NHS
Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 2 January 2020 at West Offices, York YO1 6GA

Present

Dr Nigel Wells (NW) (Chair)	Clinical Chair
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member, Chair of Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing / Chief Nurse
Dr Helena Ebbs (HE)	North Locality GP Representative
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
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Caroline Alexander (CA) – item 13	Assistant Director of Delivery and Performance
Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality
Abigail Combes (AC) – items 10,11	Head of Legal and Governance
Christine Pearson (CP) – item 9	Designated Nurse, Safeguarding Adults
Michèle Saidman (MS)	Executive Assistant
Dr Lincoln Sargeant (LS) – item 7	Director of Public Health for North Yorkshire

Apologies

Phil Goatley (PG)	Lay Member, Chair of Audit Committee and Remuneration Committee
Dr Chris Stanley (CS)	Central Locality GP Representative

There were two members of the public present.

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

Gwen Vardigans

At a York and Scarborough NHS Trust Governors meeting on Wednesday 11 December I submitted a question asking for a response over the discrepancy between outcomes for Stroke patients in York and those in Scarborough. I have included it below:

When stroke services in this area were changed in 2015 it was claimed that the change was to address staffing levels and would ensure improved outcomes for stroke patients. The latest independent information shows that Scarborough and Ryedale stroke patients have the worst outcomes in England.

Stroke services in York meet the National Standard norm mortality rate of England of 100 but Scarborough and Ryedale the mortality rate is much higher 174.5 in 2017 and 160.5 in 2018.

I understand there has been a lack of a dedicated stroke service in Scarborough since 2015. Does The Trust consider this a contributory factor to outcomes? Could improving the stroke service in Scarborough improve outcomes for stroke patients?

The reply from the governors indicated that the data is about the health of a population living in a specified geographic area and offers a measure of the general life mortality risk of stroke in a particular area and is due to a number of demographic and other health factors such as age, smoking and obesity.

I assume these factors are common to both York and Scarborough and I feel the answer does not fully explain why the mortality rate for strokes in Scarborough is so much higher than York.

The Governors indicated that my query be directed to Ryedale CCG and Vale of York CCG. Do have any comment or explanation for this discrepancy in mortality rates?

Response

AL responded that, although NHS Vale of York CCG does commission services from Scarborough Hospital as part of the contract with York Teaching Hospital NHS Foundation Trust (YFT) the lead commissioner for Scarborough Hospital based services is NHS Scarborough and Ryedale Clinical Commissioning Group (SRCCG). SRCCG are also the commissioner of broader healthcare services for the Scarborough population and thus it may be more appropriate for specific questions relating to Scarborough Hospital or the other healthcare services to be directed to SRCCG in the first instance.

We do however commission stroke services at York Hospital. This includes stroke care which patients who are transferred from Scarborough receive. The Sentinel Stroke National Audit Programme (SSNAP) reported that stroke care provided at York Hospital is B (care is rated from A (best) to E (worst)) which is good. It is our understanding that York and Scarborough patients receive the same acute stroke care, as they are cared for by the same team of staff.

In terms of comparing stroke mortality rates between areas, we would advise that this is interpreted cautiously. The demographic profiles of York and Scarborough are quite different. For example, there is more socioeconomic deprivation in Scarborough. The health profiles are also different: Scarborough has a higher prevalence of obesity (60% vs 54%), smoking (13.6% vs 11.5%), hypertension (17.2% vs 13.5%), atrial fibrillation (3.0% vs 2.4%) and diabetes (7.2% vs 5.6%). All

of these are known risk factors for stroke. The differences in the stroke figures between the York and the Scarborough areas (and indeed other parts of the country) are therefore largely due to the differences in the population in relation to these factors.

Post meeting note: The response was emailed to Gwen Vardigans on 6 January.

AGENDA

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

As noted above.

PM joined the meeting

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

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

3. Patient Story

In presenting Theo and Debbie's Story, see Appendix B, MC explained that the unusual step of naming them was Debbie's express wish and that the presentation, agreed with Debbie and Clare Hedges, Head of Quality and Performance at NHS Harrogate and Rural District CCG, was in response to a promise made to her that their story would be widely and quickly shared.

MC advised that Theo was Debbie's third child; the two older children had been born before 2012 when the pertussis vaccination in pregnancy programme had been established. She noted that women under midwifery care were advised and reminded to have the pertussis vaccination but emphasised that this was not currently within the midwifery care contract; it was the woman's responsibility to arrange an appointment for it to be administered by a GP. The vaccination reminder in the national perinatal notes, used for c60% of pregnant women, stopped at the 29 week appointment.

AB joined the meeting

Detailed discussion and further clarification by MC included:

- Potential gaps in services as GPs may not know a woman is pregnant.
- Proposal to develop a local protocol about pertussis vaccination and its timing.

- Establishing a digital reminder alert on the primary care Ardens Template from 13 weeks.
- Recognition of such as time and location pressures on pregnant women to arrange a specific vaccination appointment, not currently offered out of hours.
- Taking the learning from the level of publicity for 'flu vaccination to raise awareness and educate about the importance of pertussis vaccination, including the fact that it can be given during labour and whilst breast feeding.
- Potential to devolve the contract for pertussis vaccination from GPs to midwives.
- The context of prevention and emphasis on the need for effective communication within practices.

MC agreed to ascertain the current position with NHS England regarding their work to improve the clarity of the call and recall requirements of the Directed Enhanced Service for pertussis vaccination. She would also continue local discussions with the Head of Midwifery to develop a system approach. MC additionally noted that she planned to give the presentation at the Practice Nurse Forum and AB advised that it was being shared via the Local Medical Committee Newsletter.

Members requested an update on progress at the next meeting.

4. Minutes of the Meeting held on 7 November 2019

The minutes of the meeting held on 7 November were agreed.

The Governing Body:

Approved the minutes of the meeting held on 7 November 2019.

5. Matters Arising from the Minutes

Update on work relating to physical health checks for people with severe mental illness: DN reported that there were still only 16 practices signed up to the Local Enhanced Service for physical health checks for people with severe mental illness. She noted that NHS England had now agreed to fund the full Ardens Template for all practices, including those who had already funded it themselves, and advised that, following the pilot and based on its learning, the mental health budget for 2020/21 included these health checks. As means of incentivising take up HE proposed promotion through a patient story approach from the 16 practices and it was agreed that AL would present associated practice data at the February Council of Representatives.

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 reported that the CCG's practices were undertaking an audit of children 'was not brought'; the outcome would be presented on completion.

The other matters were confirmed as completed or agenda items.

The Governing Body:

Noted the updates and associated actions.

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; Better Care Fund; emergency preparedness, resilience and response; Directions; and strategic and national issues.

PM noted that the CCG's financial position, which would be discussed at a later agenda item, remained under pressure but delivery of the £18.8m deficit continued to be forecast. He advised that the quarter three position for the CCG's main partners – York Teaching Hospital NHS Foundation Trust, NHS Scarborough and Ryedale CCG and other surrounding CCGs – was more challenging.

PM reported that the operating framework from NHS England was still awaited. He noted the expectation of agreeing an aligned contract value with York Teaching Hospital NHS Foundation Trust by February and emphasised the CCG's intention of meeting its notified recovery trajectory. PM also advised of the expectation for a focus on mental health in 2020/21 noting that, while this was a current priority for the CCG, the historic issues in this regard must be acknowledged. Additionally, the national approach from the regulators was expected to move from procurement to system collaboration as early as quarter one; details, including in relation to funding, were awaited. PM highlighted the context of three year planning and the 1000 days challenge noting that discussion would take place at the February Governing Body workshop in this regard.

In respect of winter pressures PM noted that the next few days would be key, including in terms of impact from the weather; promotion of the 'flu vaccination programme was continuing. The Emergency Departments at York and more so at Scarborough had experienced challenges before Christmas; performance had been particularly low over Christmas, due to fewer staff, despite a relatively quiet time.

PM explained that the refreshed NHS England and NHS Improvement Directions had been formally received at the Finance and Performance Committee where it had been agreed that the CCG should send a formal reply signed by NW, DB as Chair of the Finance and Performance Committee and PG as Audit Committee Chair; this had been circulated to Governing Body members. A response was currently awaited.

The Governing Body:

Received the Accountable Officer's report.

STRATEGIC

LS joined the meeting

7. 2019 Annual Report of the Director of Public Health for North Yorkshire: *Life in times of change: health and hardship in North Yorkshire*

LS gave the presentation attached at Appendix C; full annual report available at: https://www.nypartnerships.org.uk/DPHAR.

Members sought and received clarification on aspects of the presentation and discussed LS's recommendations in detail:

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.* LS noted potential via *Selby Health Matters,* a multi sector forum, in this regard. AL confirmed that the CCG was working with them, including in the context of a potential Integrated Care System.

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.* LS recommended that 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. He noted the potential for contributing on the impact of rural deprivation to the North Yorkshire Rural Commission evidence review.

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.* LS proposed that, as part of the Joint Strategic Needs Assessment, North Yorkshire County Council and CCGs in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery. He emphasised the need for change, particularly in the face of reducing budgets, and highlighted opportunities provided through GPs' information about vulnerable groups.

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.* LS proposed that all agencies should identify and train 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. He noted work was taking place in terms of health needs assessment for groups with complex needs in Scarborough and City of York but highlighted that similar consideration was required

for Selby.
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 CCGs 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.* LS noted potential opportunities via job centres.

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.* LS proposed that all agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations. He noted benefits of the statutory sector providing communities with access to small amounts of funding but emphasised the need for effective dialogue. JH additionally highlighted opportunities for the voluntary sector through support provided in terms of venues and refreshments.

Detailed discussion included, despite the idyllic aspects of North Yorkshire, recognition of the many inequalities in addition to those relating to health, such as levels of domestic violence, transport, access to cheap food, fuel poverty, internet access and isolation. In relation to the 8.3m people identified as living in deep poverty, AL proposed analysis of smaller areas to identify particular need and target support through a concentrated partnership approach.

In respect of the 1000 Day Challenge LS emphasised the need to recognise that it was not possible to address all the issues discussed. The focus should be on areas that could be improved, including addressing causes of premature mortality and sustainability of primary care, and facilitating wide partnership working. The context of the CCG's role as a strategic leader, emphasis on innovation, movement away from the transactional basis of contracts and money, and a focus on prevention were also highlighted.

Further discussion included aspects of drug misuse, de-prescribing and associated costs from the perspective of prescription medication. LS noted that this was a national issue and not only for medicines management. It also required psycho social support.

The Governing Body:

Supported the recommendations detailed.

LS left the meeting

ASSURANCE

CP joined the meeting

9. Learning Disabilities Mortality Review Annual Report 2018/19

CP presented highlights from the report that had been circulated. These encompassed the purpose of the review process; key achievements; the York programme approach; information on age at and place of death; reported deaths in NHS Vale of York and NHS Scarborough and Ryedale CCGs; cause of death; quality of care indicators; local learning best practice; reasonable adjustments; family/carer involvement; recommendations made by reviewers; an overview of the national picture; NHS Operating Plan and Contracting Guidance 2019/20; and challenges for 2019/20.

Members sought and received clarification of aspects of the presentation. CP advised that, in addition to the specialist practitioner funded across North Yorkshire and York for two days a week, funding had recently been secured for two reviewers working one day a week. The CCG had also been successful in securing funding for a 12 month post to enable service improvement work with families; primary care and care providers.

Detailed discussion ensued including: the need to ensure existing services were made more accessible to vulnerable groups; the context of GPs as generalists, not specialists; opportunities for health checks to be carried out by other than GPs, including practice nurses and receptionists; the fact that at the age of 18 care for people with learning disabilities defaults from co-ordination by a community paediatrician to the GP; opportunities to share good practice and address the significant difference between learning disability and physical disability services; implementation of such as a care co-ordinator approach for people with learning disabilities with emphasis on anticipatory care and preventable causes of death. In response to PM emphasising that the CCG should consider flexibility in terms of funding planning for this vulnerable group DN highlighted both practices and Primary Care Networks in this regard.

It was agreed that practice data on health checks for people with learning disabilities be discussed at the Council of Representatives and that the Learning Disabilities Mortality Review programme be considered for inclusion in a future protected learning time event.

AB commented that the meeting had a theme of discussion about high demand and pressures on practices, including from staff sickness, and referred to the context of not focusing on the money. In response AL highlighted the primary care diabetes model which could be translated in to care for people with learning disabilities and severe mental illness. He emphasised that demand would always exceed capacity and it was the model of care that required change.

PM requested that consideration be given to the potential proposals and that a stocktake of progress be brought to the March Governing Body meeting, including opportunities for funding flexibility.

The Governing Body:

1. Received the Learning Disabilities Mortality Review Annual Report 2018/19.
2. Requested that an update on progress be presented at the March Governing Body meeting.

CP left the meeting

8. Quality and Patient Experience Report

Prior to presenting the report MC explained that the Quality and Patient Experience Committee, chaired by JH, would now meet monthly, instead of alternate months, with the new meetings concentrating on a specific area. The first of these, on 9 January, would focus on primary care.

In respect of the Infection Prevention and Control update MC reported that there were no new issues at York Teaching Hospital NHS Foundation Trust to report; progress against actions were being monitored through the newly formed Quality Improvement Board. MC noted that estate was an ongoing issue. She also advised that the business case to enable a more responsive approach to deep cleaning and environmental issues had been approved; funding for associated staff training was now required and a further business case was in development.

MC reported that 'flu was having an impact on York Teaching Hospital NHS Foundation Trust. The current position was a ward closed on the Scarborough site and four bays closed on the York site.

With regard to quality assurance from providers MC detailed the position relating to York Teaching Hospital NHS Foundation Trust following the convening by NHS England and NHS Improvement of a Quality Improvement Board with system partners in view of the continuing concerns about the impact on quality and safety across both sites. Of particular concern were: the significant number of 12 hour trolley breaches, mainly at Scarborough Hospital; the growing backlog of patients waiting for planned surgery; infection control issues; the staffing concerns raised by the Care Quality Commission in the Coronary Care Unit and Medical Wards in Scarborough; and quality of discharges. MC explained that the Quality Improvement Board remit had moved to an approach of NHS Scarborough and Ryedale and NHS Vale of York CCGs' Chief Nurses monitoring the position and focusing on removing the potential for the Care Quality Commission issuing a Regulation 31 Notice, i.e. closure of the wards, which would have impact across the system. MC advised that she was writing to the Care Quality Commission at manager level but they had now issued a Regulation 64 which required further information about staffing issues with a timescale of the previous day, 1 January. MC noted that the Care Quality Commission Inspector of Hospitals had informed her that the trigger for this had been the decline in performance against the A and E target, which had been a national issue, and additionally that the NHS England and NHS Improvement Chief Nurse was meeting with the Care Quality Commission Director.

MC highlighted the positive work with care home managers in relation to a more structured and comprehensive approach to observing and responding to

deterioration in their residents. Data collection had provided evidence of step change in reduced emergency admissions to hospital.

MC referred to the development of a new national service specification to improve palliative and end of life care for children and young people noting that the CCG provided additional funding for services commissioned from hospices in the form of grants. She noted that the disproportionate funding for children's end of life care was being addressed.

The Governing Body:

1. Received the update on quality and safety information and activity for commissioned services.
2. Agreed that the report provided oversight on the current quality and safety concerns and assurance that proposed actions were appropriate to manage effectively any quality and safety issues or risks.

FINANCE AND PERFORMANCE

CA joined the meeting

13. Integrated Performance Report Month 7

CA highlighted that NHS England and NHS Improvement had confirmed that there would 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 focus would be on system reporting and providing assurance on delivery of the NHS Long Term Plan.

In terms of winter and system resilience, performance against the four hour Emergency Care Standard had fluctuated across the York and Scarborough Hospital sites on a daily basis over the Christmas and New Year period but overall this period had been easier to manage as a collective system than the previous year through agreed system partner escalations.

There would be a review of performance peaks and troughs and associated impact of system actions at the January meeting of the System Resilience Group. In summary there had been one divert on 19 December and, on the Scarborough site, there had been an Opel 4 for four hours on 24 December; the busiest day over the holiday period had been 27 December. CA noted that a system 'full capacity plan' had been requested by NHS England and NHS Improvement and the Care Quality Commission at the last regional meeting in December. She also referred to the separate Quality Improvement Board held with the Care Quality Commission in attendance and on-going assurance requirements for the Scarborough Hospital site; MC had previously provided an update to this in the earlier agenda item.

CA noted the additional £319k non recurrent funding from NHS England and NHS Improvement to support elective care and diagnostics capacity to the end of the financial year; the focus was on long wait patients to avoid any 52 week breaches.

This would be utilised for 60 patients in four specialties for elective care, and in endoscopy and MRI.

In respect of cancer CA reported that 62 day performance was stable at 75.9% noting that 54% of breaches were due to diagnostic delays. Cancer two week waits were above target. CA noted that the Cancer Alliance Board and local Cancer Performance Group were currently considering the recently released draft service specification for Early Cancer Diagnosis in the five national enhanced services for supporting out of hospital care.

In response to RW expressing concern about gastroenterology and colonoscopy waiting times and previous escalations for two patients, discussion ensued about the referral and capacity pressures on upper and lower GI services and on-going work with the York Teaching Hospital NHS Foundation Trust teams to better understand these, and the subsequent impact on primary care workload if patients repeatedly requested expedition. CA explained that current capacity was not meeting demand, particularly as the impact of national screening programmes has been impacting on levels of referrals. There was as yet no finalised demand and capacity modelling and analysis available which could inform a wider system discussion around how to support current pressures. There was some discussion around how the system could ensure all endoscopy referrals were appropriate and whether direct access for gastroscopy was sustainable. There was also discussion around the current waiting times for surveillance follow-ups for patients and how this could be better communicated to patients to support them in understanding their surveillance.

CA referred to the Total Waiting List position emphasising the need to understand the associated risks of patients waiting for up to and beyond 18 weeks without any date for appointment or intervention. She advised that 866 patients had waited over 15 weeks having had no activity and 3508 patients had waited 26 weeks with no activity. The Rapid Expert Input programme had started working with priority specialties to provide better advice for clinicians to avoid patients joining waiting lists in the first place; however, it was noted that a collective primary and secondary care clinical understanding of patients waiting would be helpful to inform actions to help mitigate any potential risk for patients while waiting.

AL commented that, while the CCG had hospital data to inform consideration of capacity and demand, it did not currently have the data from primary care which should be available via the Raidr system. Members noted, however, that all parts of the system were under similar capacity pressures.

The Governing Body:

Received the month 7 Integrated Performance Report.

CA left the meeting; AC joined the meeting.

ASSURANCE Continued

11. Audit Committee Terms of Reference

AC referred to the Audit Committee Terms of Reference which had been reviewed and approved by the Committee at its last meeting.

The Governing Body:

Ratified the Audit Committee Terms of Reference.

10. Board Assurance Framework and Risk Management Policy and Strategy

Board Assurance Framework

AC explained that the Board Assurance Framework should provide the Governing Body with assurance on progress against the CCG's strategic priorities noting that more detail was provided on each slide on the basis of a highlighted priority area with a heat map of reported risks on the last page. A down arrow demonstrated the risk was reducing, an up arrow meant the risk was increasing and a box meant the risk was stable. AC referred to the reporting of risk through the CCG's committee structure and confirmed availability of detailed information about all the risks.

Members sought and received clarification on a number of aspects of the Board Assurance Framework. Discussion included the potential for an alternative format aligned to the strategic objectives although all agreed that the points covered were appropriately those which had been the subject of good discussion within the meeting. Highlighted the need for the risk register to be linked to the Framework to provide additional assurance. The need for consistency in reporting approach was also noted; staff would be given further support and training in this regard although the Governing Body would frame some of this highlighting the approach they preferred wherever possible.

Members particularly supported the summary approach on the last page. AC advised that that this would be a standing agenda item at Governing Body meetings noting that further work was taking place on its development.

Risk Management Policy and Strategy

AC gave a presentation highlighting changes to the Risk Management Policy and Strategy following review as a result of the Governing Body's new risk appetite statement. She highlighted in particular the simplified risk assessment matrix and colour coding of risk management through the committee structure noting that PG had seen and supported the document. Additionally, committee chairs would include risk as well as "good news" in their reports to the Governing Body.

AC also explained that all quality and safety risks, including those relating to primary care, would now be reported to the Quality and Patient Experience Committee and all aspects of financial risk would to the Finance and Performance Committee. There would not be a risk register supplied to Primary Care Commissioning Committee.

AC proposed, and members agreed, that the Audit Committee be asked to approve the amended Risk Management Policy and Strategy which would then be brought back to the Governing Body for ratification. She agreed to circulate the document to members. *(Post meeting note: This was circulated later the same day).*

The Governing Body:

1. Received the Board Assurance Framework, noting that further development was taking place and confirming that it provided assurance appropriate to the strategic objectives of the organisation.
2. Noted that the majority of the risks were reported at committee level which was appropriate and that the scoring may change as staff became more familiar with the strategy and policy.
3. Agreed to receive the Risk Management Policy and Strategy for ratification following its approval by the Audit Committee and that the Risk Appetite Statement contained within the strategy and policy was approved as correct.

AC left the meeting

FINANCE AND PERFORMANCE Continued

12. Financial Performance Report 2019/20 Month 8

SB noted that this report, which forecast delivery of the £18.8m deficit plan despite slippage against the system recovery plan, had been discussed at the December meeting of the Finance and Performance Committee. He highlighted a number of areas of improvement and explained that the deterioration in month related to section 117 placements and the prescribing position, the latter being mainly due to profiling of the 'flu vaccinations budget and therefore potentially non-recurrent. There was additionally the need for identification of £2.2m non recurrent recovery actions still to be delivered by the end of the financial year.

SB referred to the CCG's financial positions of £20.1m deficit in 2018/19, £20.0m deficit in 2019/20 and the current forecast of £18.8m deficit emphasising the context of the current plan being set at a realistic, but stretching level. He noted, however, that the underlying position was c£24.0m deficit which would still need to be addressed in 2021/22 in the context of the recovery trajectory for that year which is a £16.5m deficit.

SB also explained that identification of further savings would continue to be required from the system perspective in 20/21. He noted that early agreement of a contract and risk position with York Teaching Hospital NHS Foundation Trust, as referred to at item 6, would be important alongside system ownership of current constraints and performance against standards.

In response to DB enquiring about potential further emerging costs relating to continuing healthcare SB advised that the £1.5m contingency for high cost packages was currently forecast at a £750k underspend, and that a similar reserve would be recreated in 2020/21. He emphasised that the CCG would maintain the approach of realistic financial planning.

The Governing Body:

Received the month 8 Financial Performance Report.

RECEIVED ITEMS

The Governing Body noted the following items as received:

14. Executive Committee chair's report and minutes of 16 October, 20 November and 4 December 2019.

15. Audit Committee chair's report and minutes of 28 November 2019.

16. Finance and Performance Committee chair's report and minutes of 24 October and 28 November 2019.

17. Primary Care Commissioning Committee chair's report and minutes of 21 November 2019.

18. Quality and Patient Experience Committee chair's report and minutes of 12 December 2019.

19. Medicines Commissioning Committee recommendations of September, October, November 2019.

20. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 5 March 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 2 JANUARY 2020 AND CARRIED FORWARD FROM PREVIOUS MEETING

Meeting Date	***Item***	***Description***	***Director/Person Responsible***	***Action completed due to be completed (as applicable)***
5 September 2019	Update on work relating to physical health checks for people with severe mental illness	• Further update to the next meeting	DN	7 November 2019
7 November 2019		• Further discussion to take place outside the meeting	DN	
2 January 2020		• Practice data on physical health checks for people with severe mental illness to be presented at the February Council of Representatives meeting	AL	20 February 2020

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
2 January 2020	Patient Story	• Update on establishing a local system approach for pertussis vaccination in pregnancy	MC	5 March 2020
2 January 2020	Learning Disabilities Mortality Review	• Update on potential proposals and a stocktake of progress	MC	5 March2020
2 January 2020	Board Assurance Framework and Risk Management Policy and Strategy	• Risk Management Policy and Strategy to be presented for ratification	AC	5 March or 2 April 2020

NHS Harrogate and Rural District CCG

Appendix B

Theo and Debbie's Story

QSG 22nd November 2019

Clare Hedges & Debbie Smith

What Happened?

Date	Event
14th September 2018	Debbie visited GP and coded as being pregnant and signposted to midwife led care
29th November 2018	Had flu vaccine
23rd April 2019	Baby Theo born
12th May 2019	NHS111 contacted re cough and breathlessness
	Attended GP out of hours
14th May 2019	Attended GP with history of cough
18th May 2019	Not feeding well rang NHS111
	Attended GP out of hours
	Seen and admitted immediately. Pertussis diagnosed
20th May 2019	Transferred to Leeds Teaching Hospitals PICU
	Baby Theo passed away

What has been learnt?

1	GPs are not always aware if women are pregnant
2	Call and recall requirements for pertussis vaccination under NHSE DES could be clearer
3	Hand held record (green book) does not have check box re pertussis after 29w gestation.
4	High vaccination rates can lead to false levels of assurance
5	Vaccination can be given from 16 weeks but tends to occur after anatomy scan. It can also be given after 32 weeks if missed.
6	Pregnant women who are mothers to previous children prior to 2012 may not be aware of vaccination need and may not go to information sessions or pick up leaflets as may be confident of process

What actions are being taken?

1	To ensure robust sharing of information between GP practices and midwives
2	Increase clarity of the national guidance regarding Pertussis vaccination
3	There is a need to actively review if pertussis vaccine has been given and recall if not
4	Increase education and awareness. Leaflets and posters to be prominent.
5	Consider pertussis vaccine invite to be added to all flu letters to pregnant women
6	HDFT now offers flu and pertussis vaccination for all pregnant women under consultant care
7	Lever for ensuring electronic sharing of safeguarding concerns between GPs and midwifery

Sharing

Debbie and Theo's story shared with:

- GP Practices across North Yorkshire and York
- Quality Lead Managers NY&H and WY&H
- Child Death Overview Panel (CDOP)
- Perinatal Institute
- CORM at HDFT
- SI Panel at North Yorkshire & East Riding
- Midwives through Maternity Steering Group
- NHSE through Screening and Immunisation Manager

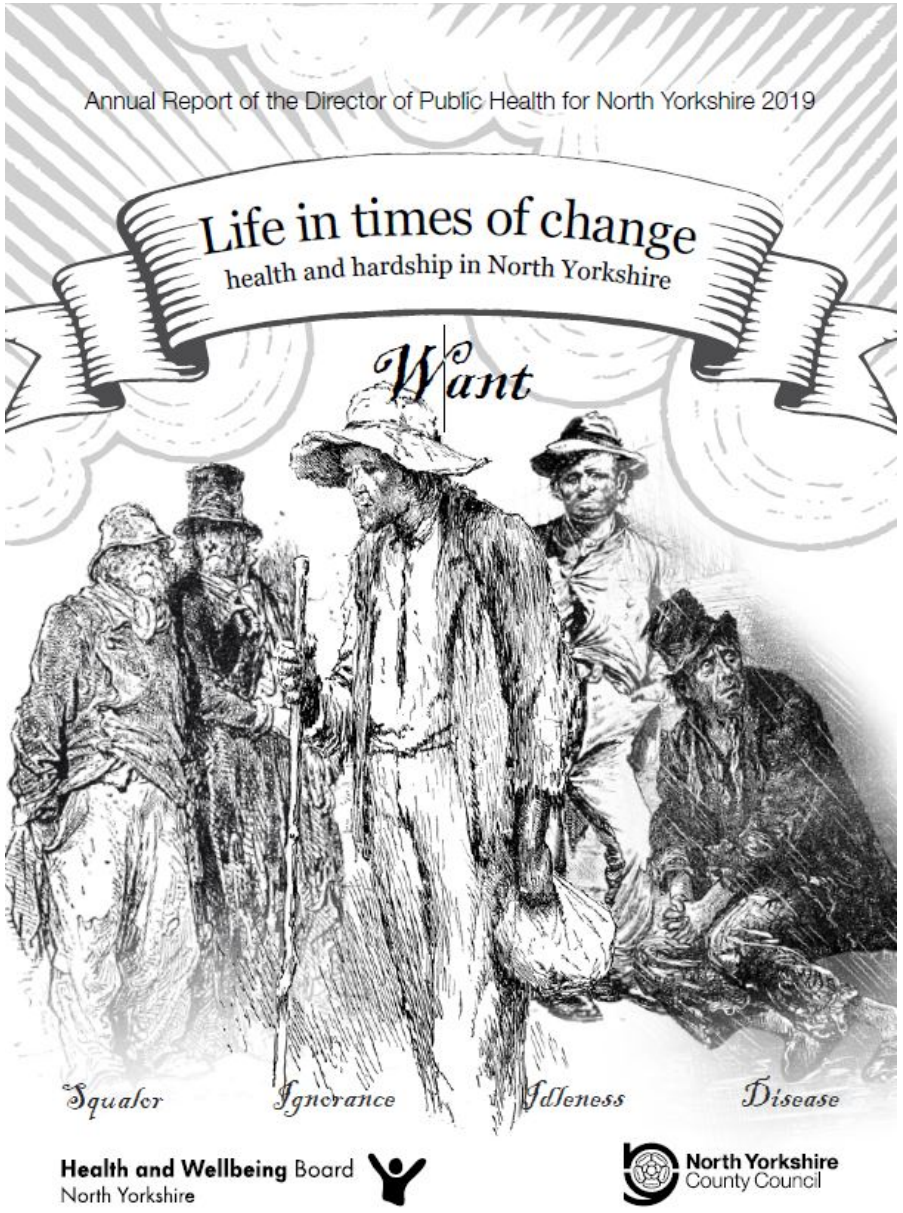
Harrogate and Rural District
Clinical Commissioning Group

Thank you for listening

Any Questions?

NHS

Harrogate and Rural District
Clinical Commissioning Group



Outline

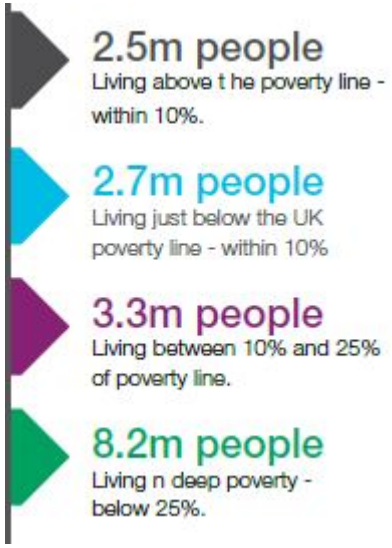
- Poverty – a very wicked problem
- From the workhouse to the workplace
- The extent and variation in poverty
- Progress so far
- The way forwards

Ripon workhouse in the 1850s

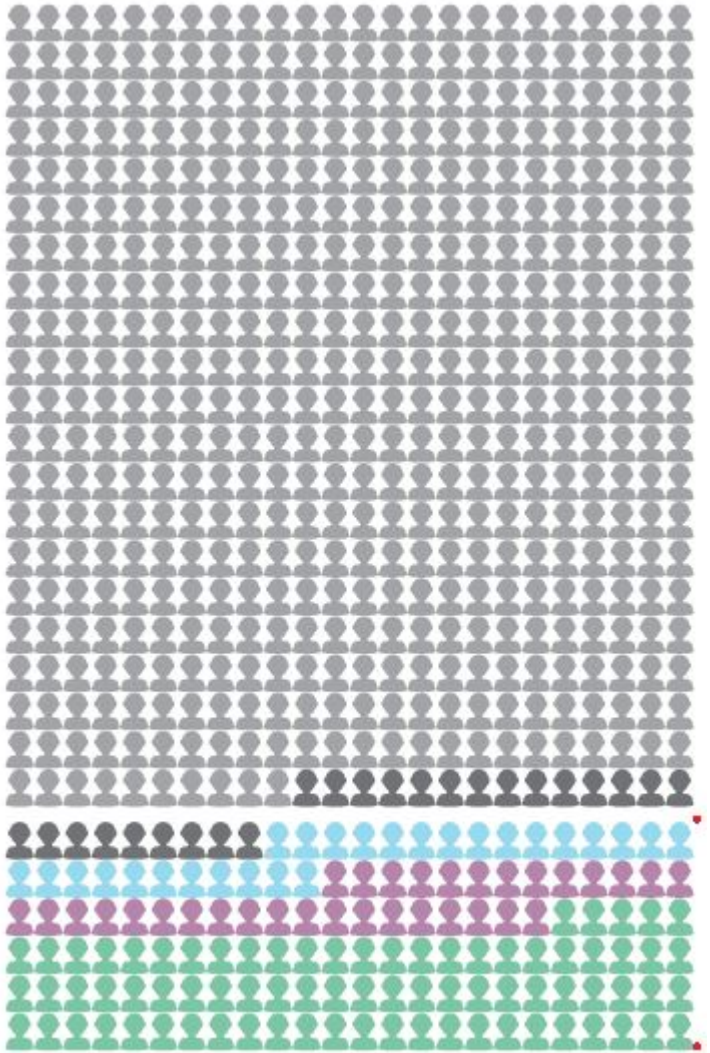
- Response to poor relief
- Workhouses ensured access to
  - Secure housing
  - Food
  - Basic healthcare
  - Education for children
- Deserving v undeserving poor
- Workhouses – harsh and prison like
- Problem of vagrancy
  - Mental health and addiction not understood
- Problem of worklessness

Poor UK

The different levels of poverty in the UK and the value of the UK poverty line. More than one-in-five of the UK population lives in poverty - that is 14,300,000 people (21%).



Total UK population 66.6m

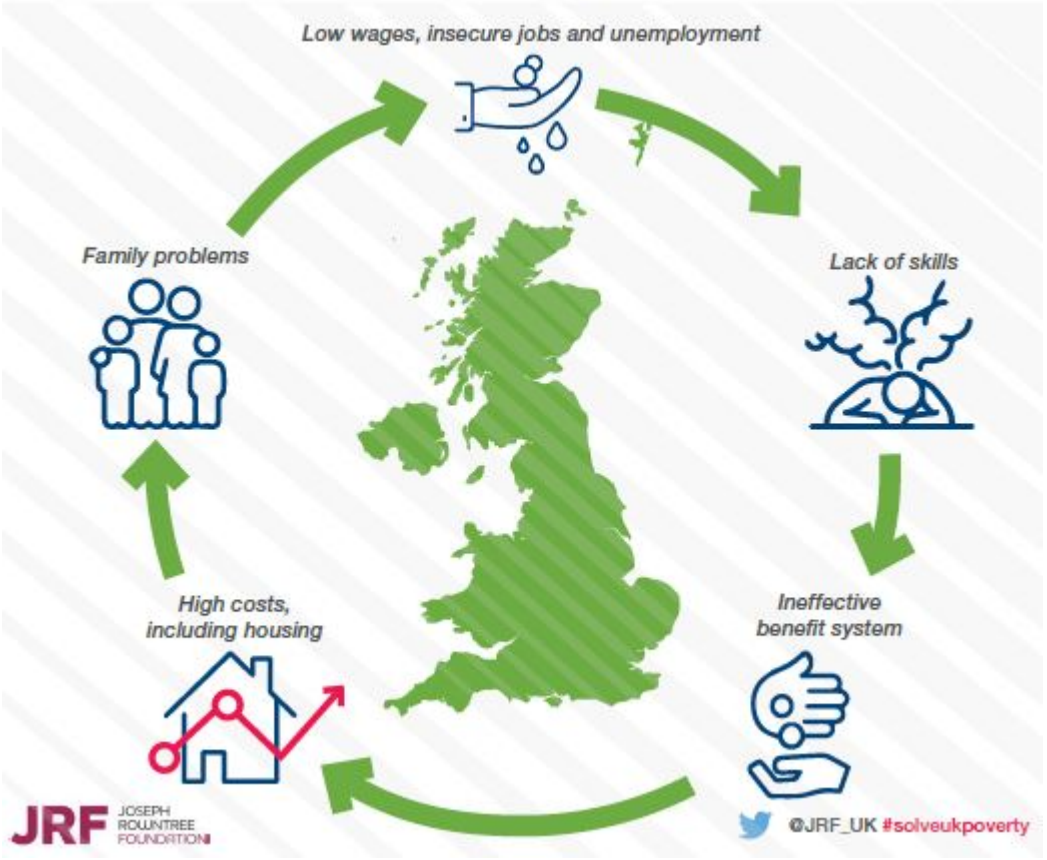


14.3m People Living below the poverty line

Cycle of poverty

Based on a household with two adults and two dependent children, the current annual value of the Government's HBAI poverty line, after housing costs have been deducted, is set at £22,100.

The deep poverty line is measured at 40% of the annual average income, which is £14,733, based on the same family structure of two adults with two dependent children.

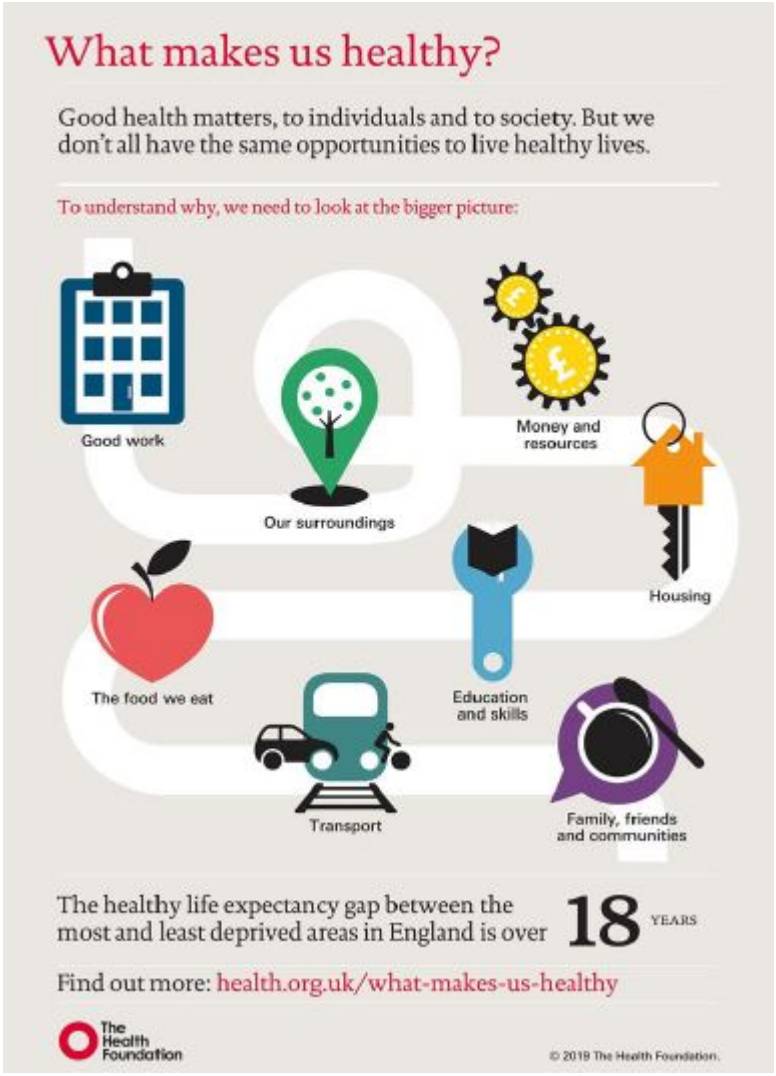


How does poverty affect health?

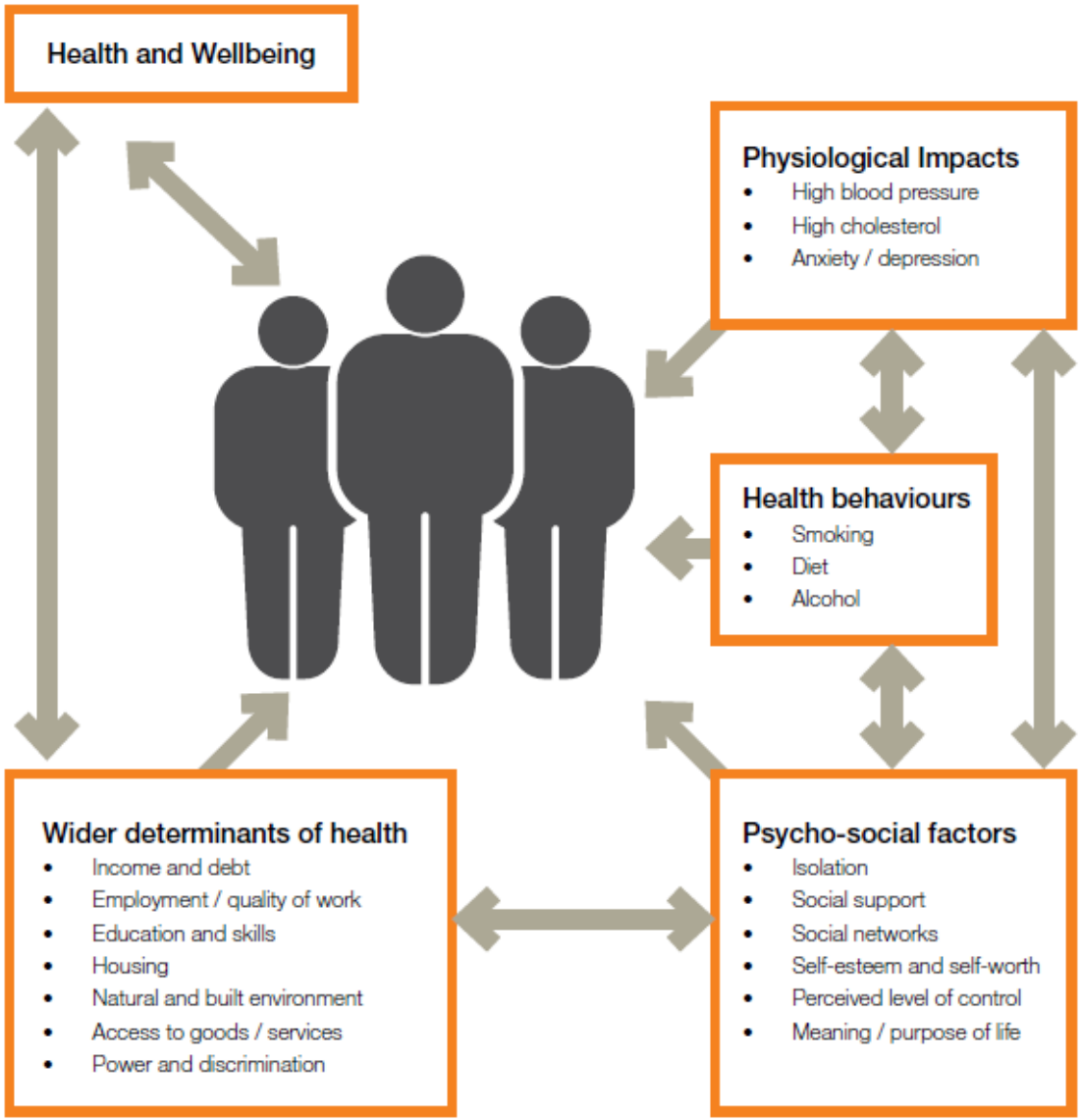
Lack of money in itself does not cause someone to be poorly, but the indirect influence of poverty does have a marked effect on health.

The wider determinants of health, which include economic characteristics such as unemployment and household income, have been found to have a greater influence on population health than health care and lifestyle behaviours.

Lifestyle factors, which are inextricably linked with the wider determinants such as household income, can lead to ill health.



System map of the causes of health inequalities



The Marmot Review

Set out the scale and distribution of health inequalities in England and the actions required to reduce them.

It outlined six policy objectives for reducing health inequalities:

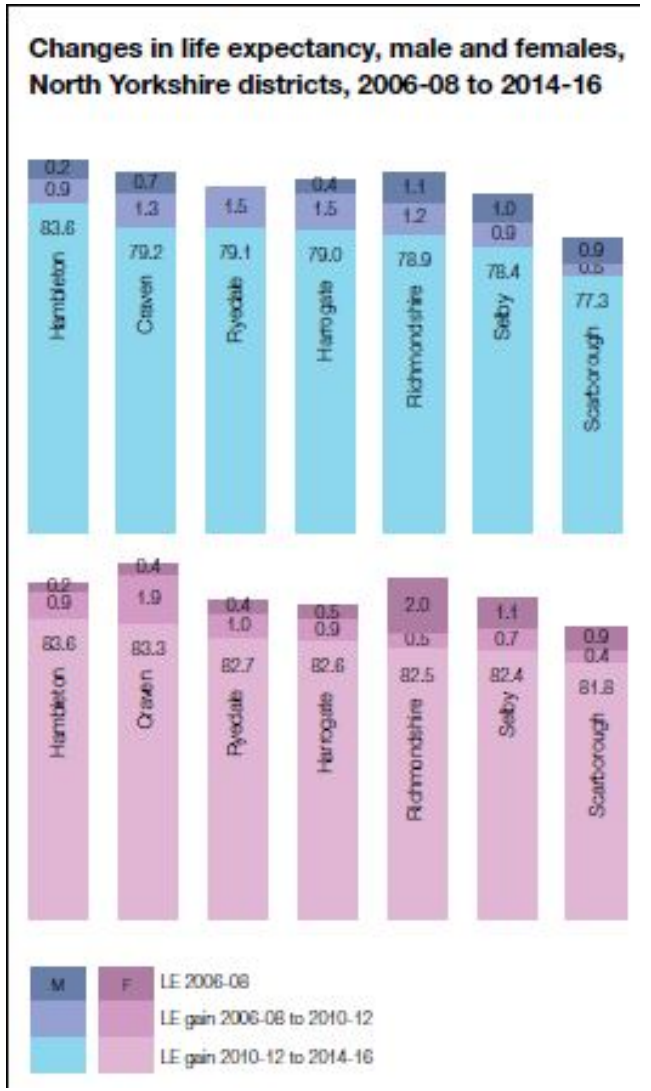
- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

Life expectancy in North Yorkshire

Overall, health in North Yorkshire is better than average for England. Life expectancy (LE) at birth is significantly higher for males and females, but the rate of change appears to be reducing.

Scarborough continues to have the lowest life expectancy in North Yorkshire

Healthy life expectancy in North Yorkshire - the number of years someone can expect to live in good health from birth to death - is significantly higher than the England average for females, but not significantly different for males.

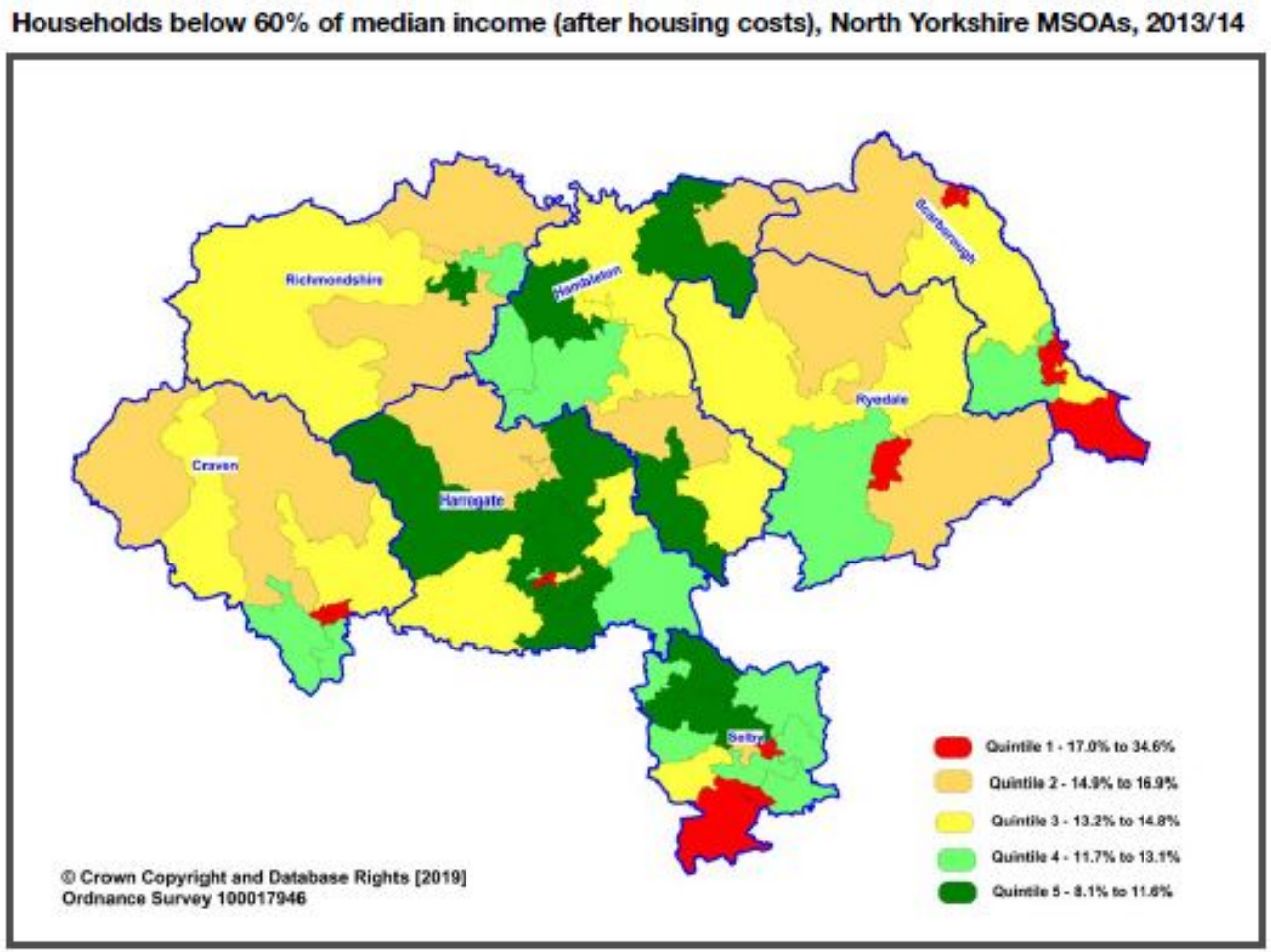


Poverty in North Yorkshire

Households in poverty

Range from 8.1% (Harrogate) to 34.6% (Scarborough)

92,000 people in North Yorkshire
15% of the population



The eleven most deprived neighbourhoods in North Yorkshire, 2015

The Index of Multiple Deprivation (IMD) is an area-based, relative measure of deprivation.

All are in the most deprived decile nationally for employment deprivation.

Nine are in the most deprived 10% nationally for the Income domain

Seven are in the most deprived decile for Health Deprivation and Disability.

Seven are in the most deprived decile for Education, Skills and Training Deprivation

					Seven domains – national decile (1 is most deprived)						
LSOA Code	LSOA name (2011)	Ward containing LSOA	Rank of 42,844 LSOAs in England	Rank (NY)	Employment	Income	Health Deprivation and Disability	Education, Skills and Training	Crime	Living Environment	Barriers to Housing and Services
E01027874	Scarborough 007D	Woodlands	313	1	1	1	1	1	3	8	3
E01027819	Scarborough 012B	Eastfield	318	2	1	1	1	1	1	7	3
E01027806	Scarborough 006B	Castle	319	3	1	1	1	1	1	1	5
E01027847	Scarborough 006D	North Bay	751	4	1	1	2	1	1	1	4
E01027804	Scarborough 010A	Castle	1,005	5	1	1	1	3	1	1	5
E01027817	Scarborough 012A	Eastfield	1,714	6	1	1	1	1	3	6	4
E01027907	Selby 005C	Selby West	2,057	7	1	1	2	1	4	9	5
E01027740	Harrogate 013F	Woodfield	2,283	8	1	1	1	3	4	7	6
E01027820	Scarborough 012C	Eastfield	2,515	9	1	1	2	1	5	6	6
E01027805	Scarborough 006A	Castle	2,561	10	1	2	2	2	1	1	8
E01027869	Scarborough 001C	Whitby West Cliff	2,792	11	1	2	1	4	2	1	5

Recommendation - support deprived areas

There are 11 Lower Level Super Output Areas (LSOA), out of 373 in the county, with Index of Multiple Deprivation scores (IMD 2015) amongst the most deprived 10% in England and a further 12 LSOA amongst the more deprived 10-20% in England. Many of these are located in the coastal town of Scarborough but they exist in other places as well.

The evidence indicates that interventions to increase income in these LSOAs will help to lift these away from the most deprived group. These might include supporting people into employment and better paid, more stable jobs; improving opportunities for in-work progression through skills training, and increasing uptake of benefits to which people are entitled. The changing face of work due to increased digitalisation, artificial intelligence and technology advances needs to be monitored to prevent adverse impacts on employment opportunities in the county.

Recommendation

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.

Recommendation - tackle rural poverty

Rural locations are associated with transport issues, decreased access to services and opportunities, and fuel poverty. These concerns are especially challenging in a county with a high proportion of older residents. 43% of the North Yorkshire population live either in the countryside or in small villages with less than 4,000 residents. This compares with 6% of the population of Teesside or West Yorkshire. Rural poverty may often be hidden in the statistics. The integral links between the rural economy of North Yorkshire and that of neighbouring city regions of Teesside and West Yorkshire needs greater emphasis.

Recommendation

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

Recommendation - reduce childhood inequalities

The impacts of prolonged austerity and cuts to welfare benefits have driven an increase in levels of childhood poverty. Children in workless families are especially at risk but many poor children are in families where parents work. Single parent families are particularly hit by welfare cuts.

Recommendation

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.

Actions may include support for managing household budgets, facilitating access to employment and training opportunities including provision for childcare, and signposting and making referrals to debt and benefits advice to maximise income where appropriate.

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 of child poverty across North Yorkshire to inform strategies and service delivery.

Recommendation - work with military families and veterans

Catterick Garrison is the largest military base in Western Europe, housing 6,500 service personnel in 2019. It is scheduled to expand to 9,000 service personnel from 2023. There are over 50,000 veterans in North Yorkshire. Lack of opportunities for spousal employment and the transition from military to civilian life can increase the risk of poverty. This is identified in the recent armed forces and veterans needs assessment. The new Ministry of Defence (MODs) Defence Transition Service (DTS) aims to support ex-armed service veterans as they transition into civilian life in North Yorkshire.

Recommendation

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

All agencies should identify and train 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.

Recommendation - create safe environments for high-risk groups

Deprivation and inequality can be concentrated in particular groups of people – such as those who are addicted to drugs; are homeless; have a disability; or experiencing mental ill health. Often these factors co-exist and place individuals at high risk for poverty and its negative consequences. Some families and individuals may have multiple interventions by different services which are not coordinated. Safe and stable housing is often a prerequisite for the targeted and individualised approaches that may be more beneficial for these groups compared to universal services which may not be sensitive to their multiple complex needs.

Recommendation

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.

Recommendation - develop priorities to mitigate the impact of changes to the benefit system

Navigating the benefits system is often challenging for people who are vulnerable. There are elements of how the system works including sanctions which causes loss of income at a time of greatest need. These sanctions appear to disproportionately target single parents, those with long-term health conditions or disabilities and keep people locked in poverty. The way in which the benefits system is operated at times has more in common with the workhouse than with the aspiration of Beveridge, that benefits should support people to live dignified lives. There appears little real evidence to support the notion that a harsh benefits regime will motivate people out of poverty. In fact, it appears to be having the opposite effect.

Recommendation

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.

Recommendation - improve community engagement

Working with people and communities to create a shared future is more effective than doing things for them or to them. This principle is supported by a growing body of evidence that community participation leads to sustainable poverty reduction, especially where attention is given to training and building capacity in the community.

Poverty can undermine social networks and approaches that seek to build social capital in communities can increase the resources available to people to tackle the problems they face. The aspiration of working with communities is to design, reshape and deliver services equally with those who use them to create better outcomes.

Recommendation

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.

Actions may include identifying influential community members reflecting different perspectives; providing training and support for communities to develop local plans; and facilitating communities to work with relevant agencies to co-produce plans and services.

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