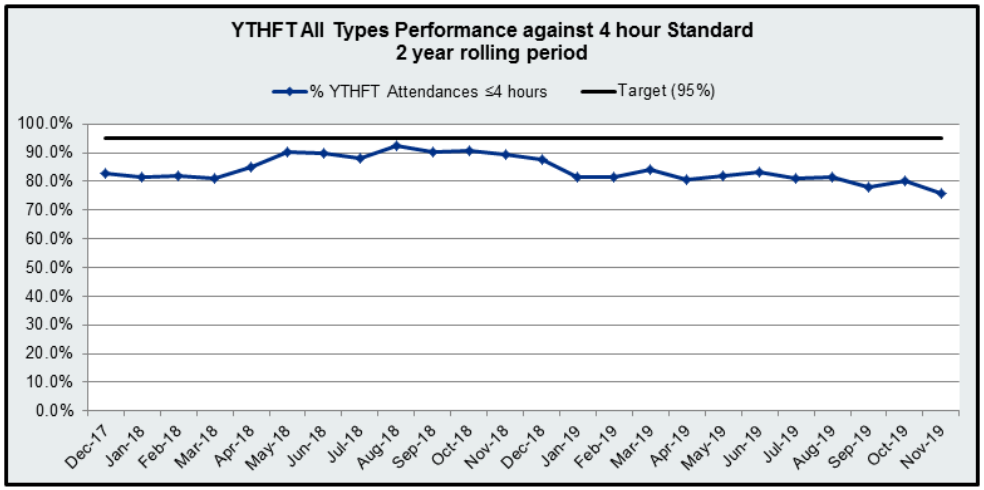
Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Primary Care Access (continued)	N/A – targets apply to year end	**Proportion of the population that 111 can directly book appointments into the contracted extended access services** For the month of August 2019 this figure is 0%. Data collection has moved from monthly to quarterly and therefore the next available update will be following publication of Quarter 2 2019/20 data.	The technical solution is still being worked on regionally. Pilot is planned in Leeds using GP Connect for connectivity – the solution with then be rolled out more widely. No firm timescales for NHS Vale of York CCG Practices at this time.	

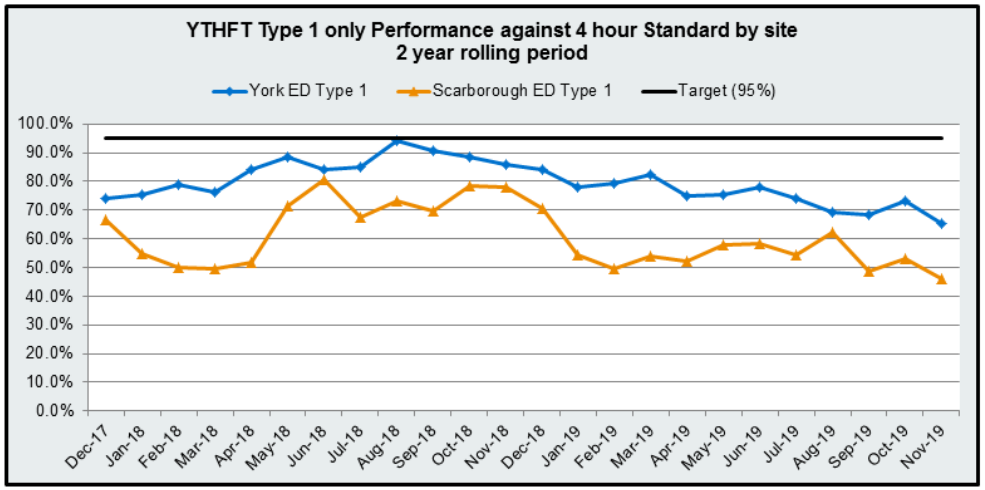
Unplanned and Out of Hospital Care

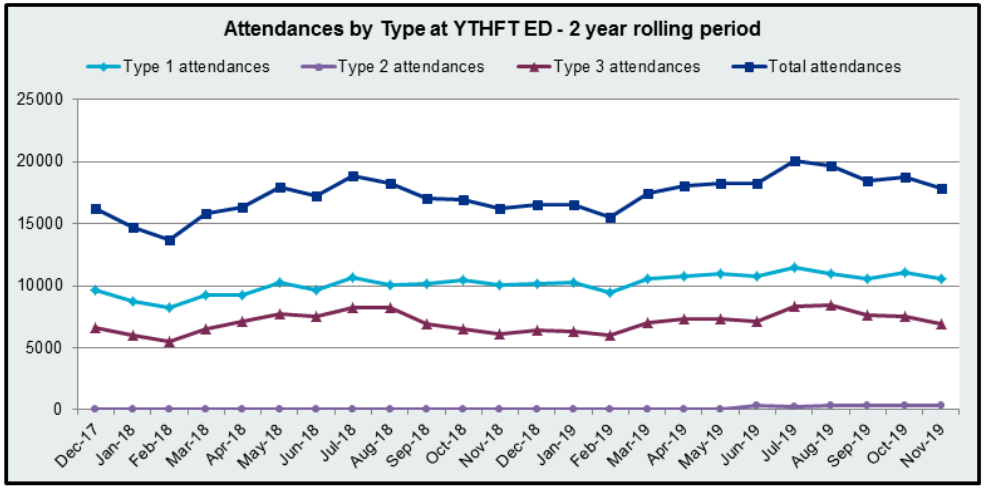
Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Delayed Transfers of Care	No (Yes for mental health DTOC and Yes for ASC)	DTOC reported by TEWV have remained below target over the past year. While the autumn saw a deterioration in performance, the situation is stable. Adult Social Care delays are stable and below the target. Since September York has improved by two places to 138th out of 153 council areas.	• Continuation of multi agency working, with case by case daily review and weekly MADE meetings (Multi Agency Discharge Events). • Venn Capacity and Demand model is being used to compare expected impact from potential commissioning decisions. • Winter resilience funds have been allocated to enable safe and timely discharge, and prevent avoidable admissions whenever possible. • Developments of trusted assessment have been initiated, and work is underway to improve discharge standards in hospital as part of the implementation of the multi agency discharge procedures. • The main cause of delays for adult social care is awaiting package of care in own home – over 400 additional hours per week have been commissioned this year, and additional arrangements for live in care have been put in place. • The main cause of NHS delays is awaiting further non-acute care.	7 day presence of social workers in hospital assists timely discharge. Daily system resilience calls are being scheduled to include Saturdays and Sundays during the deepest winter period.

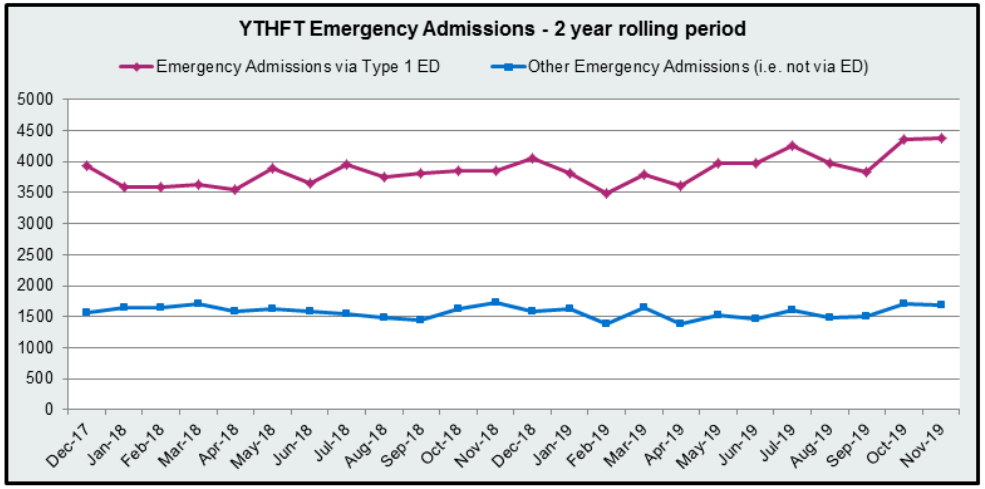
Emergency Department - YTHFT

*Note - ED data is available one month ahead of other national data









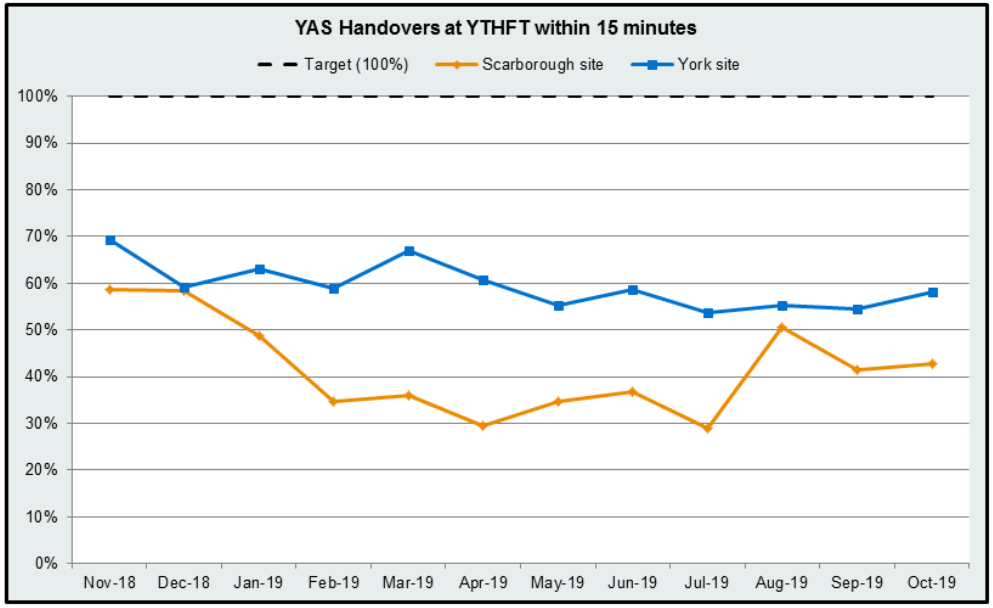
12 hour breaches at YTHFT

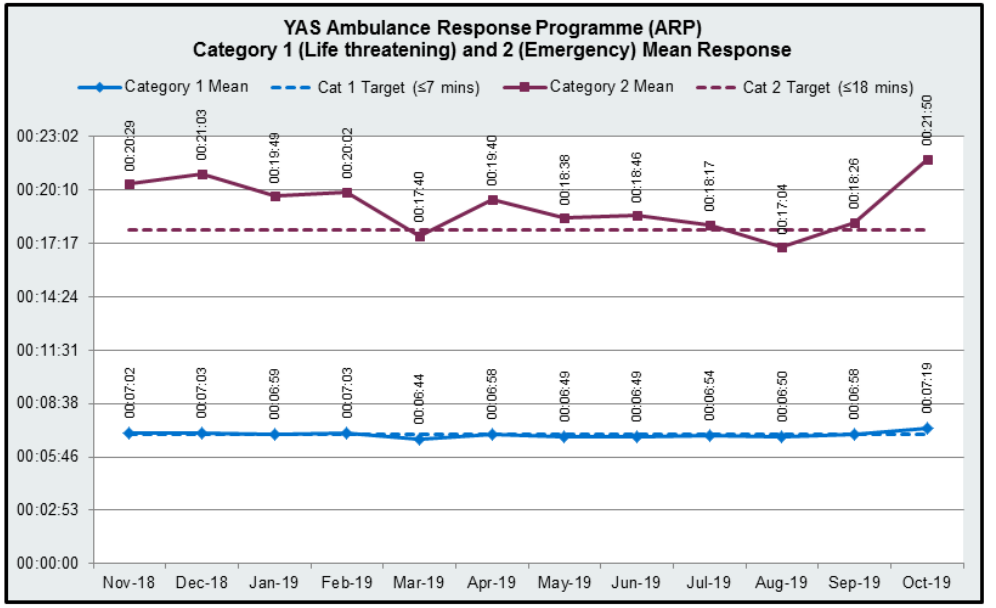
Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD
24	26	2	0	7	32	16	9					116

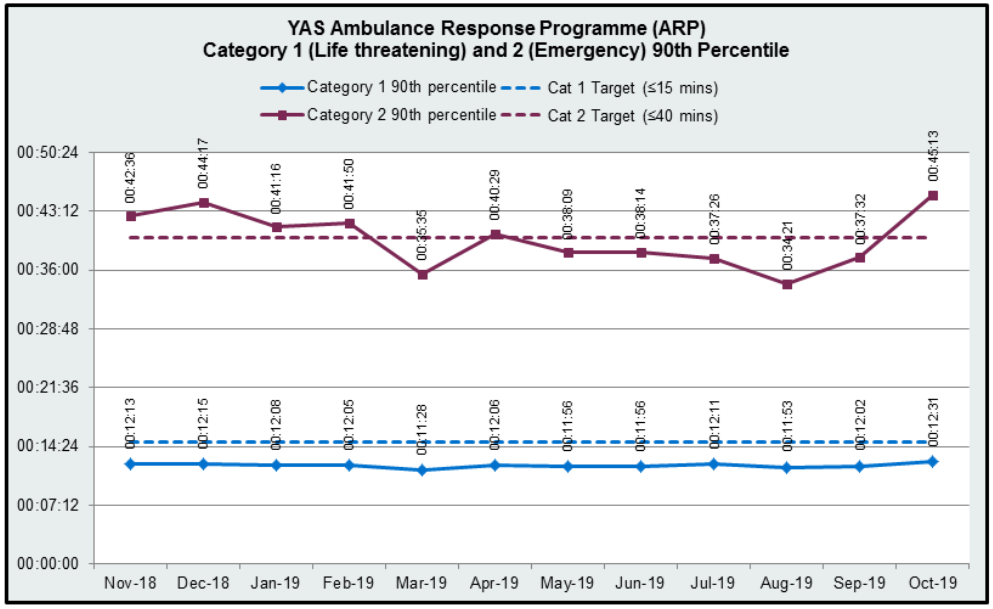
ED 4 hour target - 2019/20 Plan vs Actual - YTHFT

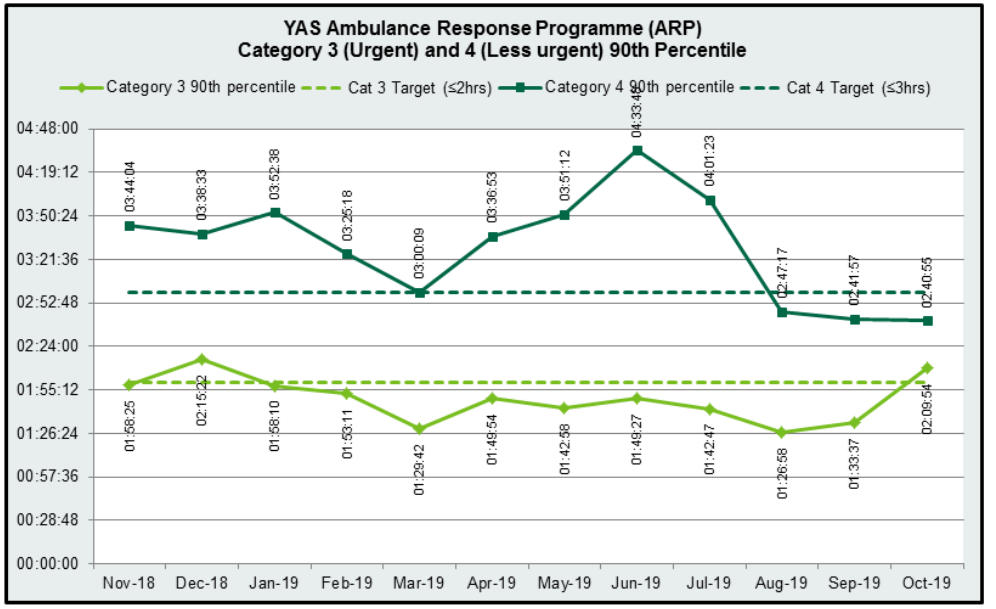
Target ≥95%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
YTHFT	2019/20 Plan	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%	85.0%	82.5%	90.0%
	2019/20 Actual	80.5%	81.9%	83.2%	81.1%	81.3%	78.1%	80.4%	75.7%	-	-	-	-
	Variance	-4.5%	-4.1%	-3.8%	-6.9%	-7.7%	-11.9%	-9.6%	-14.3%	-	-	-	-

Yorkshire Ambulance Service (YAS)



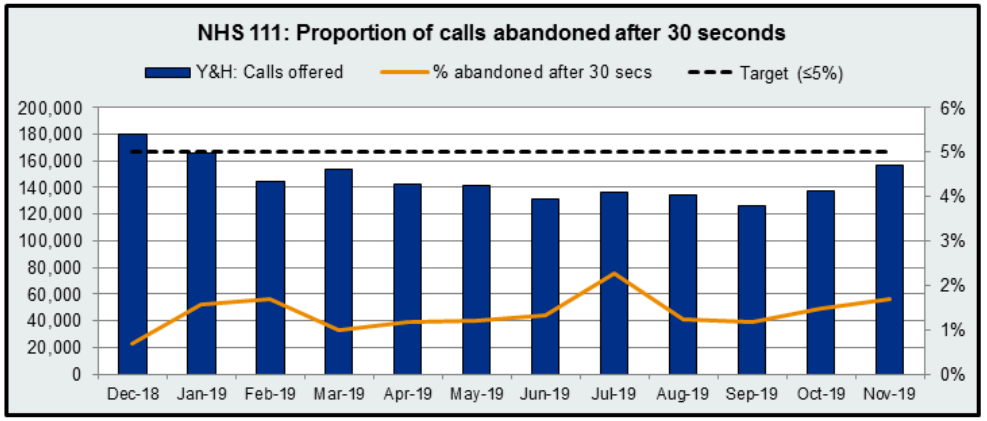


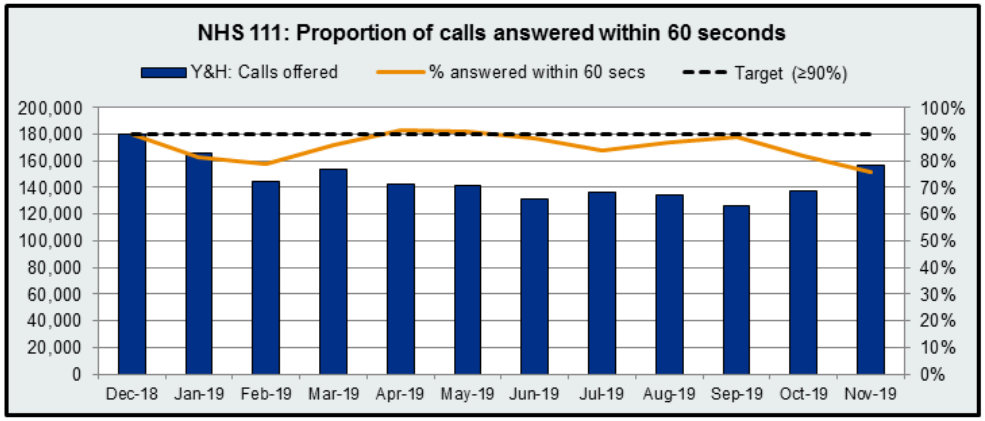


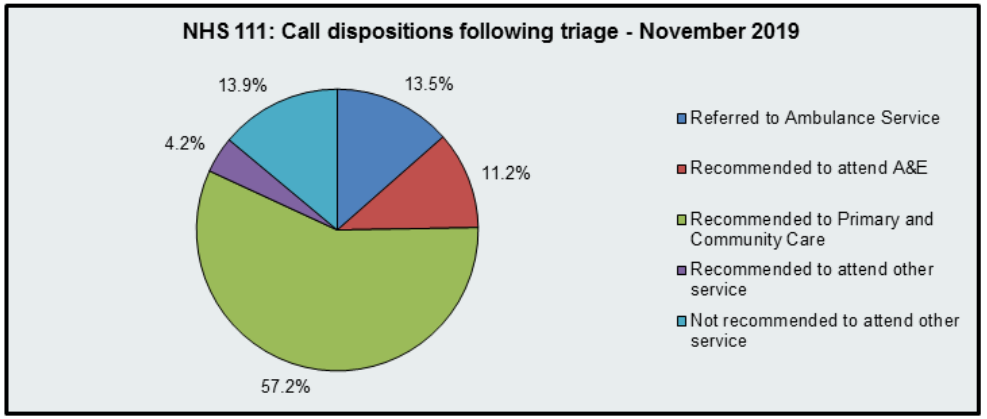


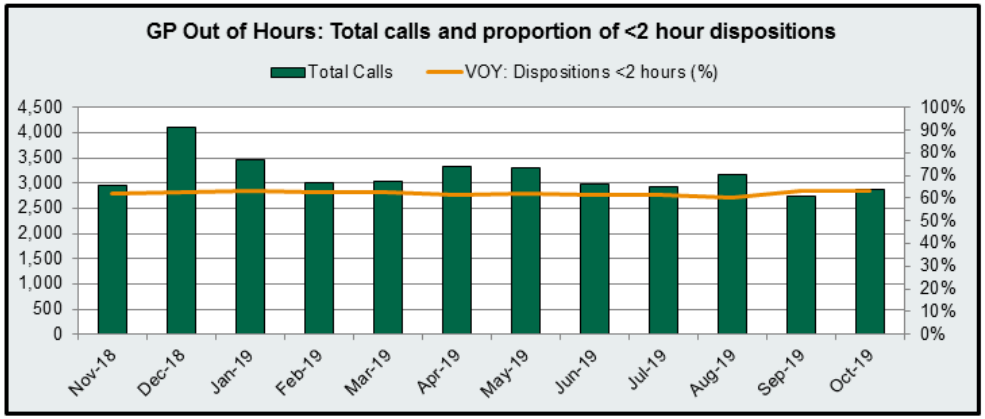
Note - all ARP data covers YAS as a whole organisation. Local breakdown to CCG/Regional level is not available at this time.

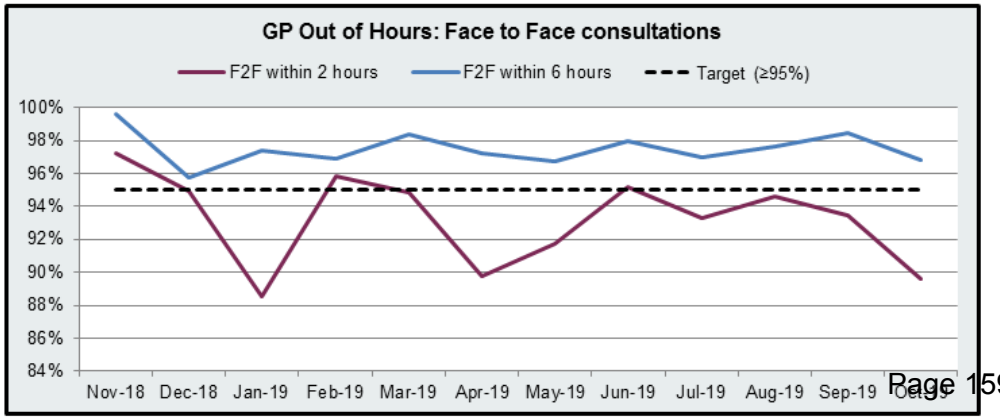
NHS 111 and GP Out of Hours

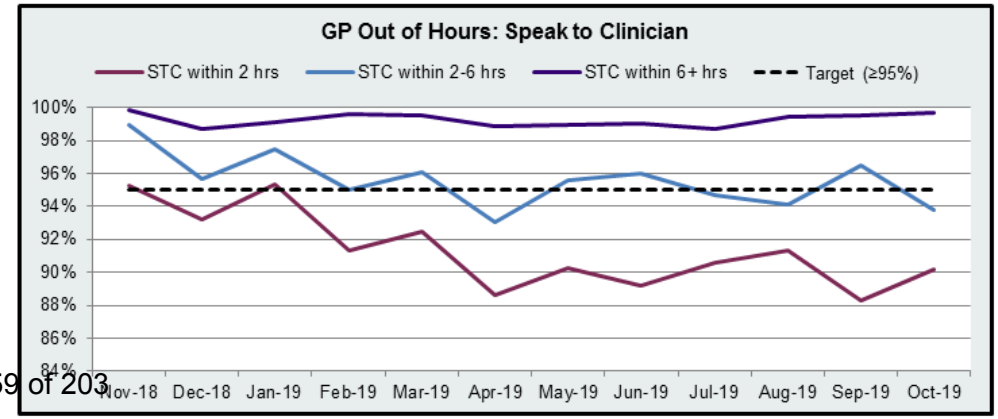






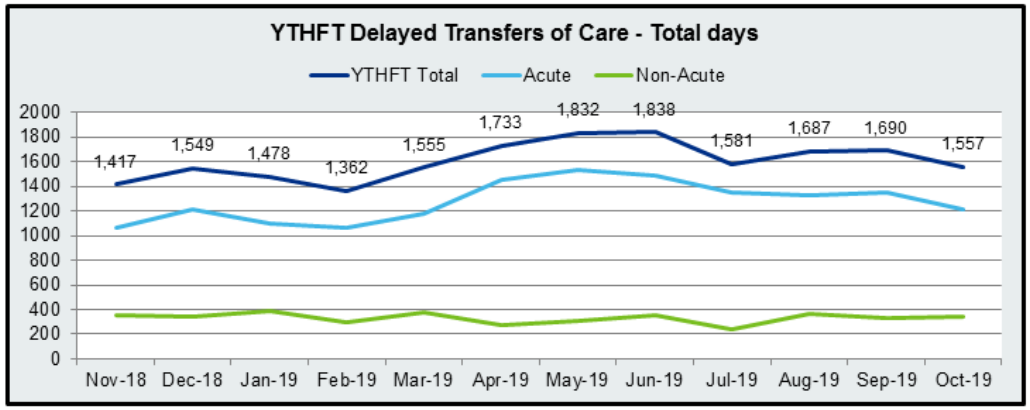




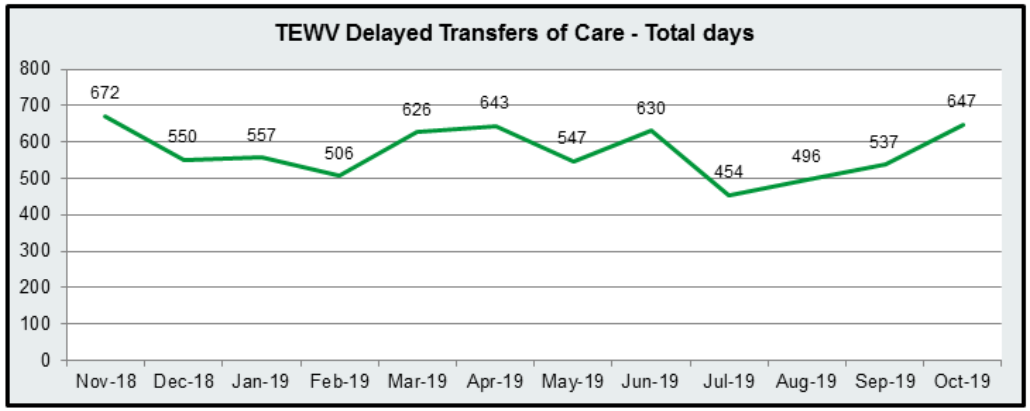


Note - all NHS 111 data is at Yorkshire and Humber level and is available one month ahead of other national data

Delayed Transfers of Care (DTOCs)

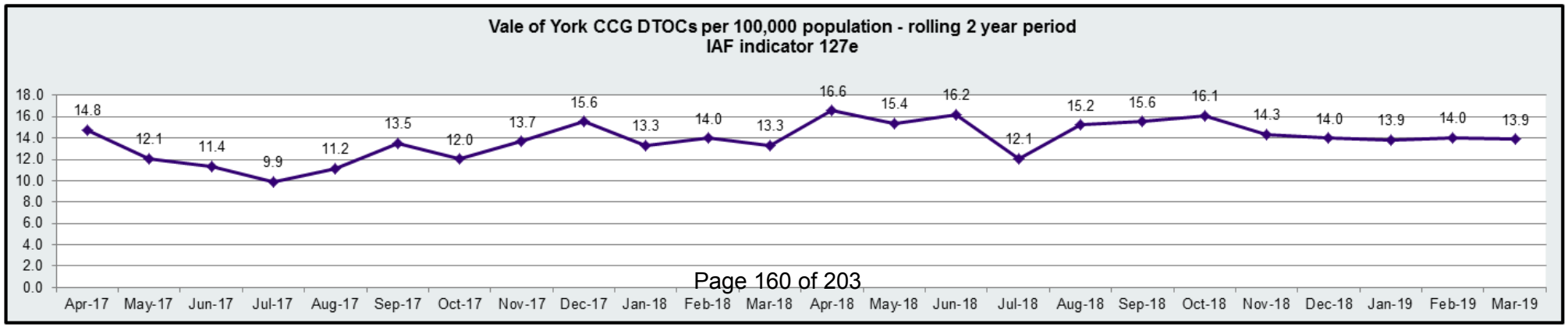


YTHFT DTOCs - October 2019		
Reason Code	**Total bed days**	**Proportion**
C) Waiting Further NHS Non-Acute Care	547	35.1%
E) Awaiting Care Package in Own Home	313	20.1%
DI) Awaiting Residential Home Placement or Availability	224	14.4%
A) Completion of Assessment	204	13.1%
DII) Awaiting Nursing Home Placement or Availability	203	13.0%
F) Awaiting Community Equipment and Adaptions	36	2.3%
G) Patient or Family Choice	24	1.5%
H) Disputes	6	0.4%
B) Public Funding	0	0.0%
O) Other	0	0.0%
I) Housing - Patients Not Covered by NHS and Community Care Act	0	0.0%
Grand Total	**1,557**	**100.0%**



TEWV DTOCs - October 2019		
Reason Code	**Total bed days**	**Proportion**
DII) Awaiting Nursing Home Placement or Availability	202	31.2%
I) Housing - Patients Not Covered by NHS and Community Care Act	192	29.7%
DI) Awaiting Residential Home Placement or Availability	124	19.2%
B) Public Funding	76	11.7%
G) Patient or Family Choice	29	4.5%
E) Awaiting Care Package in Own Home	24	3.7%
A) Completion of Assessment	0	0.0%
F) Awaiting Community Equipment and Adaptions	0	0.0%
O) Other	0	0.0%
C) Waiting Further NHS Non-Acute Care	0	0.0%
H) Disputes	0	0.0%
Grand Total	**647**	**100.0%**

Note - all TEWV delays are Non-Acute



Performance and Programme Overview
Mental Health

Areas Covered:

- Improving Access to Psychological Therapies (IAPT)
- Early Intervention in Psychosis (EIP)
- Dementia Diagnosis
- Children and Young People's (CYP) Mental Health Services Access Rate
- Children and Adolescent Mental Health Services (CAMHS) Referral to Treatment (RTT)
- Children and Young People's (CYP) Eating Disorders
- Autism Assessments
- Annual Health Checks for people with Severe Mental Illness (SMI)

Content:

- Summary dashboard
- Narrative
- Supporting data

NHS
Vale of York
Clinical Commissioning Group

Vale of York CCG Performance Summary Dashboard – Mental Health

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Previous 3 Quarters 2018/19 Q4	Previous 3 Quarters 2019/20 Q1	Previous 3 Quarters 2019/20 Q2	Current QTD 2019/20 Q3	Previous Financial Year 2018/19	Current Financial YTD 2019/20
Mental Health																							
123b	E.A.3		IAPT*	IAPT Access (rolling 3 months)	≥5.5% in Q4 (≥22% full year)	2.5%	2.8%	2.8%	3.8%	3.6%	3.5%	3.6%	3.5%	3.3%	3.6%	3.9%	-	3.6%	3.5%	3.9%	-	14.6%	-
123a	E.A.S.2		IAPT	IAPT Recovery (rolling 3 months)	≥50%	46.3%	41.9%	39.1%	44.8%	47.4%	50.0%	48.6%	48.5%	51.4%	50.9%	52.7%	-	47.4%	48.5%	52.7%	-	47.2%	50.7%
	E.H.1_A1		IAPT	IAPT: 6 weeks First Treatment	≥75%	100.0%	95.5%	95.1%	93.3%	94.3%	97.2%	93.0%	90.3%	91.1%	95.5%	100.0%	-	94.3%	93.6%	95.0%	-	92.2%	94.3%
	E.H.2_A2		IAPT	IAPT: 18 weeks First Treatment	≥95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	93.5%	93.3%	97.7%	100.0%	-	100.0%	97.3%	96.7%	-	99.1%	97.0%
123c	E.H.4		EIP	EIP: Within 2 weeks (rolling 3 months)	≥56%	71.4%	65.2%	52.4%	54.2%	44.4%	39.4%	41.2%	51.3%	66.7%	73.7%	82.9%	-	44.4%	51.3%	82.9%	-	45.7%	66.2%
126a	E.A.S.1		Dementia**	Dementia: Diagnosis Rate	≥66.7%	60.1%	59.6%	59.1%	58.7%	58.6%	58.0%	57.6%	57.3%	57.2%	57.5%	57.1%	57.4%	58.8%	57.7%	57.3%	57.3%	60.0%	57.4%
	E.H.9		CYPMH	Children and Young People's MH Access Rate (rolling 12 months)	34%	40.5%	41.1%	42.5%	42.7%	42.3%	43.5%	43.8%	44.8%	45.0%	45.5%	-	-	-	-	-	-	42.3%	-
			RTT***	% of patients starting treatment within 6 weeks of referral - CYP		57.7%	47.4%	47.6%	53.2%	56.5%	33.3%	43.6%	58.3%	73.4%	73.8%	68.5%	72.5%	-	-	-	-	-	-
	E.H.10		CYPMH	CYP Eating Disorders: Routine cases % within 4 weeks	In year ≥60%, ≥95% by March 2021	Quarterly indicator (rolling 12 months)												66.7%	79.2%	86.8%	-	66.7%	-
	E.H.11		CYPMH	CYP Eating Disorders: Urgent cases % within 1 week	In year ≥75%, ≥95% by March 2021	Quarterly indicator (rolling 12 months)												71.4%	82.6%	85.7%	-	71.4%	-
			Autism Assessments	Total number of CYP waiting for a full specialist assessment		220	208	210	212	208	205	201	199	187	199	199	206	-	-	-	-	-	-
				Of above, waiting up to 13 weeks		56	51	67	68	76	68	57	61	57	76	69	81	-	-	-	-	-	-
				Of above, waiting 14 to 33 weeks		84	77	75	75	57	71	84	74	77	80	76	76	-	-	-	-	-	-
				Of above, waiting 34 to 52 weeks		48	49	41	46	55	52	46	56	46	36	49	42	-	-	-	-	-	-
				Of above, waiting 52+ weeks		32	31	27	23	20	14	14	8	7	7	5	7	-	-	-	-	-	-
124b			LD AHCs	Annual health check for people on Learning Disability register	≥75%	Quarterly indicator												30.5%	18.0%	-	-		
123g	E.H.13		SMI AHCs	Annual health check for people with Severe Mental Illness (SMI)	≥60%	Quarterly indicator (rolling 12 months)												17.6%	26.2%	26.1%	-	17.6%	-

*IAPT access is calculated differently to other mental health standards in that achievement is based only on Quarter 4 performance, multiplied by 4 to give the CCG's annual rate. There is a notional target of 4.75% in Quarters 1 to 3, however this is for monitoring purposes only and does not influence year-end achievement of this standard. The key target is achievement of 5.5% in Quarter 4, which is multiplied by 4 to give a 2019/20 annual target of 22%.
The denominator for this indicator always remains the same at the annual level of need in the population. Monthly data against this target reflects a rolling 3 month position, i.e. April numerator will cover Feb+Mar+Apr. Quarterly data reflects only completed months within that quarter, i.e. in April, Q1 numerator would cover April only, in May it would cover Apr+May and so on. Annual data will be updated only at end Q4 when annual position is available for calculation.

**Dementia Diagnosis data can be at times be available one month ahead of other data sources which could affect QTD and YTD calculations

***TEWV definitions of treatment include self-help and wellbeing advice

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalation required/ underway
IAPT	Yes	The performance notice was formally withdrawn on 4th December following improved performance. There has been a significant number of referrals entering the service with 723 in October. This is a result of promotion and greater awareness of the service in primary care, the self –referral service and co-location of therapist in 2 practices with high prescribing of anti-depressants. Workforce remains a concern with 9.9 WTEs vacant. Although the pathway continues to meet NICE guidelines, the ability to access the service for treatment is hampered by workforce with HIT workers moving into the front end of the service.	On-going implementation of the improvement plan and engagement with primary care, specifically the 4 four main practices which are high prescribers of anti-depressants. TEWV Head of MH services to present a report to the LMC on the benefits of IAPT Initial scoping of a long-term condition pathway is underway	
EIP	Yes	The service achieved 100% in October of people aged 14-65 experiencing their first episode of psychosis starting treatment within 2 weeks. The ARMS pathway is currently on hold due to service capacity pressures	The expectation from the National Clinical Audit for Psychosis (NCAP)is that services are level 2 by 2019/20 with plans to achieve level 3 as defined by the NCAP process. TEWV has been asked to provide a recovery plan to outline a trajectory for achieving this standard. An EIP design event is taking place w/c 16 December to look at the structure for how EIP support is delivered across the locality and to develop a revised service model that meets national access and quality standards and workforce requirements.	

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalation required/ underway
Dementia Diagnosis	No	Multiple causes including; GP awareness and understanding of benefits of a diagnosis; confidence of GPs to diagnose advance cases of dementia in care homes; high level of diagnosis of mild cognitive impairment following assessment at the Memory Service	On-going implementation of including • Raising awareness with GPs, highlighting the pathway in terms of memory assessment and the range of post diagnostic support available. • Case finding in care homes and use of Diadem tool • Training to CHC nurses on use of Diadem tool • Data cleansing of registers using the Dementia Quality Toolkit to improve coding accuracy • Memory service design event scheduled in the New Year including scoping of pathway for mild cognitive impairment • Clinical network to produce a letter for GPs aimed at validating Diadem assessments and recommending diagnosis, also webinar for further training	

Mental Health

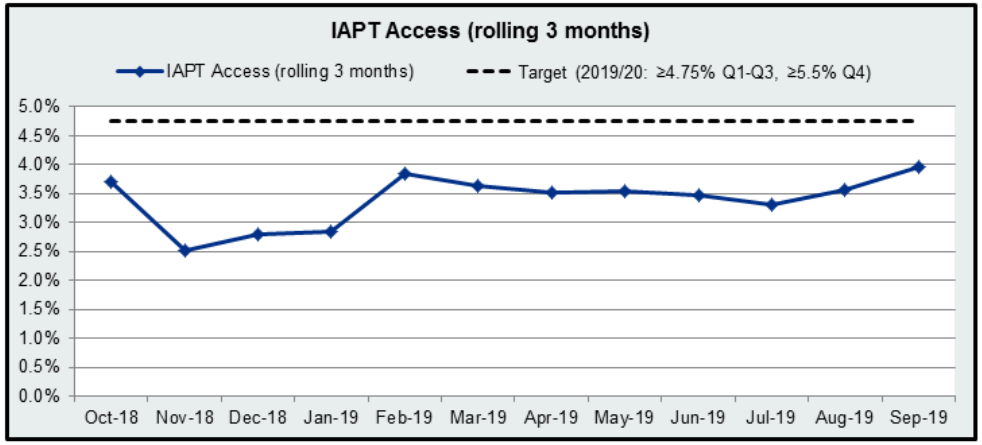
Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
CYP Access Rate	Yes	NHSE projection is for 48% by March 2020 against target of 35%. Additional funding from 2019/2020 is now taking effect in numbers of CYP seen	The position is monitored monthly at CMB	
CAMHS Referral to Treatment (RTT)	No target	Increasing percentage starting some form of treatment, mainly self directed support, within 6 weeks of external referral.	The position is monitored monthly at CMB.	Discussions around investment proposals for the MHIS for 2020/2021 are looking at further investment in face to face treatment.
CYP Eating Disorders	Yes	Once deferrals at the options of patients and families are excluded, all referrals are assessed and start treatment within the target times of 1 week for urgent and 4 weeks for routine referrals.	Caseload remains high, at 60+. Training sessions for school staff in identifying and responding quickly have been successful.	TEWV is seeking further New Models of Care funding to increase number of clinicians and offer a more consistent approach for physical health checks.
Autism Assessments	No target: NICE guidance is 13 weeks from referral	TEWV assessment is that performance has reached a plateau, at about 45 weeks wait. There will be some improvement as the new staff are now fully in post. However, referrals remains high, and the conversion rate remain in the mid 50% range for year to date.	Discussions are progressing with TEWV and LA partners regarding the pathways of support across the local system, with an emerging consensus that the pathway should be completely revised. These discussions are reflected in the proposals for investment in 2020/2021.	

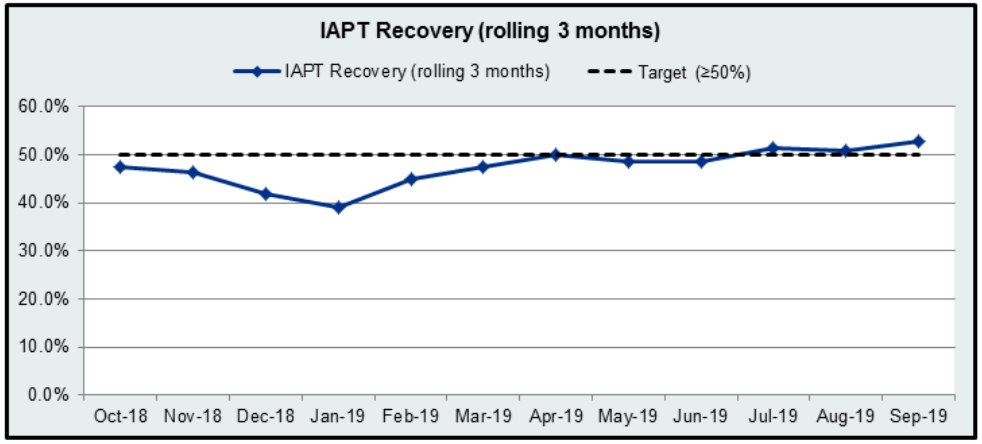
Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Annual SMI Health Checks	No	The new reporting requirement was introduced in October 2018 and work has been undertaken since then with primary care to raise awareness of the health checks and reporting. This has seen gradual improvements from 13.2% in October 2018 to the current position of 26.2%. The CCG has agreed a local target of 30% for 2019/20.	16 practices have signed up to implement a Local Enhanced Service from 31 October 2019 and to make improvements against their Q2 practice performance. 2 education and training events for Primary Care were on 6 December in York and 7 December in Escrick	CCG is considering next steps to improve update with available funding

Improving Access to Psychological Therapies (IAPT)

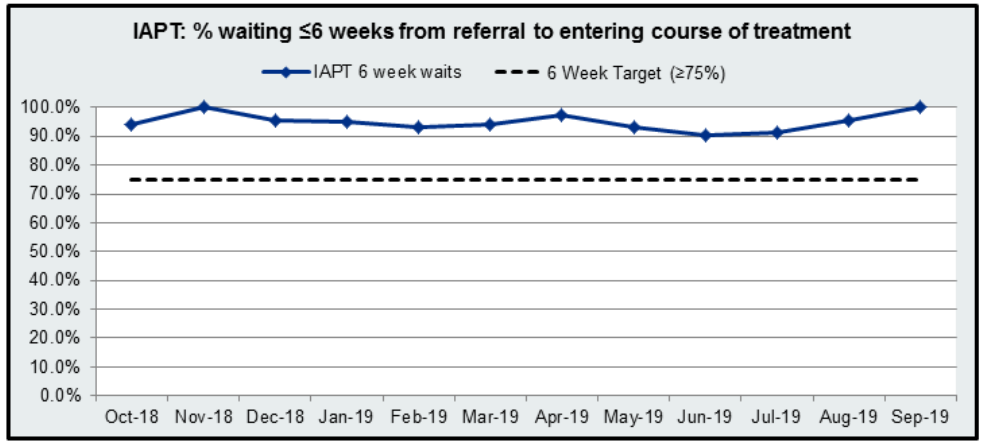
Note - There is a greater time lag in publication for the IAPT data set which will consequently be one or sometimes two months behind other data sets

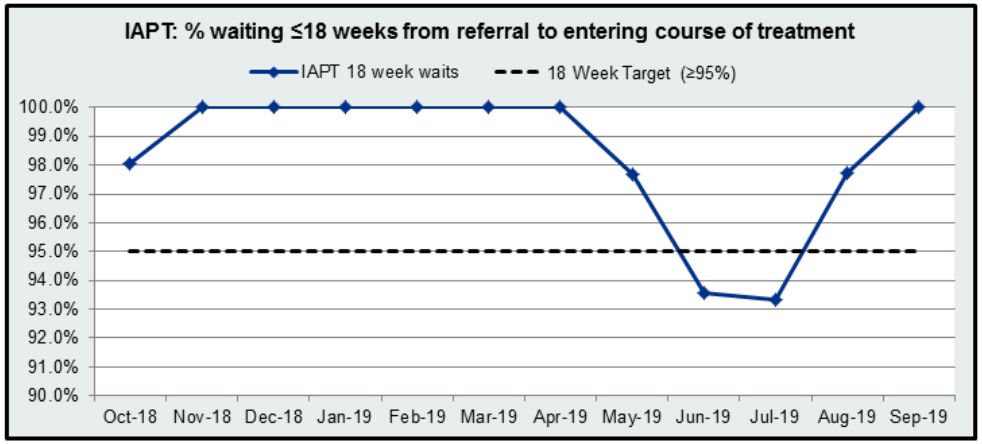




IAPT Access - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥4.75% Q1-3, ≥5.5% Q4		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	3.9%	4.0%	4.1%	4.2%
	2019/20 Actual	3.5%	3.9%	-	-
	Variance	-0.4% ▼	-0.1% ▼	-	-

IAPT Recovery - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥50%		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	50.1%	50.0%	50.0%	50.0%
	2019/20 Actual	48.5%	52.7%	-	-
	Variance	-1.6% ▼	2.7% ▲	-	-

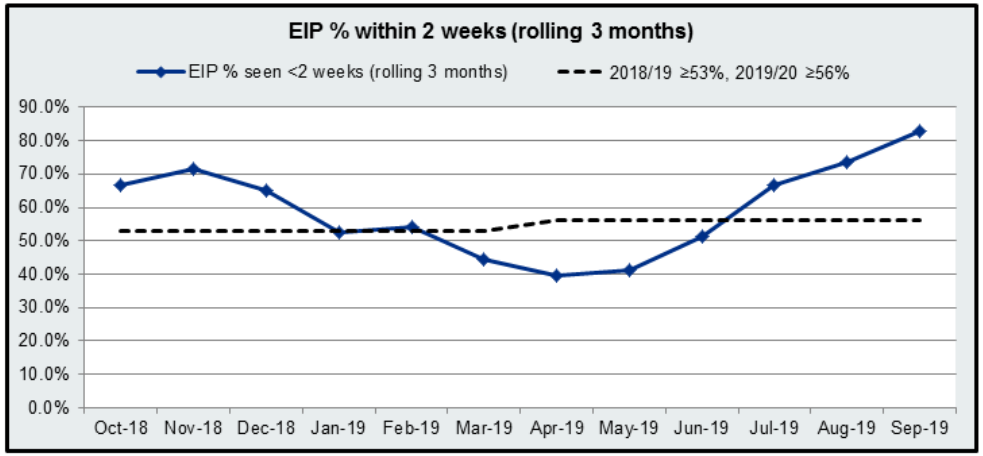


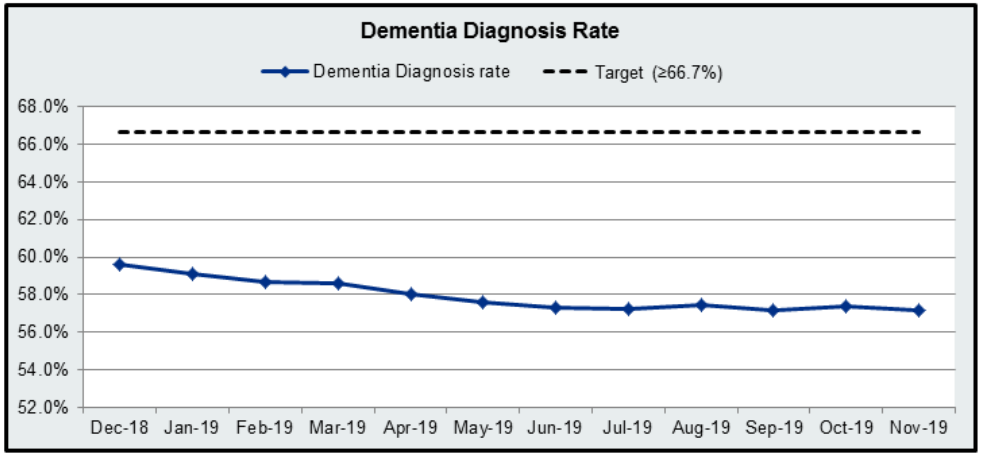


IAPT 6 weeks - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥75%		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	75.1%	75.1%	75.1%	75.1%
	2019/20 Actual	93.6%	95.0%	-	-
	Variance	18.5% ▲	19.9% ▲	-	-

IAPT 18 weeks - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥95%		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	95.2%	95.2%	95.2%	95.2%
	2019/20 Actual	97.3%	96.7%	-	-
	Variance	2.1% ▲	1.5% ▲	-	-

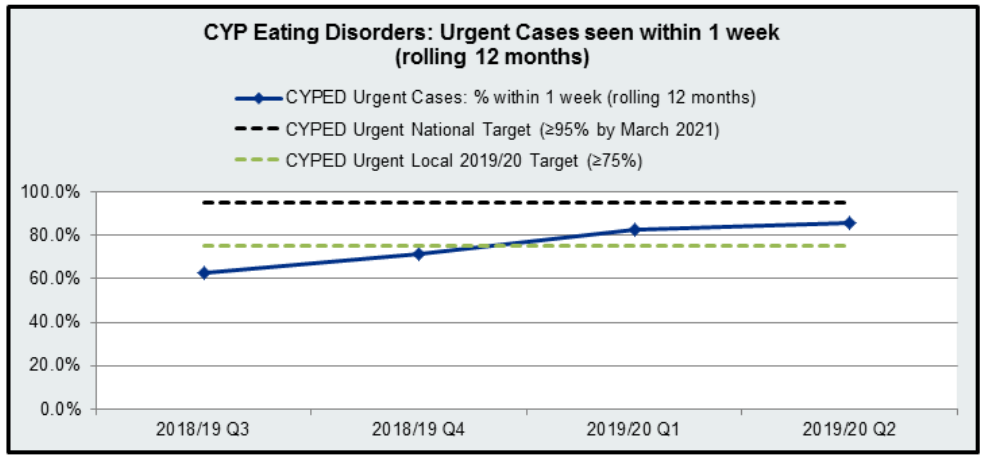
Early Intervention in Psychosis (EIP), Dementia Diagnosis and Eating Disorders

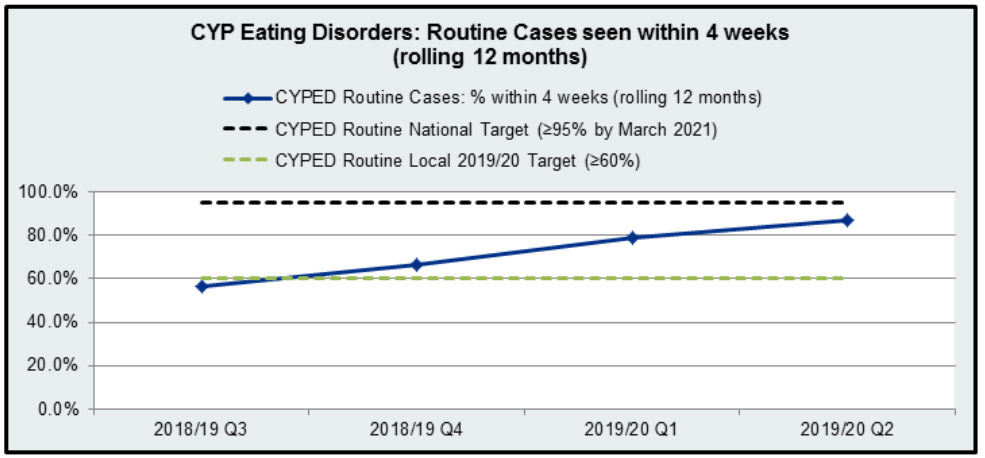




EIP - 2019/20 Plan vs Actual - Vale of York CCG					
Target 2019/20 ≥56%		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	54.5%	54.5%	59.1%	59.1%
	2019/20 Actual	51.3%	82.9%	-	-
	Variance	-3.2% ▼	28.3% ▲	-	-

Dementia Diagnosis Rate - 2019/20 Plan vs Actual - Vale of York CCG												
Target ≥66.7%		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Vale of York CCG	2019/20 Plan	60.8%	61.0%	61.1%	61.3%	61.5%	61.7%	61.8%	62.0%	62.1%	62.1%	62.1%	62.1%
	2019/20 Actual	58.0%	57.6%	57.3%	57.2%	57.5%	57.1%	57.4%	57.2%	-	-	-	-
	Variance	-2.8% ▼	-3.4% ▼	-3.8% ▼	-4.1% ▼	-4.0% ▼	-4.5% ▼	-4.4% ▼	-4.8% ▼	-	-	-	-





CYP ED Urgent Cases - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥95% by March 2020		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	76.2%	76.2%	76.2%	76.2%
	2019/20 Actual	82.6%	85.7%	-	-
	Variance	6.4% ▲	9.5% ▲	-	-

CYP ED Routine Cases - 2019/20 Plan vs Actual - Vale of York CCG					
Target ≥95% by March 2020		Q1	Q2	Q3	Q4
Vale of York CCG	2019/20 Plan	51.3%	56.4%	59.0%	59.0%
	2019/20 Actual	79.2%	86.8%	-	-
	Variance	27.9% ▲	30.4% ▲	-	-

Performance and Programme Overview
Complex Care

Areas Covered:

- Continuing Healthcare (CHC)
- Personal Health Budgets (PHBs)

Content:

- Summary dashboard
- Narrative
- Supporting data

Vale of York CCG Performance Summary Dashboard – Complex Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Previous 3 Quarters 2018/19 Q4	Previous 3 Quarters 2019/20 Q1	Previous 3 Quarters 2019/20 Q2	Current QTD 2019/20 Q3	Previous Financial Year 2018/19	Current Financial YTD 2019/20
Complex Care																							
131a		Y	CHC	% DSTs undertaken in acute setting	≤15%	0.0%	0.0%	0.0%	2.1%	3.8%	13.6%	0.0%	6.3%	0.0%	9.5%	7.7%	0.0%	0.8%	5.6%	5.0%	7.7%	2.0%	5.6%
		Y	CHC	% of Standard CHC referrals with a decision on DST within 28 days	≥80%	70.2%	84.3%	96.9%	87.5%	82.1%	85.3%	89.7%	82.5%	86.7%	86.7%	92.1%	89.3%	88.5%	85.7%	85.0%	92.1%	74.8%	86.5%
105b	E.N.1		PHBs	Total Personal Health Budgets in place	330 by March 2020	-	-	-	-	-	38	39	42	47	74	74	-	38	38	44	74	38	74

*Note - CHC data is generated internally within the CCG and therefore is available one month ahead of other data. Data is published nationally on a quarterly basis only.

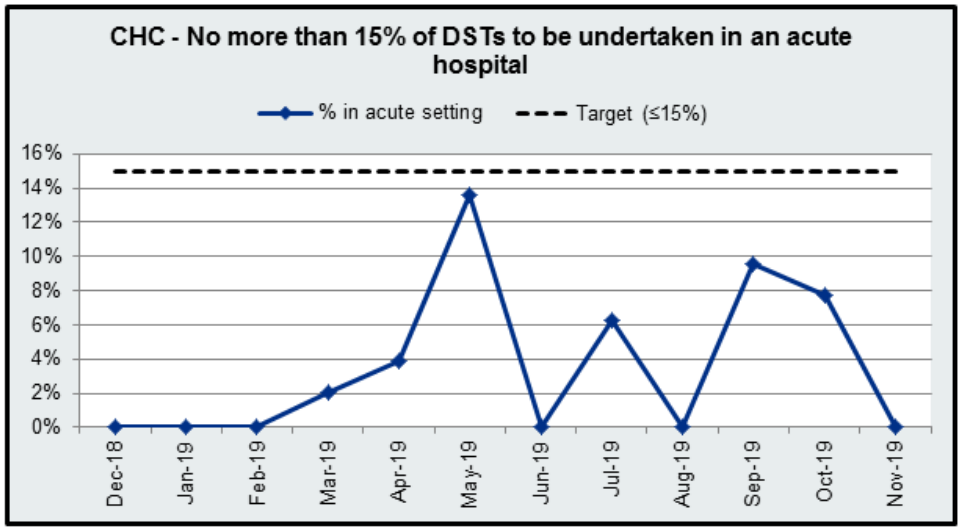
Complex Care

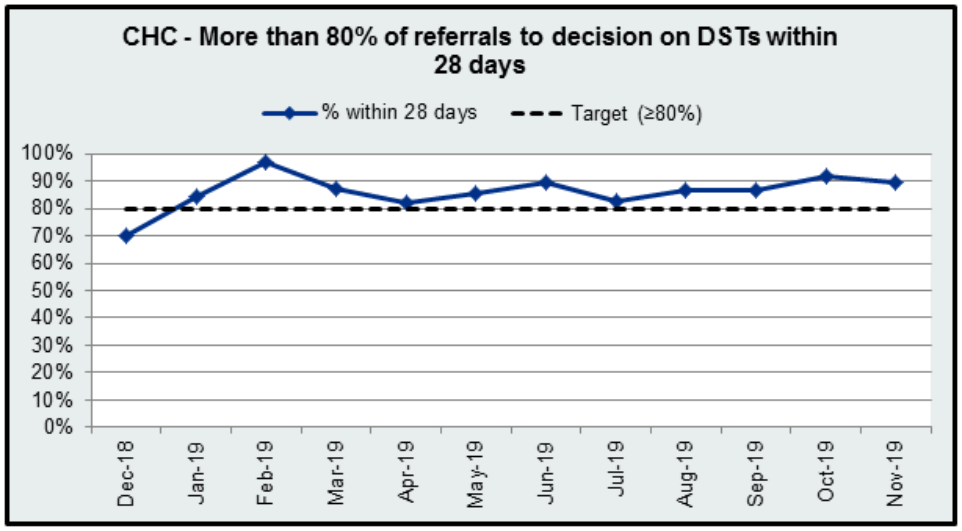
Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
CHC – DST taking place in Acute Hospital	Yes	Due to process embedded within CHC regarding requests for DSTs undertaken in hospital we believe this target is currently sustainable	The Discharge to Assess pathway works to reduce DST performed in an Acute Setting although in some cases this activity is necessary.	Not Required
CHC – Decisions on DSTs within 28 days	Yes	The target was met in November but workforce issues have made this more challenging in December. However it is believed this will be met for Q3.	Tracking is in place and mitigating actions to increase throughput where possible.	Not Required
CHC – Waiting Times	Yes	All October waiters had decisions made in November.	A process is now in place to review any long waiters on a regular basis however as the DST booking process has improved it is anticipated that clients will be routinely seen within the required 28 day timeframe	Not Required
Personal Health Budgets	No	The current plan relies heavily on the implementation of Personal Wheelchair Budgets (PWBs). PWBs have started to be offered through a soft launch and the position against plan is expected to improve significantly.	All new CHC clients are considered for PHB eligibility and current CHC packages that may be suitable for PHB have been targeted so PHBs are our default position. We are expanding our PHB offer and working to implement PWBs with our community wheelchair service and PHBs for people with Section117 aftercare.	Not Required

Continuing Healthcare (CHC) and Personal Health Budgets (PHBs)

*Note - CHC data is generated internally within the CCG and therefore is available one month ahead of other data. Data is published nationally on a quarterly basis only.

CHC Decision Support Tool (DST) in acute setting and CHC Completed referrals to decision





CHC incomplete referrals waiting times and Personal Health Budgets (PHBs)

CHC referral to decision on DST - waits exceeding 28 days							
Period	*Within 28 days*	1 to 14 days over	15 to 28 days over	29 to 84 days over	85 to 182 days over	≥183 days over	Total over 28 days
Apr-19	*Data not available for this month*						
May-19	*20*	0	0	3	1	0	4
Jun-19	*15*	0	1	2	0	0	3
Jul-19	*17*	3	0	2	0	0	5
Aug-19	*14*	0	2	0	1	0	3
Sep-19	*19*	0	1	1	0	0	2
Oct-19	*20*	1	2	1	0	0	4
Nov-19	*17*	4	2	1	0	0	7
Dec-19							
Jan-20							
Feb-20							
Mar-20							

Personal Health Budgets (PHBs)				
Period	Wheelchair PHBs	CHC PHBs	Other PHBs	Total PHBs*
Qtr 1	0	39	0	39
Qtr 2	23	47	4	74
Qtr 3				
Qtr 4				

*2019/20 full year trajectory for Vale of York CCG is 330 by March 2020

NHS Oversight Framework (NHS OF)

NHS Oversight Framework (NHS OF)

The NHS Oversight Framework for 2019/20 was published in August 2019, and outlines the joint approach NHS England and NHS Improvement will take to oversee organisational performance and identify where commissioners and providers may need support. The NHS Oversight Framework has replaced the provider Single Oversight Framework and the CCG Improvement and Assessment Framework (IAF).

It is intended as a focal point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs).

NHSE/I have described that changes to oversight will be characterised by several key principles:

- NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations
- a greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals
- working with and through system leaders, wherever possible, to tackle problems
- matching accountability for results with improvement support, as appropriate
- greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

Oversight will incorporate:

- System review meetings: discussions between the regional team and system leaders, drawing on corporate and national expertise as necessary, informed by a shared set of information and covering:
    - performance against a core set of national requirements at system and/or organisational level. These will include: quality of care, population health, financial performance and sustainability, and delivery of national standards
    - any emerging organisational health issues that may need addressing
    - implementation of transformation objectives in the NHS Long Term Plan.

    In the absence of material concerns, the default frequency for these meetings will be quarterly, but regional teams will engage more frequently where system or organisational issues make it necessary.
- Focused engagement with the system and the relevant organisations where specific issues emerge outside these meetings.

The specific dataset for 2019/20 broadly reflects existing provider and commissioner oversight and assessment priorities. A brief summary is provided on the next slide.

NHS Oversight Framework (NHS OF)

A brief summary of the indicators contained within the framework is outlined below.

- The 2019/20 framework 65 indicators in total, plus a sub-set of approximately 30 provider based indicators
- 54 indicators have been carried over from the 2018/19 CCG IAF
- 1 of the 54 indicators has retained its reference but with definition amended:
  - 128c in the 2018/19 framework was 'Proportion of population benefiting from extended access services'. 128c in the 2019/20 framework has been amended to a placeholder indicator titled 'Patient experience of booking a GP appointment' with the comment 'The work to develop the specific metric will be taken forward as part of the National Access Review'.
- 4 indicators from the 2018/19 framework have been removed:
  - 121c – High quality care – adult social care
  - 123e – Mental Health - crisis team provision
  - 123h – Mental Health – cardio-metabolic assessments in mental health environments
  - 128e – Primary care transformation investment
- 6 new indicators for CCG oversight have been added:
  - 134a – Evidence based interventions
  - 124d – Learning disabilities mortality review: % of reviews completed within 6 months of notification
  - 129b – Overall size of the waiting list
  - 129c – Patients waiting over 52 weeks for treatment
  - 123k – CYP and eating disorders investment as a percentage of total mental health spend
  - 109a – Reducing the rate of low priority prescribing
- There are 4 indicators contained in the framework not previously monitored by the CCG, these are provider oversight measures:
  - Effectiveness of shared objective-setting and teamworking
  - Providing equal opportunities and eliminating discrimination
  - Black and minority ethnic (BME) leadership ambition for executive appointments
  - Reducing/eliminating bullying and harassment from managers and other staff
- In addition to the 4 indicators above, a fifth indicator has been added which references a sub-set of provider oversight indicators:
  - Quality of Care metrics: a set of 30 quality proxies to identify any emerging quality concerns at acute, mental health, ambulance and community trusts
  - This sub-set has been queried with the NHSE/I Oversight and Assessment team as the provider annex contains more than 30 metrics so clarity has been sought on which are to be included for assessment.

Clinical Standards Review 2019

NHS
Vale of York
Clinical Commissioning Group

Clinical Standards Review 2019

- In March 2019 an interim report was published by Professor Stephen Powis, NHS National Medical Director, setting out recommendations for determining whether patients would be well served by updating and supplementing some of the older targets currently in use across the NHS. Professor Powis proposed a number of revised standards which will be rigorously field tested during 2019/20 to gather further evidence on clinical, operational, workforce and financial implications. These standards apply to four service areas:
    - Mental Health
    - Cancer
    - Urgent and Emergency Care
    - Elective Care
- 2019/20 will therefore be a transition year between the old targets and updated standards. Slides outlining the current and proposed standards across the four service areas were submitted to Finance and Performance Committee in March 2019.
- Field testing of the new suite of access standards is taking place at a selection of sites across England, before wider implementation. The approach and timeframe for this testing varies across the four service areas according to the nature of care and the changes that are being proposed. Prior to testing, detailed guidance will be provided to test sites to ensure clarity and consistency in what they are testing and measuring, and to support robust evaluation.

Urgent and emergency care

- The following hospital trusts have worked with the NHS nationally to agree how they will safely test the urgent and emergency care proposals, and began the first phase of the trial from May 22nd 2019: Cambridge University Hospitals, Chelsea and Westminster Hospital, Frimley Heath, Imperial College Healthcare, Kettering General Hospital, Luton and Dunstable University Hospital, Mid Yorkshire Hospitals, North Tees and Hartlepool, Nottingham University Hospitals, Plymouth Hospitals, Poole Hospital, Portsmouth Hospitals, Rotherham, West Suffolk.
- The first six-week phase of testing explored whether an average (mean) time in A&E could be implemented safely, and provide clinicians with a useful measure of activity and patient experience. Findings from this phase were that the measure was introduced successfully across all sites, with no reported safety concerns linked to the testing. The Clinical Advisory Group for this workstream, and the trusts involved, therefore support that a second phase of testing should go ahead, beginning Wednesday 31 July.
- This phase included:
    - measuring time to initial assessment;
    - collecting data to examine the feasibility of measuring how fast critically ill or injured patients arriving at A&E receive a package of tests and care developed with clinical experts, and;
    - test sites to continue monitoring average (mean) total time in department and long waits from arrival, aiming for continual improvement.

- The list of critical conditions included in testing in this phase is: stroke, major trauma, heart attacks (MI – STEMI), acute physiological derangement (including sepsis), and severe asthma.
- Later in the process, neighbouring mental health trusts will be testing standards for urgent community mental health services that can prevent avoidable A&E attendances by providing mental health crisis care in more suitable environments where possible.
- When people do need to attend A&E, the trusts above will be measuring how long people who arrive at A&E experiencing a mental health crisis wait for a psychiatric assessment and, where required, a transfer to appropriate mental health care.

Routine (elective) care

- The following hospital trusts have worked with the NHS nationally to agree how they will safely test the elective care proposals, and began the first phase of the trial from early August: Barts Health, Calderdale and Huddersfield, East Lancashire Hospitals, Great Ormond Street Hospital for Children, Harrogate and District, Milton Keynes University Hospital, Northampton General Hospital, Surrey and Sussex Healthcare, Taunton and Somerset, The Walton Centre, University Hospitals Bristol, University Hospitals Coventry and Warwickshire.
- These trusts will be testing the use of an average (mean) wait measure for people on the waiting list as a potential alternative to a threshold target, currently set at 18-weeks, to see whether keeping the focus on patients at all stages of their pathway can help to reduce long waits.
- They will also be helping to understand the impact of removing a third of outpatient appointments on both the current 18-week threshold or a potential mean, in order to set a more appropriate standard in the future.

Cancer

- The following hospital trusts have worked with the NHS nationally to agree how they will safely test the elective care proposals, and began the first phase of the trial from late August: Mid Essex Hospital Services, Epsom and St Helier University Hospitals, Kingston Hospital, Chesterfield Royal Hospital, Northampton General Hospital, Doncaster and Bassetlaw Teaching Hospitals, East Lancashire Hospitals, Warrington and Halton Hospitals, Hampshire Hospitals, The Royal Bournemouth and Christchurt Hospitals, Torbay and South Devon.
- These trusts will be testing the use of a faster diagnosis standard for people with suspected cancer – meaning that people can expect to be told whether or not they have cancer within 28 days of an urgent referral from their GP or a cancer screening programme – instead of the current standard of seeing a specialist within 14 days, with no measurement of when someone should be told the result.

Mental health

- The interim report proposes new standards across different types of mental health care, and these require different approaches to testing.
- The following trusts will test different aspects of the proposed new standards for urgent and emergency mental health care: Cambridgeshire and Peterborough, Central North West London, East London, Livewell South West, Northamptonshire Healthcare, Nottinghamshire Healthcare, Rotherham, Doncaster and South Humber, South West Yorkshire, Surrey and Borders, and Berkshire, Tees, Esk and Wear Valley, West London
- As described above, these trusts will work with their neighbouring hospital trusts who are participating in the testing of proposed new A&E standards. They will also help NHS leaders to better understand the impact of the new standards in the context of efforts to deliver more care quicker and closer to home.
- A further 12 areas of the country are already piloting the four-week waiting time standard for children and young people's community Mental Health Support Teams. These are: Bromley, Buckinghamshire, Camden, Doncaster and Rotherham, Gloucestershire, Greater Manchester, Haringey, Northumberland, Oxfordshire, South Warwickshire, Stoke on Trent and North Staffordshire, Tower Hamlets
- Work is underway to design a field-testing approach for the proposed four-week standard for adult community mental health services, and confirm which organisations will be involved. Details will be published here when they are confirmed.
- Testing had begun in all sites by October 2019.

Evaluation

- As there have been positive initial results in each of the four service areas, testing will continue across all of them. The data that this provides will continue to be monitored and analysed, alongside learning from independent research on patient experience (led by Healthwatch England) and on how staff view the current and proposed standards.
- All of this will help inform refined proposals, which will be subject to public consultation, which would expect to launch in early 2020. The results of that consultation, combined with further analysis and evaluation and continued input nationally from clinician and patient groups will inform a final report and set of recommendations by the end of March 2020. If recommendations require changes to the NHS Constitution, they will be subject to further consultation.
- The approach to implementation of the proposals for each pathway will therefore be considered individually, to ensure that sufficient time and consideration is given to each, and to their interplay with the ongoing review of access to general practice.

Acronyms

Acronyms

2WW	Two week wait (urgent cancer referral)	DQIP	Data Quality Improvement Plan
A&E	Accident and Emergency	DTOC	Delayed Transfer of Care
AEDB	Accident and Emergency Delivery Board	ECS	Emergency Care Standard (4 hour target)
AHC	Annual Health Check	ED	Emergency Department
AIC	Aligned Incentive Contract	EDFD	Emergency Department Front Door
CAMHS	Child and Adolescent Mental Health Services	EMI	Elderly Mentally Infirm
CHC	Continuing Healthcare	ENT	Ear Nose and Throat
CIP	Cost Improvement Plan	F&P/F&PC	Finance and Performance Committee
CMB	Contract Management Board	FIT	Faecal Immunochemical Test
COPD	Chronic Obstructive Pulmonary Disease	FNC	Funded Nursing Care
CQC	Care Quality Commission	GA	General Anaesthetic
CQUIN	Commissioning for Quality and Innovation	GPSI	GP with Special Interest
CSF	Commissioner Sustainability Fund	HCV	Humber Coast and Vale
CT	Computerised Tomography Scan	IAF	Improvement and Assessment Framework
CYC	City of York Council	IAPT	Improving Access to Psychological Therapies
CYP	Children and Young People	ICS	Integrated Care System
DEXA	Dual Energy X-ray absorptiometry scan	IST	Intensive Support Team
DNA	Did not attend	LD	Learning Disabilities

Acronyms (cont.)

MDT	Multi Disciplinary Team	QP	Quality Premium
MHIS	Mental Health Investment Standard	RRV	Rapid Response Vehicle
MIU	Minor Injuries Unit	RSS	Referral Support Service
MMT	Medicines Management Team	RTT	Referral to Treatment
MRI	Magnetic Resonance Imaging	SOP	Standard Operating Procedure
MSK	Musculoskeletal	S&R/SRCCG	Scarborough and Ryedale CCG
NHS	National Health Service	STF	Sustainability and Transformation Fund
NHSE	NHS England	STP	Sustainability and Transformation Plan
NHSI	NHS Improvement	SUS	Secondary Uses Service
NYCC	North Yorkshire County Council	TEWV	Tees Esk and Wear Valleys NHS Foundation Trust
OOH	Out of Hours	T&O	Trauma and Orthopaedics
PCH	Primary Care Home	TIA	Transient Ischaemic Attack
POLCV	Procedures of Limited Clinical Value	ToR	Terms of Reference
PMO	Programme Management Office	VOY	Vale of York
POD	Point of Delivery	WLI	Waiting List Initiative
PSF	Provider Sustainability Funding	YAS	Yorkshire Ambulance Service
PTL	Patient Tracking List	Y&H	Yorkshire and Humber
QIPP	Quality Innovation Productivity and Prevention	YTHFT	York Teaching Hospital NHS Foundation Trust

Vale of York
Clinical Commissioning Group

Item 14

Chair's Report: Executive Committee

Date of Meeting	16 October, 20 November and 4 December 2019
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee continued its overview of the 2019.20 financial plan noting the position at month 7 and the related risks to delivery. Additionally, the Committee approved an approach to funding the development of safeguarding reports prepared by General Practice.

A number of infrastructure and support services were reviewed. Potential enhancements to the Medicines Management Team were noted; the transition of the Business Intelligence service options were considered; and enhancements to the Continuing Healthcare Team were approved. Additionally, the Committee supported a request to co-commission a health resource within the MASH (Multiagency Safeguarding Hub) to review health assessments for children in care.

The Committee approved a refresh of the 2019/20 Local Transformation Plan for children and young people's mental health.

The Committee approved the governance proposed for Rapid Expert Input and considered the preparation across the system for the planned SEND ((Special Educational Needs and/or Disabilities) review.

The preparation for increased service demand during winter and the escalation protocol were discussed for assurance and mobilisation.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Audit Committee

Date of Meeting	28 November 2019
Chair	Phil Goatley

Areas of Note from the Committee Discussion

- The approach to considering outcomes from the, soon to be undertaken, annual review of Internal Audit Effectiveness, Counter-Fraud and Security was agreed. This is that all staff will be asked questions via Survey Monkey about our internal auditors' approach to all aspects of their work, from selection of areas to look at through to agreement of audit recommendations. The survey results will be discussed initially by the Senior Executive Team and Deputies together and the conclusions and any recommendations for change then considered in private session by the Audit Committee. This work will be completed before release and subsequent discussion of survey results and the CCG's collective response to them with Audit Yorkshire.

- Audit Committee approved the draft policy for use of Government Procurement Cards, noting that this properly balanced the need for expenditure control with convenience of operation in the CCG.

- Audit Committee Members were very pleased to see significant evidence across the CCG of strong control regimes around information governance and the management of conflicts of interest. The levels of losses and special payments recorded this year and information governance incidents, all of which at the time of the Committee were closed, were also impressively low.

Areas of Escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 16

Chair's Report: Finance and Performance Committee

Date of Meeting	24 October and 28 November 2019
Chair	David Booker

Areas of note from the Committee Discussion

24 October

- Whilst noting the continuing challenges facing the CCG and the wider health economy, the Committee commends the work of Executive Team and staff to establish longer term financial planning and the promotion of system working.
- The Committee agreed that the focus of NHS Vale of York CCG activity should be to increase the voices of clinicians and patients in service provision and service improvement. This will necessitate the review of analytical papers presented to the Committee. The ambition is to move out of legal Directions at the earliest opportunity.

28 November

- The Committee notes and accepts that regulators have refined and refreshed the application of Directions. However, the focus of the CCG will not change and it will continue to provide robust, proactive leadership within the system, based on sound clinical practice.
- A letter in response will be sent to Warren Brown, Director of Performance and Improvement, NHS England and NHS Improvement (North East and Yorkshire), expressing the concerns of the CCG, describing the extensive work the CCG has undertaken to demonstrate leadership within the wider NHS and other networks, and expressing concern regarding the equity of application of Directions or compliance with targets within the system.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Item 17

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	21 November 2019
Chair (Interim)	Julie Hastings

Areas of note from the Committee Discussion

The Committee:

- Commended the clinical change achieved by the statin optimisation pilot and supported its extension through partnership working across the CCG.
- Welcomed the presentation from the Primary Care Workforce and Training Hub and the opportunities offered.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 18

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	12 December 2019
Chair	Julie Hastings

Areas of note from the Committee Discussion

The Committee:

- Expressed concern about quality and safety of services at Woodlands Neurological Rehabilitation Unit in York.
- Noted establishment of the Quality Improvement Board in light of the continuing concerns about the impact on quality and safety across the York and Scarborough sites of York Teaching Hospital NHS Foundation Trust.
- Discussed the ongoing infection control issues at York Teaching Hospital NHS Foundation Trust.
- Noted that the CCG had sought additional assurance regarding the Never Events at York Teaching Hospital NHS Foundation Trust.
- Noted that the first focused meeting, in January 2020, would consider quality in primary care.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

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Item Number: 19

Name of Presenter: Dr Andrew Lee

Meeting of the Governing Body

Date of meeting: 2 January 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Commissioning Committee Recommendations September, October, November 2019

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

Reason for Report

These are the latest recommendations from the Medicines Commissioning Committee – September, October, November 2019

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

☐ Quality Impact Assessment
☐ Equality Impact Assessment
☐ Data Protection Impact Assessment
☐ Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Recommendations

For information only

CCG Executive Committee have approved these recommendations

Decision Requested (for Decision Log)

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

Responsible Executive Director and Title	**Report Author and Title**
Dr Andrew Lee Director of Primary Care and Population Health	Faisal Majothi – Senior Pharmacist Callie Turner – Pharmacy Technician

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee September 2019

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA596: Risankizumab for treating moderate to severe plaque psoriasis		Risankizumab is recommended as an option for treating plaque psoriasis in adults, only if: • the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and • the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated and • the company provides the drug according to the commercial arrangement. • Stop risankizumab treatment at 16 weeks if the psoriasis has not responded adequately.	RED	NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £9,000 per 100,000 population. This is because the technology is a further treatment option and the overall cost of treatment will be similar. Note: 30 day implementation TA from 21.8.2019
2.	TA597: Dapagliflozin with insulin for treating type 1 diabetes		Dapagliflozin with insulin is recommended as an option for treating type 1 diabetes in adults with a body mass index (BMI) of at least 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy, only if: • they are on insulin doses of more than 0.5 units/kg of body weight/day and • they have completed a structured education programme that is evidence based, quality assured, delivered by trained educators and includes information about diabetic ketoacidosis • treatment is started and supervised by a consultant physician specialising in endocrinology and diabetes Assess haemoglobin A1c (HbA1c) levels after 6 months and regularly after this. Stop	AMBER Specialist Initiation	The costs according to NICE for implementing this guidance from year 2023/24 once steady state is reached is equivalent to around £6,100 per 100,000 population.

		dapagliflozin if there has not been a sustained improvement in glycaemic control (that is, a fall in HbA1c level of at least 0.3%).		
NHSE commissioned Technology Appraisals – for noting				
3.	TA592: Cemiplimab for treating metastatic or locally advanced cutaneous squamous cell carcinoma	Cemiplimab is recommended for use within the Cancer Drugs Fund as an option for treating locally advanced or metastatic cutaneous squamous cell carcinoma in adults when curative surgery or curative radiotherapy is not appropriate. It is recommended only if the conditions in the managed access agreement are followed. Treatment with cemiplimab should be continued until disease progression or for up to 24 months (whichever is sooner).	RED	No cost impact to CCGs as NHS England commissioned.
4.	TA593: Ribociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer	Ribociclib with fulvestrant is recommended for use within the Cancer Drugs Fund as an option for treating hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer in people who have had previous endocrine therapy only if: • exemestane plus everolimus is the most appropriate alternative to a cyclin-dependent kinase 4 and 6 (CDK 4/6) inhibitor and • the conditions in the managed access agreement for ribociclib with fulvestrant are followed.	RED	No cost impact to CCGs as NHS England commissioned.
5.	TA594: Brentuximab vedotin for untreated advanced Hodgkin lymphoma (terminated appraisal)	NICE is unable to make a recommendation about the use in the NHS of brentuximab vedotin for untreated advanced Hodgkin lymphoma because Takeda did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because it considers that, at this time, there is insufficient evidence to provide a UK submission for this appraisal. The company has confirmed that it does not intend to make a submission for the appraisal until data from a key study in this indication are available in	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.

		June 2021.		
6.	TA595: Dacomitinib for untreated EGFR mutation-positive non-small-cell lung cancer .	Dacomitinib is recommended, within its marketing authorisation, as an option for untreated locally advanced or metastatic epidermal growth factor receptor (EGFR) mutation-positive non-small-cell lung cancer (NSCLC) in adults. It is recommended only if the company provides it according to the commercial arrangement	RED	No cost impact to CCGs as NHS England commissioned.
7.	TA598: Olaparib for maintenance treatment of BRCA mutation-positive advanced ovarian, fallopian tube or peritoneal cancer after response to first-line platinum-based chemotherapy	Olaparib is recommended for use within the Cancer Drugs Fund as an option for the maintenance treatment of BRCA mutation-positive, advanced (FIGO stages 3 and 4), high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer that has responded to first-line platinum-based chemotherapy in adults. It is recommended only if the conditions in the managed access agreement for olaparib are followed.	RED	No cost impact to CCGs as NHS England commissioned.
Formulary applications or amendments/pathways/guidelines				
8.	Acetylcysteine 600mg effervescent tablets	Formulary currently lists both Acetylcysteine 600mg effervescent tablets and capsules but there is significant cost difference. Agreed that formulary should be amended to only include Acetylcysteine 600mg effervescent tablets noting their sodium content, with NACSYS® being the current brand of choice.	n/a	No cost impact to CCGs expected as advising most cost-effective product be prescribed. Aceteff® 600 mg effervescent tablets = £16.50 per month NACSYS® 600 mg effervescent tablets = £16.50 per month Acetylcysteine 200 mg powder for oral solution = £1012 per month Acetylcysteine 600 mg capsules = £119.91 per month
9.	Alu-cap® (aluminium hydroxide) 475 mg Capsules	Product been discontinued and agreed to remove from formulary.	n/a	No cost impact to CCGs expected. ScR £205 and 20 issues in last 12 months VoY £754 and 37 issues in last 12 months
10.	Biologic Pathway for Psoriasis .	New pathway for use of Biologics in Psoriasis approved. Pathway follows NICE guidance and relevant NICE TAs. Noted all biologics are currently RED drugs	n/a	No significant cost to CCGs expected as all the proposals are current practice and promotes use of the most cost-effective biologics

Recommendations from York and Scarborough Medicines Commissioning Committee October 2019

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					

1.	**TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia**		Sodium zirconium cyclosilicate is recommended as an option for treating hyperkalaemia in adults only if used:
			• in emergency care for acute life-threatening hyperkalaemia alongside standard care or
			• in outpatient care for people with persistent hyperkalaemia and chronic kidney disease stage 3b to 5 or heart failure, if they:
			  ○ have a confirmed serum potassium level of at least 6.0 mmol/litre
			  ○ are not taking an optimised dosage of renin-angiotensin-aldosterone system (RAAS) inhibitor because of hyperkalaemia and
			  ○ are not on dialysis.
			Sodium zirconium cyclosilicate is recommended only if the company provides it according to the commercial arrangement.
			In outpatient care, stop sodium zirconium cyclosilicate if RAAS inhibitors are no longer suitable.
			This recommendation is not intended to affect treatment with sodium zirconium cyclosilicate that was started in the NHS before this guidance was published.
				RED	No cost impact to CCGs as RED status proposed as patient numbers expected to be low and given the nature of these patients they would be managed in secondary care anyway.

2.	**TA601: Bezlotoxumab for preventing recurrent Clostridium difficile infection (terminated appraisal)**		NICE is unable to make a recommendation about the use in the NHS of bezlotoxumab for preventing recurrent Clostridium difficile infection in adults because Merck Sharp & Dohme did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because the technology is unlikely to be used at this point in the treatment pathway.	BLACK	No cost impact to CCGs as not recommendation made by NICE.

NHSE commissioned Technology Appraisals – for noting				
3.	**TA600: Pembrolizumab with carboplatin and paclitaxel for untreated metastatic squamous non-small-cell lung cancer**	Pembrolizumab, with carboplatin and paclitaxel, is recommended for use within the Cancer Drugs Fund as an option for untreated metastatic squamous non-small-cell lung cancer (NSCLC) in adults only if: • pembrolizumab is stopped at 2 years of uninterrupted treatment, or earlier if disease progresses, and • the company provides pembrolizumab according to the managed access agreement. This recommendation is not intended to affect treatment with pembrolizumab, with carboplatin and paclitaxel, that was started in the NHS before this guidance was published.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.
4.	**TA602: Pomalidomide with bortezomib and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal)**	NICE is unable to make a recommendation about the use in the NHS of pomalidomide with bortezomib and dexamethasone for treating relapsed or refractory multiple myeloma in adults because Celgene did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because the technology is unlikely to be a cost-effective use of NHS resources.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.
5.	**TA603: Lenalidomide with bortezomib and dexamethasone for untreated multiple myeloma (terminated appraisal)**	NICE is unable to make a recommendation about the use in the NHS of lenalidomide with bortezomib and dexamethasone for untreated multiple myeloma in adults because Celgene did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because there is unlikely to be sufficient evidence that the technology is a cost-effective use of NHS resources in this population.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.

Formulary applications or amendments/pathways/guidelines				
6.	Bezafibrate and review of fibrates due to supply issues with bezafibrate	Agreed that fenofibrate should remain only fibrate listed on the formulary. NICE no longer recommend the routine use of fibrates for CVD prevention. Fibrates are now only used for treating established familial hyperlipidaemia and hypertriglyceridemia to prevent CVD events or pancreatitis. This is an ideal opportunity to review and stop unnecessary fibrate prescriptions given bezafibrate shortages and high cost of ciprofibrate.	GREEN (no change)	Potential cost saving if current ciprofibrate patients reviewed and switched to fenofibrate.
7.	Modafinil 100mg & 200mg tablets in Parkinson's disease	Agreed to keep as BLACK as just an option in NICE for excessive daytime sleepiness in people with Parkinson's disease. Also no appetite from local specialists to use.	No change	No cost impact to CCGs expected as BLACK drug. 100mg tablets = £3.94 for 30 200mg tablets = £6.98 for 30
8.	Clonidine 100microgram tablets for Hypertension	Approved change from RED to AMBER SR. Locally used by the renal team where patients are unresponsive tor alternative anti hypertensives and methyldopa is not appropriate due to e.g. a history of depression. Note both methyldopa and clonidine can cause depression, but methyldopa is contra indicated.	AMBER Specialist Recommendation	Clonidine dose= 50 - 100 micrograms three times daily monthly cost = £6.25 - £6.75 Less than 5 patients
9.	Calcipotriol/betamethasone cutaneous foam spray (Enstilar®) for the treatment of psoriasis vulgaris in adult patients	Enstilar is a combination product containing a synthetic vitamin D3 analogue and a synthetic topical corticosteroid (in the same proportions as in Dovobet; 50 micrograms/g + 0.5 mg/g) licensed for topical treatment of psoriasis vulgaris in adults. It may provide an alternative for patients who are unable to tolerate the ointment/gel formulation. Some evidence to suggest that Enstilar is clinically more effective than current betamethasone/calcipotriol preparations for body psoriasis (Dovobet Gel and Dovobet Ointment), and also clinically significantly more effective than the individual components (betamethasone dipropionate	GREEN	No cost impact to CCGs expected as advising most cost-effective product be prescribed. Calcipotriol 0.005% / Betamethasone dipropionate 0.05% gel x 60 g = £37.21 Calcipotriol 0.005% / Betamethasone dipropionate 0.05% ointment (Dovobet) x 30 g = £19.84 Calcipotriol 50micrograms/g / Betamethasone dipropionate 500micrograms/g foam (Enstilar) x 60 g = £39.68 COST (per course based on 15grams per day): Enstilar® cutaneous foam for 4 weeks, £277.762 Dovobet® gel for 8 weeks, £520.942 It would be reasonable to assume that around 50% of the Dovobet patients might use Enstilar instead.

		and calcipotriol). The foam spray preparation may be more acceptable for psoriasis patients to apply than ointment and gel preparations		
10.	Paravit CF Capsules and oral liquid	Paravit CF is one of 2 multivitamin supplements which have been specifically formulated for use in CF patients (the other is DEKA). The content of vitamin K in DEKA means it is not the preferred option and cost would be similar. The capsules and liquid have cost advantage compared to separate constituents.	AMBER Specialist Initiation	No cost impact to CCGs expected as advising most cost-effective product be prescribed <u>Paravit CF Oral Liquid</u> Total daily cost for under 1 year old = 251.6p VS 114.3p (Paravit CF) Total daily cost for over 1 year old = 260.5p VS 114.3p (Paravit CF) <u>Paravit CF Capsules</u> Total daily cost for 1-8 year old = 212.4p VS 63.3p (Paravit CF) Total daily cost for over 8 years = 220.2p VS 126.7p (Paravit CF)
11.	Self-care Quick Reference Guide	Final draft to support Self-Care agenda in both primary and secondary care approved.	Approved	No significant cost to CCGs expected. Potential for cost savings if patients encouraged to
12.	YFT Outpatient Prescribing Guidelines	Updated guideline with minor amendments about Self-Care and OTC meds.	Approved	No significant cost to CCGs expected as all the proposals are current practice
	MCC Commissioning Position With Regard to Drugs Initiated by Tertiary Centres (e.g. Leeds)	VoY CCG would like to clarify the position for items recommended by tertiary centres, there have been instances where tertiary centres have recommended products that may be not be on Y&S MCC Formulary or they are black. Agreed in principal to letter sent by Leeds CCG/Trust to commissioners in Dec 2016 regarding tertiary services: • If they are referred to Leeds as a tertiary service (specialised service or referred from another secondary care provider for a specialist opinion) then the Leeds agreed prescribing recommendation should be followed. • If they are referred to Leeds for a secondary care service, through patient	n/a	n/a

		choice or because they live on a CCG boundary, then Leeds understand that there may be drug choice differences that require further compromise and negotiation. However in all cases agreed final decision rests with GP to accept prescribing or not, and that Y&S MCC reserves right to query/challenge Leeds APC on their formulary decisions if MCC feel decision is inappropriate or not all evidence has been considered.		
13.	Lisdexamfetamine in adults - review formulary status for Tuke Centre	Agreed should be AMBER Shared Care as per all other ADHD drugs in adults with Tuke following TEWV shared care guidelines. Noted Lisdexamfetamine is now a first-line option for adults in NICE guidelines.	AMBER SC	No significant cost to CCGs expected as all the proposals are current practice

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee November 2019

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA605: Xeomin (botulinum neurotoxin type A) for treating chronic sialorrhoea**		Xeomin (botulinum neurotoxin type A) is recommended, within its marketing authorisation, as an option for treating chronic sialorrhoea caused by neurological conditions in adults. It is recommended only if the company provides it according to the commercial arrangement. Xeomin is only licensed brand of botulinum toxin for sialorrhoea.	RED	• 34,100 people in England with chronic sialorrhoea are eligible for treatment with Xeomin • 30,700 people in England will have Xeomin from year 2023/24 onwards once uptake has reached 90% No cost impact to CCGs expected as other botulinum toxin options similar in price. Also from 2021/21 moving to tariff included.
2.	**TA607: Rivaroxaban for preventing atherothrombotic events in people with coronary or peripheral artery disease**		Rivaroxaban plus aspirin is recommended within its marketing authorisation, as an option for preventing atherothrombotic events in adults with coronary artery disease or symptomatic peripheral artery disease who are at high risk of ischaemic events. For people with coronary artery disease, high risk of ischaemic events is defined as: • aged 65 or over, or • atherosclerosis in at least 2 vascular territories (such as coronary, cerebrovascular, or peripheral arteries), or • 2 or more of the following risk factors: ○ current smoking ○ diabetes ○ kidney dysfunction with an estimated glomerular filtration rate (eGFR) of less than 60 ml/min (note that rivaroxaban is contraindicated if the eGFR is less than 15 ml/min) ○ heart failure ○ previous non-lacunar ischaemic stroke.	AMBER specialist initiation	NICE estimate 41,500 people in England to choose Rivaroxaban by year 2. This equates to cost impact of £48,976 per 100,000 population. VoY CCG = £182,648 cost impact from year 2 ScR CCG = £59,937 cost impact from year 2 This costs from NICE could be an underestimate.
NHSE commissioned Technology Appraisals – for noting					
3.	**HST11: Voretigene neparvovec for treating inherited retinal dystrophies caused by**		Voretigene neparvovec is recommended, within its marketing authorisation, as an option for treating RPE65-mediated inherited retinal dystrophies in people with vision loss caused by inherited retinal dystrophy from confirmed	RED	No cost impact to CCGs as NHS England commissioned from limited specialist centres only.

	RPE65 gene mutations	biallelic RPE65 mutations and who have sufficient viable retinal cells. It is recommended only if the company provides voretigene neparvovec according to the commercial arrangement.		
4.	**TA604: Idelalisib for treating refractory follicular lymphoma**	Idelalisib is not recommended, within its marketing authorisation, for treating follicular lymphoma that has not responded to 2 prior lines of treatment in adults.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.
5.	**TA606: Lanadelumab for preventing recurrent attacks of hereditary angioedema**	Lanadelumab is recommended as an option for preventing recurrent attacks of hereditary angioedema in people aged 12 and older, only if: • they are eligible for preventive C1-esterase inhibitor (C1-INH) treatment in line with NHS England's commissioning policy, that is, they are having 2 or more clinically significant attacks (as defined in the policy) per week over 8 weeks despite oral preventive therapy, or oral therapy is contraindicated or not tolerated • the lowest dosing frequency of lanadelumab is used in line with the summary of product characteristics, that is, when the condition is in a stable, attack-free phase and the company provides lanadelumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned from limited specialist centres only. NHS England commissions highly specialist allergy services from highly specialist allergy centres, which includes services for people with hereditary angioedema.
6.	**TA608: Ibrutinib with rituximab for treating Waldenstrom's macroglobulinaemia (terminated appraisal)**	NICE is unable to make a recommendation about the use in the NHS for this indication in adults because Janssen did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because there is unlikely to be sufficient evidence that the technology is a cost-effective use of NHS resources in this population.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.
7.	**TA609: Ramucirumab for treating unresectable hepatocellular carcinoma after sorafenib (terminated appraisal)** .	NICE is unable to make a recommendation about the use in the NHS of ramucirumab for treating unresectable hepatocellular carcinoma in adults who have had sorafenib, when disease has progressed or sorafenib is not tolerated, because Lilly did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because the technology is unlikely to be a cost-effective use of NHS resources.	BLACK for this indication	No cost impact to CCGs as NHS England commissioned.
Formulary applications or amendments/pathways/guidelines				

<table>
<tr><td>8.</td><td>Coaguchek Test Strips for Paediatric Cardiology</td><td>Approved for use as part of agreed pathway for paediatric patients managed by the Tertiary Paediatric Haematology & Congenital Cardiac service at LTHT.
The meters are supplied and maintained by LTHT. All dosing information and management of abnormal results carried out by LTHT.
Once patient reached adult hood expect them transfer to local anticoagulant service and this may mean provision of test strips may cease.</td><td>AMBER specialist recommendation</td><td>CoaguChek test strips (24's) = £69.90
CoaguChek test strips (48's) = £136.66

Currently 9 paediatric patients in York & ScR CCGs
Cost per year for all patients = £1363-£1740

CCG to put in place process to ensure not paying twice to monitor these patients through current local enhanced service for anticoagulant monitoring.</td></tr>
<tr><td>9.</td><td>Alendronate 70mg Effervescent Tablets</td><td>Not approved for use in patients who cannot tolerate oral bisphosphonates because not cost advantage over IV bisphosphonate.
Concerns no difference in dosing administration advice and contra-indications to other oral bisphosphonate.
Also concerned if not just restricted to those with swallowing difficulties could lead to creep in use, and is IV not a better option in these patients for efficacy plus compliance.</td><td>BLACK</td><td>
<table>
<tr><th>Product</th><th>Monthly secondary care cost</th><th>Monthly primary care cost</th></tr>
<tr><td>Alendronate 70mg tabs</td><td>19p</td><td>86p</td></tr>
<tr><td>Risedronate 35mg</td><td>37p</td><td>£3.04</td></tr>
<tr><td>Alendronic acid effervescent</td><td></td><td>£22.80= £273.60 per 12 months</td></tr>
<tr><td>Denosumab injection 60mg (every 6 months)</td><td>£219</td><td>£183.00 / 6months (£366 per 12 months)</td></tr>
<tr><td>Zoledronic acid 5mg (annually)</td><td colspan="2">£144
(but in practice have been using 2x4mg for 5mg dose = £3.48 + sodium chloride 100mL @ 49p)</td></tr>
</table>
</td></tr>
<tr><td>10.</td><td>Melatonin Oral Liquid Formulations</td><td>Agreed to clarify on formulary that if an oral liquid is required because crushing tablets is unsuitable then only the Melatonin 5mg/5mL oral solution which is alcohol free and propylene glycol free (unlicensed special from Rosemont) should be used.
This the product currently included in local shared care guidelines.</td><td>AMBER SC</td><td>No cost impact expected as product currently used just clarifying product is alcohol free and propylene glycol free.</td></tr>
<tr><td>11.</td><td>Co-codamol Effervescent tablets</td><td>Agreed to add note to formulary to state only for use in patients with confirmed swallowing difficulties noting concerns around sodium content which may contra-indicate use in some patients.</td><td>n/a</td><td>n/a</td></tr>
<tr><td>12.</td><td>Sacubitril with valsartan – review of current RAG status</td><td>No change in current RAG status recommended as NICE state should be specialist initiation.</td><td>AMBER specialist initiation</td><td>No significant cost impact to CCGs expected as GPs currently prescribe once patient stable usually after 6-8 weeks.</td></tr>
</table>

13.	Emollient medal ranking guidance - updated	Update to the medal ranking guidance due to the changes in our local formulary and the additional medicines included in NHS England's items not to be routinely prescribed in primary care approved. Bath oil/additives/shower preparations are now BLACK on the formulary and appropriate changes have been made within this guidance to reflect this.	n/a	No significant cost to CCGs expected. May result on cost saving as Bath oil/additives/shower preparations made BLACK on formulary previously.
14.	Continence Formulary	Approved. The continence formulary aims to support prescribers and nurses in prescribing cost effective and appropriate products. It is envisaged that this formulary will manage any inappropriate prescribing of continence products, with support from the specialist team.	n/a	No significant cost to CCGs expected. Potential for cost savings if correct quantities prescribed.
15.	Aspirin in Pregnancy – updated guidance	Update of the guideline on the use of aspirin in pregnancy at patients at risk of pre-eclampsia approved with dose now recommended as 150mg instead of 75mg.	n/a	No significant cost to CCGs expected.
16.	Supply of Baby Milk for women with HIV	MCC support making baby milk available to women with HIV who should not breast feed to prevent vertical transmission of HIV but this is not the sole responsibility of CCGs. It is also a public health issue and CCGs should work with public health to put in place a system to supply these milks to HIV mothers, particularly those low incomes. Noted that baby milk is not available on prescription unless specialised formula (e.g for CMPA) so a non-prescription supply route is required. Any requests prior to local commissioning position/supply route being put in place should be dealt with on individual basis by CCGs.	n/a	Patient numbers expected to be very ~2-3 per year. Age of child and Number of tins of powder for 28 days Under 6 months: 13 x 400g tins (3.25 tins per week) or 6 x 900g tins 6-12 months: 7-13 x 400g tins or 3-6 x 900g tins Cost of baby milks on average £9 per 800g tin Over first 6 months (26 weeks) 26 x3.25 = 84 x 400g tins Over second 6 months (26 weeks) 26 x 2.5 = 65 x 400g tins Total of 149 x 400g or 74x 800g = £666 Healthy start vouchers for 52 weeks if qualify = £322
17.	Guideline for initiation and de-prescribing of PPIs	Approved with change in title of initiation of PPI with antiplatelet.	n/a	May result in cost saving to CCGs as supports review and deprescribing where appropriate. Dose of PPI chosen may result in savings as 15mg lansoprazole cheaper (this changed approved by CCGs previously).