Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

5 July 2018 9.30am to 12.30pm

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

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

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

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 5 to 18	Minutes of the meeting held on 3 May 2018	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 19 to 68	Accountable Officer's Report	To Receive	Executive Team on behalf of Phil Mettam, Accountable Officer
6.	Pages 69 to 73	Risk Update Report	To Receive	Abigail Combes, Head of Legal and Governance

STRATEGIC – 10.10am				
7.	Pages 75 to 85	Healthier You: NHS Diabetes Prevention Programme	To Receive	Dr Kevin Smith, Exectuive Director of Primary Care and Population Health
FINANCE AND PERFORMANCE – 10.20am				
8.	Pages 87 to 103	Financial Performance Report 2018/19 Month 2	To Receive	Michael Ash-McMahon, Acting Chief Finance Officer
9.	Pages 105 to 109	Financial Control, Planning and Governance Assessment	To Receive	Michael Ash-McMahon, Acting Chief Finance Officer
10.	Pages 111 to 206	Integrated Performance Report Month 2	To Receive	Caroline Alexander, Assistant Director of Delivery and Performance
ASSURANCE – 11.00am				
11.	Separate document	2017/18 Annual Report and Annual Accounts	To Ratify	Michael Ash-McMahon, Acting Chief Finance Officer
12.	Pages 207 to 254	Governing Body Committees	To Approve	Abigail Combes, Head of Legal and Governance
13.	Pages 255 to 299	Quality Assurance Framework	To Receive	Michelle Carrington, Executive Director of Quality and Nursing / Chief Nurse
14.	Pages 301 to 335	Quality and Patient Experience Report	To Receive	Michelle Carrington, Executive Director of Quality and Nursing / Chief Nurse

RECEIVED ITEMS – 12.15pm				
15.	Pages 337 to 355	Audit Committee Minutes: 26 April and 23 May 2018		
16.	Pages 357 to 386	Executive Committee Minutes: 4 and 18 April, 2 and 16 May and 6 June 2018		
17.	Pages 387 to 411	Finance and Performance Committee Minutes: 26 April and 24 May 2018		
18.	Pages 413 to 422	Primary Care Commissioning Committee: 22 May 2018		
19.	Pages 423 to 433	Quality and Patient Experience Committee: 14 June 2018		
20.	Pages 435 to 443	Medicines Commissioning Committee 11 April and 9 May 2018		
NEXT MEETING				
21.	Verbal	9.30am on 6 September 2018 at West Offices, Station Rise, York YO1 6GA	To Note	All
CLOSE – 12.30pm				
EXCLUSION OF PRESS AND PUBLIC				
In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it is considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted as it contains commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.				

A glossary of commonly used terms is available at

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Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 3 May 2018 at West Offices, York

Present

Dr Nigel Wells (NW)	Clinical Chair
Michael Ash-McMahon (MA-M)	Interim Chief Finance Officer
David Booker (DB)	Lay Member, Finance and Performance Committee Chair
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Dr Helena Ebbs (HE)	North Locality GP Representative
Dr Andrew Field (AF)	Central Locality GP Representative
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS) - Part	Director of Public Health, City of York Council

Apologies

Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Keith Ramsay (KR)	Lay Member, Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee

There were two members of the public and one member of the press present.

There were no questions from members of the public.

In opening his first meeting since appointment as Chair NW welcomed in particular MA-M, who had been appointed as Interim Chief Finance Officer following Tracey Preece's departure on 27 April, and RW who was also attending her first meeting since appointment as GP representative for the South Locality. NW emphasised that the clinicians were present in the role of commissioners and also expressed appreciation to KR for chairing the April Governing Body meeting and for his work as Lay Chair.

AGENDA

STANDING ITEMS

1. Apologies

As noted above.

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

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

3. Minutes of the Meeting held on 5 April 2018

The minutes of the meeting held on 8 March were agreed subject to amendment at item 9 Draft Financial Plan 2018/19 paragraph 7 to read '…£14m deficit and 3.1% QIPP…'

Additionally, there was an omission from the response to the question at the start of the meeting of a post meeting note to read: *'The CCG is working to support practices to be sustainable in the long term and this includes working with them to secure sufficient resources, workforce and premises. Under current arrangements, practices are independent businesses with very little access to public capital. As such, many will look to private finance options for premises improvements. This does not impact on the contract with the CCG and an independent valuation is undertaken in relation to payment for any additional space.*

Any change to practice locations or premises is subject to appropriate scrutiny including public consultation where the change is significant.'

The Governing Body:

Approved the minutes of the meeting held on 8 March 2018 subject to the above amendments.

4. Matters Arising from the Minutes

Integrated Performance Report Month 8 - Proposal for a revised Governing Body committee structure to be developed: PM reported that the new governance structure was now complete and would be presented at the July Governing Body meeting.

A number of matters were noted as ongoing.

The Governing Body:

Noted the updates and associated actions.

5. Accountable Officer's Report

PM presented the report which provided an update on turnaround, legal Directions and the CCG's financial position; joint commissioning and the York Health and Care Place Based Improvement Board; Council of Representatives meeting; Better Care Fund update; Emergency Preparedness, Resilience and Response; CCG 360° Stakeholder Survey; changes to Governing Body membership; and national issues.

PM emphasised the CCG's progress in achieving the in-year £20.1m deficit for 2017/18 which represented stabilisation and improvement on previous years, noting that at the start of the year there had been a forecast potential £44m deficit and £23m deficit from 2016/17. He highlighted this achievement in the context of many CCGs in North and West Yorkshire experiencing serious deterioration in their financial positions. PM noted that this improvement had been achieved through managing resources more efficiently, not through cutting services. The aim was to improve the deficit further through efficiencies whilst maintaining quality services. PM also noted that the CCG was working collaboratively with other organisations in the system, particularly York Teaching Hospital NHS Foundation Trust, who were experiencing a greater level of challenge.

PM reported that the 2017/18 accounts had been submitted in line with the required timescale and were expected to be signed off accordingly. He expressed appreciation to Tracey Preece, MA-M and the Finance Team in this regard.

PM highlighted the CCG's annual review with NHS England for 2017/18 welcoming the positive feedback on the leadership team's progress with delivery in all areas, including the stabilisation of the financial position, improvements in the majority of performance indicators and working with partner organisations. He noted that NHS England would work with the CCG on developing a strategy to exit legal Directions and special measures. This release, subject to delivery of the 2018/19 financial plan, would provide flexibility for longer term planning in such areas as prevention, early intervention and working with the third sector on development of the Out of Hospital model of care.

PM noted that the 'Significant Assurance' audit report for the CCG's Stakeholder Communication and Engagement provided further validation of the strong delivery, governance and assurance processes now in place.

PM reported that the York Health and Care Place Based Improvement Board, chaired by Mary Weastell, Chief Executive of City of York Council, and with membership of leaders of health and social care partner organisations including Dr Mike Holmes representing General Practice in the City, had held its second meeting and would now meet every two months. The first meeting on 4 April had focused on principles and values; the second meeting on 2 May had centred on development of a five to ten year plan with investment in prevention. SS had been asked to work with Dr Mike Holmes and KS to consider how this could be achieved in the context of meeting the varying locality needs of the City. Discussion at the meeting had also included digital communication in the public sector and the need for the various systems and frameworks to be joined up to maximise efficiencies in care.

In response to DB referring to agreement at the previous Governing Body meeting of establishment of a Joint Committee for Acute Commissioning, PM reported that the first meeting had taken place. The focus had been on establishing governance arrangements, the 2018/19 contractual framework with York Teaching Hospital NHS Foundation Trust and securing efficiencies to deliver financial plans. PM advised that the Committee had agreed to prioritise orthopaedic services as this had been identified as the area with the greatest opportunities for efficiencies. He also noted that the additional Lay Member representation, requested at the last Governing Body meeting, had been supported and was now being considered across the three CCGs.

RW expressed concern about potential inequalities and enquired whether a similar approach to the York Health and Care Place Based Improvement Board was being considered with North Yorkshire County Council. PM expressed the hope that this would develop for both the South and North Localities and noted that work was taking place in this regard but it was more complex due to the geography and North Yorkshire County Council's preference for one arrangement with providers despite the number of organisations involved. KS added that the CCG wished to work with the localities to present proposals to North Yorkshire County Council as soon as practicable noting opportunities to learn from work in Scarborough with the District Council. He also advised that the CCG was now working more closely with the North Yorkshire County Council Director of Public Health and emphasised that developments must be integrated and in response to locality needs. In this regard HE noted the benefit of Local Authority representatives at locality meetings and RW highlighted the need for a forum for the localities to share learning information.

DN explained developments with North Yorkshire County Council at an operational level, including their offer to the CCG to commission newly developed dementia residential beds and their interest in residential beds at Selby for discharge to assess. This increased engagement at service level required communication to the North and South Localities to enable further development.

In response to HE highlighting the multi-factorial challenge, including three different localities, for York Teaching Hospital NHS Foundation Trust's management of discharges, PM referred to the establishment of the localities and the CCG's restructuring of the Governing Body noting that consideration of presentation of locality information was now required. This needed to take account of effectiveness at locality but also in the context of the Governing Body. PM also noted that the role and model of the Council of Representatives now required consideration.

MC commented that the clinical locality presence on the Governing Body was already having impact and emphasised the need for constant feedback. HE agreed and noted that development of mechanisms was required both in this regard and for progression of ideas generated from primary care.

With regard to the April Council of Representatives meeting KS reported that the presentation on the NHS Diabetes Prevention Programme, which aimed to provide concentrated support for access to a better quality service, had been well

received. He noted that a standard code defining increased risk of diabetes addressed the challenge relating to coding of blood test results. HE added that this programme was welcome as it was a safe service which diverted work away from GPs.

PM referred to the update on the Better Care Fund highlighting that performance measures, in particular delayed transfers of care, needed monitoring. He assured members that if this required escalation, this would be done.

PM explained that all CCGs were required to participate in an annual 360^{o} Stakeholder Survey and receive feedback from partners and stakeholders based on c20 headline indicators; these were supported by further detailed information. PM noted that NHS Vale of York CCG's results for all indicators showed improvement but further work was required in the context of comparison with other CCGs in Yorkshire. PM proposed that an improvement plan, based on analysis of the survey information, be developed to continue the improvement trend.

PM added his personal welcome to NW and appreciation of Tracey Preece's contribution to the CCG.

In response to DB referring to the cyber security risk detailed in the Emergency Preparedness, Resilience and Response information and requesting that this be added to the Audit Committee's remit, PM asked MA-M, as Interim Senior Responsible Officer, to progress this.

The Governing Body:

1. Devolved responsibility for the development of a proactive Organisational Development and Improvement Plan for 2018/19 to the Executive Committee.
2. Received the Accountable Officer's Report.
3. Requested that cyber security be added to the Audit Committee's remit.

6. Risk Update Report

MC referred to the significant work that had taken place on the risk report to attribute risks to the appropriate committees and highlighted that the Risk Report presented on this occasion only related to new events. She assured members that risks were being managed by the committees and would be escalated as required.

With regard to the corporate event relating to the planned reduction in the provision of in-patient care at The Retreat MC referred to recent press coverage about the proposed plans explaining that staff consultation had commenced earlier in the week. The plans followed a review of The Retreat's mental health and learning disability services with the aim of responding as a system to population need. MC noted that there could be impact on services nationally in terms of out of area placements.

MC reported that after discussion with The Retreat it may be that c60% of patients may still receive their care by The Retreat but that this may be through different models of care. The in-patient bed base was likely to be most affected and The Retreat is working with Tees, Esk and Wear Valleys NHS Foundation Trust and City of York Council to possibly provide different types of accommodation for people with complex dementia and learning disabilities; less impacted services were not expected to change.

MC advised that eating disorder services were currently commissioned by NHS England. The Retreat wished to extend these services which could potentially address the current gap in provision.

MC noted that, although some staff had left due to concern about their futures, The Retreat was confident they would be able to meet the needs of patients.

MC explained that information on plans for The Retreat's estate was expected by the end of June. She was unable to provide information on potential opportunities for primary care in this regard at the present time.

In terms of risk to the CCG's patients MC advised that there were six patients in The Retreat funded by continuing healthcare and six Tees, Esk and Wear Valleys NHS Foundation Trust patients. The risk related to the specialist nature of services at The Retreat and the potential need for alternative accommodation and packages of care to be found.

With regard to Child and Adolescent Mental Health Service DN highlighted that the risk had been split into separate components which enabled a better understanding both for discussion with Tees, Esk and Wear Valleys NHS Foundation Trust and internal CCG work. She also noted this reflected risk relating to *Future in Mind – Improving Mental Health Services for Young People* and advised that NHS England's letter to the CCG on quarter 3 performance in this regard had recognised areas of progress. These had included partnership working and the impact of the introduction of the Child and Adolescent Mental Health Services Single Point of Access; the need for additional investment had also been reflected. DN noted that the quarter 4 performance information had recently been submitted and whilst, there was improvement, this remained a priority risk for the CCG.

DN reported that discussions were taking place with City of York Council and Tees, Esk and Wear Valleys NHS Foundation Trust regarding GP referrals to Child and Adolescent Mental Health Services to ensure clarity about the services provided by them and also availability of other services for the 30% of young people whose needs required an alternative provision to Child and Adolescent Mental Health Services. DN noted the fact that triage of referrals was being done by the Single Point of Access provided a level of assurance but advised that the CCG was now starting to work with Tees, Esk and Wear Valleys NHS Foundation Trust on an Aligned Incentives approach to understand shared priorities and agree opportunities to release money to reinvest in children's mental health services. This was a new development but demonstrated the commissioner and provider alignment of priorities. DN also explained that Tees, Esk and Wear

Valleys NHS Foundation Trust had agreed to provide the CCG with additional information relating to diagnosis of autism and attention deficit hyperactivity disorder and waiting times for emotionally unwell children to enable prioritisation of any investment.

In relation to non compliance with national access and waiting times for children and young people with eating disorders, DN noted that staff training was needed on a technical issue about "stopping the clock"; this was being delivered. The numbers, based on population list size, were higher than anticipated in the contract. Following a query from HE DN noted that demand could be assessed on a locality basis and highlighted the need for both mental health and physical needs to be considered, for example the respective roles of York Teaching Hospital NHS Foundation Trust for paediatrics, Tees, Esk and Wear Valleys NHS Foundation Trust for mental health and GPs.

In referring to long waiting lists for autism diagnosis for children DN noted that a waiting list initiative had achieved a temporary improvement. She emphasised that improving this performance was a priority and noted that the CCG had included improving access for children and young people to mental health services as a Local Indicator for the 2018/19 Quality Premium.

Discussion included concern about the impact on families, the child and primary care as a result of the long waiting times.

SS welcomed the work described but expressed concern that opportunities may be being missed to work with the 30% of children and families who required alternatives to the services provided by Child and Adolescent Mental Health Services. She also advised that there was a Children and Young People's Health and Wellbeing Partnership across City of York and sought additional clinical engagement in this. DN responded that the CCG did have input into this Partnership but recognised that the clinical aspect required review. She also emphasised that the CCG currently had a greater urgency to address the issues than was possible at present through this route.

In response to AF's concerns about waiting times relating to the City of York Council School Wellbeing Service, SS explained that this was a pilot programme with School Wellbeing Officers in three school clusters. Additional funding had been made available to extend the programme but it was not sustainable in its current format as the Future in Mind funding was scheduled to end in 2019/20. SS emphasised that a system solution was required to address the current impact on GPs, schools and families. MC noted that there was positive feedback about the School Wellbeing Service and proposed that discussion take place with SS outside the meeting in this regard highlighting the expectation that a new model would be in place by 2020.

RW and HE referred respectively to the North Yorkshire County Council Prevention Team and Compass REACH but reported that improved communication with GPs was required. It was agreed that this would be progressed by MC, DN and SS with Jon Stonehouse, City of York Council Corporate Director of Children, Education and Communities, and a representative from North Yorkshire County Council.

In conclusion DN commented that, despite the issues identified, feedback from families on Child and Adolescent Mental Health Services who had received services was excellent.

The Governing Body:

1. Received the Risk Update Report.
2. Noted that concerns about communication between GPs and the Local Authorities regarding services and referrals would be progressed by MC, DN and SS.

FINANCE AND PERFORMANCE

7. Financial Performance Report 2017/18 Month 12

MA-M reiterated PM's confirmation at item 5 that the CCG had achieved an actual outturn position of £20.1m deficit and explained that the improvement against the £22.5m forecast outturn at month 9 was due to the instruction from NHS England for CCGs to release the 0.5% national risk reserve, £2.0m, and the £0.4m Category M prescribing benefit. MA-M highlighted that the year-end position also included the £1.9m impact of the No Cheaper Stock Obtainable issue noting that had this non recurrent national issue not occurred the CCG's outturn would have been c£18m deficit, which was effectively the same as the in-year position from 2016/17 further adding to the stabilisation message.

MA-M explained that the reported underlying outturn position of £21.2m deficit in the Financial Performance Headlines and the £21.7m deficit in the plan was due to calculations varying in the NHS England financial templates. He noted that both figures were an improvement on the £22.4m forecast deficit at the start of 2017/18.

In reporting that the CCG had delivered £7.9m, 55%, QIPP (Quality, Innovation, Productivity and Prevention) in 2017/18 MA-M highlighted that this was a significant improvement on previous years and testament to work undertaken both within the organisation and across the system.

MA-M reported that the CCG had delivered the cash target and had consistently through the year met the Better Payment Code of Practice requirements.

MA-M advised on the main areas of risks. The reported forecast outturn included the agreed year-end position with all providers except Ramsay and Nuffield Hospitals, Harrogate and District NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust as none of these organisations were willing to agree a fixed position. These would be paid based on the actual level of activity as an agreed value had not been reached.

With regard to the risk associated with NHS Property Services MA-M explained that a full and final settlement had been agreed for 2015/16 and 2016/17 but there was an emerging risk in respect of 2017/18. He emphasised however that the CCG had been prudent in assessment of this risk and was exerting challenge where appropriate.

MA-M noted that the uncertainty about the continuing healthcare year-end position had not yet been resolved but work was progressing since the Partnership Commissioning Unit had been brought in-house.

SS left the meeting

With regard to QIPP delivery MA-M explained the contribution of the Health Optimisation programme noting that, although this was in the main non recurrent, it would be incorporated in the 2018/19 plans. He also highlighted that the CCG continued to be a high performer in effectiveness of prescribing both nationally and across Yorkshire and the Humber. KS added that this achievement was in the context of appropriate prescribing that was the most effective and best value for money. He commended this consistent achievement also noting that prescribing incentives enabled savings to be shared with primary care. HE additionally noted GP support across the CCG for deprescribing.

The Governing Body:

Received the month 12 Financial Performance Report

8. Integrated Performance Report Month 11

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

PM highlighted that the CCG had met the Cancer two week wait target of 93% for the fourth consecutive month and noted the system focus on delayed transfers of care for financial and performance recovery in 2018/19.

With regard to A and E four hour performance PM reported that, as nationally, York Teaching Hospital NHS Foundation Trust had been under significant pressure. He noted workforce challenges across their York, Scarborough and Bridlington sites with associated impact on capacity. This had included impact on flow of patients through the hospital and cancellation of planned surgery which affected waiting times. PM highlighted, however, in respect of the latter that locally orthopaedic waiting times were among the best in the country.

HE referred to educational work for Practices to increase the referral rate for the Sleep Studies pathway, a service affected by capacity issues and one that could be comparatively easy to address alleviating impact on sufferers. In response PM referred to the Commissioning Intentions and the commitment that any available investment should go to mental health and primary care. Whilst the CCG would continue to have a deficit for two to three years, there was at the same time commitment to debate with the public on prioritising resources.

MC reported, with regard to the Sleep Studies, that the last Executive Committee had considered a detailed business case to change the current pathway. This would be both cost saving and address the backlog.

Discussion ensued in the context of concerns about inequality in view of differential waiting times, for example the comparison between mental health and orthopaedic services.

PM referred to the deterioration in Cancer 62 day performance and emphasised that investment in cancer services must be a priority along with the focus on primary care and mental health.

In response to PM referring to the impact of winter pressures on 18 week referral to treatment performance and emphasis on the need for improvement, AF highlighted that General Practice required earlier notification for planning purposes than in previous years. KS explained that winter monies were included in the plan from the start of 2018/19 and referred to the Improving Access to Primary Care monies. MA-M added that specific funding had been set aside for 2018/19 primary care sessions.

PM advised that the CCG wished to develop a new partnership with the media to enhance communication and reach people appropriately. Discussion ensued on varying approaches with recognition that the most effective communication with patients may vary between localities.

MC referred to diagnostic six week waits reporting that a proportion of these patients were children waiting for routine or follow up MRI, mainly head, scans. She noted that these were not all provided by York Teaching Hospital NHS Foundation Trust and advised that assurance had been requested. MC also advised that there was a process for escalation if required.

The Governing Body:

Received the Integrated Performance Report as at month 11.

ASSURANCE

9. Quality and Patient Experience Report

MC highlighted that NW and KS would be joining the Quality and Patient Experience Committee to strengthen both quality per se and reporting; primary care quality would also be incorporated.

MC referred to the Quality and Patient Experience Report and noted that she would provide clarification on request but would focus on updates not included. She referred to the earlier discussion on The Retreat and two matters that had been the subject of recent national media attention. Firstly, with regard to the issue of women between 68 and 71 not being called for breast screening MC reported that detailed information, including the helpline number, had been sent to Practices earlier in the day. She had no knowledge as to whether any CCG patients were affected. Secondly, MC referred to the Danny Tozer inquest at which the coroner had determined that Danny had died from natural causes with no evidence of neglect. She advised that nevertheless a lessons learnt review was taking place and a report would be provided to the Governing Body in due course.

In response to clarification sought by RW, NW and HE about the care homes information in the report, MC explained that only closures or suspensions were reported and most homes did re-open. She noted that 68 of the 78 care homes in the CCG were assessed as 'Good' by the Care Quality Commission but also highlighted workforce challenges. With regard to quality benchmarking at CCG level, such as Advance Care Planning, MC explained that the CCG bought packages of care for patients. City of York Council had a quality regime with local indicators in addition to the national indicators and also undertook annual reviews. The CCG was working jointly with the Local Authorities in this regard.

MC explained that concerns at care homes were usually the result of safeguarding or infection control alerts. She noted that there were regular meetings of partner organisations and additionally quarterly meetings of the CCG Care Homes Forum (Partners in Care) which included sharing of best practice. MC also noted that Continuing Care Nurses had a responsibility to review care home packages but highlighted the need for improved informal feedback such as from GPs. In this regard a clear mechanism, including point of contact, was required for raising concerns and seeking support.

RW referred to data indicating improvements in respect of Improving Access to Psychological Therapies and noted that this was not representative of patients' experiences. She explained that to access the service patients were required to first attend a course which most did not find helpful and after which they were still waiting for true therapy. In response DN advised that a multi-factorial model was required across primary and secondary care and the advice of the NHS England Intensive Support Team on improving performance against the national target for Improving Access to Psychological Therapies was that the CCG would need more than one to one provision. However, the overall backlog was an issue in addressing the delays. The CCG recognised that investment in the service was required and would work with primary care to identify specific areas for development. DN requested that the Locality Leads provide feedback to her to inform discussions.

The Governing Body:

1. Received the Quality and Patient Experience Report.
2. Noted the additional updates.

RECEIVED ITEMS

The Governing Body noted the following items as received:

10. Audit Committee Minutes of 7 March 2018.

11. Executive Committee Minutes of 7 and 21 March 2018.

12. Finance and Performance Committee Minutes of 22 March 2018.

13. Primary Care Commissioning Committee Minutes of 27 March 2018.

14. Quality and Patient Experience Committee Minutes of 12 April 2018.

Unconfirmed Minutes

15. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 5 July 2018 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.

Follow Up Actions

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

A glossary of commonly used terms is available at:

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

Appendix A

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 3 MAY 2018 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

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

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
4 January 2018 5 April 2018	Accountable Officer Report	• Confirmation to be provided as to whether the end of December 2017 target date for the rollout of free wi-fi capability to GP Practices had been achieved • Delayed – new projected completion date	TP MA-M	31 March 2018 31 May 2018
4 January 2018 5 April 2018 3 May 2018	Integrated Performance Report Month 8	• Proposal for a revised Governing Body committee structure to be developed • New governance structure to be presented at the July Governing Body	AC	 Ongoing 5 July 2018
3 May 2018	Accountable Officer's Report	• Cyber security to be added to the Audit Committee's remit	MA-M	Completed 23 May 2018
3 May 2018	Risk Update Report	• Concerns about communication between GPs and the Local Authorities regarding services and referrals to be progressed	MC, DN, SS	

Item Number: 5

Name of Presenter: Executive Team

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Accountable Officer's Report

Purpose of Report
To Receive

Reason for Report

To provide an update on a number of projects, initiatives and meetings which have taken place since the last Governing Body meeting and any associated, relevant national issues.

Strategic Priority Links

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

Local Authority Area

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

Impacts- Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

The Governing Body is also asked to note the report.

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

Annex 1 - Next steps on aligning the work of NHS England and NHS Improvement
Annex 2 – Patient and Public Participation Annual Report

GOVERNING BODY MEETING: 5 JULY 2018

Accountable Officer's Report

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

1.1 The CCG has now agreed an Aligned Incentive Contract (AIC) arrangement with NHS Scarborough and Ryedale CCG, NHS East Riding of Yorkshire CCG and York Teaching Hospital NHS Foundation Trust. This includes an agreed contract value and associated risk share in line with proposals previously shared with the Governing Body both of which will now form part of a Contract Variation with effect from 1 April 2018.

1.2 The AIC itself will not deliver the required system cost reduction, but it is a key enabler in creating the right environment for all organisations to meet the system's financial challenge in terms of the following:

1.2.1 Putting clinical leadership at the heart of this. Clinicians will be encouraged to look at the whole journey of patients looking at how best to use the hospital for the best results.

1.2.2 There is a fixed amount of funding for healthcare, and over time, more of this needs to be spent on prevention, on keeping people well and on care closer to people's homes. At the same time, we need to support first class hospital services that work with the services in the community.

1.2.3 All partners have agreed a process for what will happen if the activity costs more than the money set aside, and how this will be managed, but the approach assumes that all parties will work throughout the year to reduce the risk of this.

1.3 The CCG has submitted an updated Financial Recovery Plan (FRP) on the 28 June to reflect the AIC development and taking on board the detailed feedback from NHS England following the original draft submission. An NHS England approved FRP is one of the criteria for accessing the Commissioner Sustainability Funding throughout 2018-19.

1.4 The CCG's financial position as at Month 2, which will be reported in more detail later in this meeting, is in line with the planned deficit and stands at £300K better than anticipated.

1.5 The CCG has now received its Independent Auditors Report of its 2017-18 financial accounts. In the auditors opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its net operating expenditure for the year then ended;

- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder..

1.5.1 With regards to the Qualified Opinion on Regularity for expenditure above allocation in the opinion, except for the effects of the matter described in the basis for qualified opinion on regularity paragraph, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

1.5.2 The auditors thanked the CCG's finance team for their support and quality of their responses during their work.

2. Joint Commissioning and the York Health and Care Place Based Improvement Partnership

2.1 At the second meeting of the Place Based Improvement Board in May 2017, members adopted the title Place Based Improvement Partnership as a better reflection and name for its role. Members continued their discussion on local priorities, and alignment to the Sustainable Transformation Programme's Workforce and Estates, Digital Integration and Capital work-streams. Following the Care Quality Commission's Local System Review in 2017, a local working group has been in place to manage work plans and oversee its actions.

2.2 The Head of the Joint Commissioning Programme for City of York Council and the CCG was appointed to the role of Assistant Director for Joint Commissioning on 11 June 2018. In line with the local strategy, updates to the 2018-19 Joint Commissioning Plan are currently underway. The Plan will be submitted to the York Health and Wellbeing Board in July 2018.

3. Better Care Fund update

3.1 The CCG is currently preparing the quarterly returns for the Better Care Fund with our three local authority partners for submission in July.

3.2 In July, the executive team will be receiving a report from the desktop review and evaluation of all the Better Care Fund schemes. The Executive Committee will be asked to consider a number of recommendations and next steps in terms of the future of the Better Care Fund, and the drive towards integration with partner agencies.

3.3 The York Better Care Fund Performance and Delivery Group's evaluation and development events in May 2017 have enhanced the shared understanding of York's approach to integration, and enabled greater collaboration between schemes. A robust performance framework has been established and will provide detailed quarterly reports. The focus for York Better Care Fund is prevention and promoting community resilience.

3.4 The target trajectory for the reduction in Delayed Transfers of Care has been reviewed by HM Government, with a marginal easement being set for York compared to the previous target. However, conditions have been placed on York's Improved Better Care Fund, requiring a proportion to be specifically directed towards reducing pressure on the NHS. It is the local understanding that the conditions were met by the plan, and no adjustment is required. Further improvement in Delayed Transfers of Care performance is required and continues to be the major focus of partnership work. The availability of packages of care or care home placements remain the most significant root cause of delays for people leaving acute settings.

4. Council of Representatives meeting

4.1 Among the agenda items at the meeting on the 21 June 2018, members received updates from the North, Central and South localities and a presentation on local Prescribing Indicative Budgets work.

5. New mental health facilities, Haxby Road

5.1 The purchase of the land for the new mental health facilities has now been completed. The Tees, Esk and Wear Valleys NHS Foundation Trust's Board of Directors has signed off the Full Business Case for the new build. The new facilities are scheduled to open in April 2020 with a planned phased transfer of inpatient services.

6. CCG Annual Review meeting

6.1 The CCG met with its regulators on the 23 April 2018 to discuss the organisation's performance which will be rated and reported in the upcoming 2017-18 Annual Performance Assessment. The meeting focused on the CCG's performance and successes under Legal Directions. Discussions also included the CCG's plans, QIPP programme and the re-set of the Governing Body. The local health and care system's performance was also the focus of discussion.

6.2 NHS England has a statutory duty to conduct an annual performance assessment of each CCG. The Government's Mandate to NHS England specifies the four 'Ofsted-style' headline categories to be used: Outstanding; Good; Requires Improvement and Inadequate. The 2017-18 Annual Performance Assessment rating is expected to be announced in July 2018.

7. Patient and Public Participation Report 2017-18

7.1 The engagement and involvement of patients, partners and other stakeholders are key to the commissioning of services in the Vale of York. The CCG puts quality and safety of patients at the heart of its work, with the commissioning of services informed by local need and influenced by the engagement and involvement of the community through open and honest conversations with patients, service users, our partners and other stakeholders. The CCG has produced an annual report of its patient and public participation work, available in Annex 2. This was approved by the Quality and Patient Experience Committee at its latest meeting. The report will be circulated to partners and will be made available on the CCG's website.

8. NHS England and NHS Improvement – working together for the NHS

8.1 In March 2018, Boards from NHS England and NHS Improvement agreed ambitious proposals to transform the way they work together to provide more joined-up, effective and comprehensive system leadership to the NHS. A paper that sets out the next steps to create an operating model that best supports local health systems has been produced that reflects both organisations' duties to co-operate with each other in the exercise of their functions and doing so economically, efficiently and effectively; and to facilitate, where beneficial, integrated provision of healthcare services. The paper has been attached to this report in Annex 1.

9. Emergency Preparedness, Resilience and Response (EPRR) Assurance

9.1 Dr Kevin Smith, Director of Primary Care and Population Health and Michael Ash-McMahon, acting Chief Finance Officer and Senior Information Risk Owner (SIRO) have joined the CCG's Director On-Call rota bringing the total number of Directors on-Call to five. The rota has been agreed to September 2018.

9.2 The CCG was represented at the North Yorkshire and Humber Health Group meeting on 6 June 2018. NHS England advised that the CCG will be expected to complete the annual EPRR self-assessment and assurance process and are awaiting guidance on the scoping of the 2018-19 analysis, anticipated to focus on 'control and command' plans and processes.

9.3 The CCG attended NHS England's Exercise Accentus table-top exercise that explored the health response to deliberate incidents that cause large numbers of casualties. Four members of staff attended the exercise that was facilitated by Public Health England. The information gathered during the exercise has been used to produce an exercise report and de-brief to inform the future plans for CCG's and health providers. The CCG also attended Tees, Esk and Wear Valley NHS Foundation Trust's White Rose Exercise on 7 June 2018.

The exercise tested the providers Control and Command plans and processes across its sites in York, Middlesbrough and Harrogate.

9.4 The CCG has been invited to attend York Teaching Hospital NHS Foundation Trust's and the Armed Forces medical personnel at Strensall Barra LIVEX events on 2 and 3 July 2018 in York the 4 and 5 July 2018 in Scarborough. This exercise will test the York Teaching Hospital NHS Foundation Trust's emergency department's plans in the event of a mass casualty event.

9.5 System calls with partner organisations are currently taking place on a weekly basis. The CCG now receives regular reports from the Met Office regarding potential heatwave weather and these are shared with the Director on-Call and, where appropriate, the CCG's partner organisations.

10. National issues

10.1 NHS England has announced £10 million of additional funding in 2018-19 to support the retention of the GPs and specifically to facilitate the establishment of local schemes and initiatives that enable local GPs to stay in the workforce. The funding will help to promote new ways of working and offer additional support – through the new Local GP Retention Fund, and establish seven intensive support sites across the country in areas that have struggled most to retain GPs. Sites are expected to be announced by the end of June 2018.

10.2 The national data opt-out introduced on the 25 May 2018 coincided with the introduction of the General Data Protection Regulation (GDPR). The national data opt-out programme will be writing to GP practices to ensure they are aware and are considering the actions they need to take - actions such as advising patients on their options, using the new national data opt-out instead of the current type 2 opt-out, and using the communication materials being provided by the programme.

10.3 The 'Your Data Matters to the NHS' campaign has been launched following the introduction of the General Data Protection Regulation. This informs the public how the strict rules about how health and care data can and cannot be used have been further strengthened. The campaign will also inform the public they can choose whether their confidential patient information is used for research and planning.

10.4 NHS England, together with NHS Improvement and NHS Employers, has developed a new NHS Workforce Health and Wellbeing Framework for all NHS organisations. Improving staff health and wellbeing provides benefits for individual staff, organisations and ultimately patients. Drawing on the evidence base and developed with 12 NHS organisations and expert input the Framework and accompanying diagnostic tool outlines what CCGs can do to

improve the health and wellbeing of staff. The Framework also provides guidance on developing a staff health and wellbeing plan and evaluating this over time.

10.5 The progress update on the General Practice Forward View at the end of year two has been published. It gives details on the progress made against the key commitments of the General Practice Forward View as at May 2018, two years in. The General Practice Forward View is a package of support for general practice, backed by increased investment, which addresses immediate challenges, and facilitates longer term transformation.

10.6 NHS Digital is seeking participants to support a new child health services project. GPs, practice managers and practice administrators are invited to shape the future National Failsafe Management Service. This service is part of the wider National Events Management Service, which aims to ensure that all children in England receive the standard programme of care defined by the Healthy Child Programme. No specialist digital knowledge is necessary to be a participant, just a passion for improving health services and willingness to get involved.

10.7 NHS England has launched the new Improving Access to Psychological Therapies (IAPT) Manual. This manual will help commissioners, managers and clinicians expand their local IAPT services while maintaining quality and ensuring that patients receive effective and compassionately delivered care. It provides guidance on setting up and running an efficient IAPT service that achieves good outcomes, and which creates an innovative and supportive environment for staff and clients. It also explains how to use local and national data to better understand the strengths and limitations of a service.

10.8 On 12 June 2018 NHS England announced £10 million funding over two years to help people who experience severe mental illness (SMI) find and retain employment. The funding will support expansion of Individual Placement and Support (IPS) services. IPS provides employment support for people with SMI. It has been shown to be twice as effective as vocational rehabilitation and associated with reduced use of services. Wave one IPS funding will support the expansion of established services in 2018-19 and 2019-20. Wave two will follow to support areas with IPS services requiring development, or those with no IPS service.

10.9 As part of work to improve wheelchair service provision and move towards more personalised care, personal wheelchair budgets are currently being introduced across England to replace the wheelchair voucher scheme. A series of newly published questions and answers about the scheme are now available on the NHS England website, for all commissioners and providers involved in introducing personal wheelchair budgets locally.

10.10 The Arthritis and Musculoskeletal Alliance (ARMA), supported by NHS England, has launched a new digital knowledge hub to support improvement in musculoskeletal (MSK) and arthritis services. The interactive forum provides commissioners and STP leads with resources, good practice examples and data and research to support them in improving MSK services locally. Resources are aimed at those responsible for shaping services and include evidence and indicators on value, quality and cost of MSK services.

10.11 NHS Improvement and NHS England have published a guide to demonstrate how allied health professionals (AHPs) benefit NHS emergency care by improving patient flow - particularly when they are fully involved in patient flow planning. The guide includes references to discharge planning, admissions avoidance and the Home First initiative, highlighting the role of AHPs in local system working. Bringing the highly trained AHP professional workforce into patient flow planning can improve quality, effectiveness and productivity across care pathways.

10.12 New clinical guidelines on onward referral has been published a year since new measures were introduced into the NHS Standard Contract. To support delivery of new 2017-19 NHS Standard Contract measures, the Academy of Medical Royal Colleges, in collaboration with partners including NHS England, has published new clinical guidelines on onward referral.

10.13 NHS England is launching a free national resource of guidance, case studies, templates and toolkits to support NHS colleagues to plan and deliver high quality public engagement and consultation on major health service changes. The resource bank is available on the futureNHS collaboration platform in the, 'Engagement and communications for sustainability and transformation' workspace.

10.14 At the NHS England public board meeting on 30 November 2017, NHS England and the National Institute for Health Research (NIHR) published a joint statement that committed to 12 actions to support and apply research in the NHS. Between November 2017 and February 2018, NHS England, working with the Department of Health and Social Care, the Health Research Authority and the NIHR launched a public consultation on proposals to better manage excess treatment costs and eliminate delays and further improve commercial clinical research set-up and reporting.

10.15 The rotating paramedic programme, funded by Health Education England, aims to support health and social care systems by maximising the unique skillset and experience of paramedics. The model aims to contribute to the ability of health and social care systems to manage their unscheduled care activity, as well as the opportunity to support winter pressure challenges - its

starting premise is to provide the right response to each 999 call or primary care contact, first time

11. Recommendation

11.1 The Governing Body is asked to note the report.

Meeting in Common of the Boards of NHS England and NHS Improvement

Meeting date: Thursday 24 May

Agenda item: 01

Report by: Ben Dyson, Executive Director of Strategy, NHS Improvement
Emily Lawson, National Director: Transformation & Corporate Operations, NHS England

Report on: **Next steps on aligning the work of NHS England and NHS Improvement**

Progress on delivering joint working between NHS England and NHS Improvement; specifically proposals for:
a) Joint governance and accountability
b) Integrated regional teams and new regional geographies
c) Aligning appropriate national functions
d) Managing change well

Request: The Boards are asked to consider and endorse the proposals

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Introduction

1. The National Health Service is turning 70 on 5 July 2018. Over the last seven decades the NHS has helped transform the health and wellbeing of the nation and in turn has earned the enduring support of the British people. Through a process of continuous evolution and modernisation it has delivered huge medical advances, improvements in population health and innovations in patient care.

2. Now, as the NHS moves into its next decade, local health and care systems across the country are rising to the challenge of a growing and ageing population by collaborating across organisational boundaries to develop more integrated models of care. In line with the vision of the NHS Five Year Forward View, we are seeing a growing movement towards commissioners and providers focusing on population health supported by local system-wide action. This means working together to mobilise community assets and collective capabilities to improve quality of care for individuals, health outcomes for populations, and wise stewardship of taxpayers' resources.

Rationale

3. Faced with that challenge, NHS England and NHS Improvement now need themselves to evolve and adapt, to transform the way we work to provide a single system view that supports and enables integrated care.

4. In March, our Boards agreed ambitious proposals to transform the way we work together to provide more joined-up, effective and comprehensive system leadership to the NHS. This paper sets out our next steps in moving from fragmentation to coherence, to create an operating model that best supports local health systems and the patients and public they serve. This reflects both our organisations' duties to co-operate with each other in the exercise of our functions; to exercise those functions economically, efficiently and effectively; and to facilitate, where beneficial, integrated provision of healthcare services

5. For NHS Improvement, this will represent a shift from regulation to improvement in order to protect and promote the needs of all those who use the NHS over the next period of its history. NHS Improvement will focus more clearly on the areas that will bring greatest value in driving improvement and transformation both for the provider sector and for local health systems – see more detail in Appendix One. This will include a significant change in the senior organisational structure in NHS Improvement to enable it to deliver its refocused purpose.

6. In designing this new approach to joint working, we recognise that the statutory framework established by Parliament assigns NHS England and NHS Improvement (Monitor) some distinctive and non-shareable functions, and that primary legislation implies separate board governance, chairs and CEOs for the two organisations. The statutory framework also establishes distinct functions for clinical commissioning groups (CCGs) and NHS trusts and foundation trusts, which are also reflected in part in the functions of each organisation, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA).

7. That need not, however, stand in the way of enhanced joint working in many areas where the NHS will benefit from our doing so. Specifically, we want to:

    a. Move from a world where local health organisations (trusts, CCGs) sometimes receive different and conflicting messages from the national bodies, to one where – through our integrated regional teams – we have a single conversation with them.

    b. Take a more holistic view of NHS resources across commissioners and providers, both locally and nationally, better aligning financial incentives and architecture for whole-system improvement.

    c. Leverage NHS England's and NHS Improvement's distinctive competencies across both organisations (such as NHS Improvement's work on patient safety and trust procurement efficiencies, and NHS England's on cancer and mental health, on care integration and on pharmaceuticals).

d. Build out capabilities where there has been a gap in national leadership (such as on NHS people management and leadership development).

e. Mobilise national implementation resource for the forthcoming NHS 10 Year Plan.

f. Reduce administrative costs for redeployment into frontline patient care, recognising the differing requirements of this on our separate organisations, and agreeing what this means for our collective resources as we work together more closely.

Transforming the way we work: key proposals

8. Our guiding principle in this work is setting ourselves up to provide effective system leadership to the NHS. This will require us to be agile and adaptive, developing a learning culture that allows us to be flexible to the changing needs of the health and care system. We are now proposing our next set of changes to support this, encompassing all aspects of our current operating models: governance, systems and processes; organisation structures and capabilities; and culture and behaviours.

9. In terms of **governance, systems and processes**:

   a. While respecting the legal need for the NHS England and NHS Improvement Boards separately to oversee their distinctive responsibilities, the Boards will also want to consider over the next several months the extent to which some of NHS England's and NHS Improvement's non-executive led *board committees* might be reshaped and aligned, building on the recent experience of the joint finance advisory committee.

   b. NHS England and NHS Improvement will establish a new *NHS Executive Group*. Co-chaired by the two CEOs, membership will comprise all national directors and regional directors from the two organisations.

   c. A new *NHS Assembly* (provisional title) will be created, drawn from – amongst others – national clinical, patient and staff organisations; the voluntary, community and social enterprise (VCSE) sector; the NHS Arm's Length Bodies (ALBs); and frontline leaders from integrated care systems (ICSs), sustainability and transformation partnerships (STPs), trusts, CCGs and local authorities. It will become the forum where stakeholders discuss and oversee progress on the NHS Five Year Forward View and help co-design the proposed upcoming NHS 10 Year Plan, and will build on the recommendations of NHS England's Empowering People and Communities Task Force.

   d. We will align all our core processes so that both our internal management and our interactions with the system are conducted once, with clear accountabilities at national, regional and system level. This will include establishing a single financial and operational planning process for the health system; a single performance management process and alignment of

regulatory interventions; a single internal talent management process; and a single process for establishing and reviewing national strategic programmes such as mental health. This builds on our already integrated management of IT across the system. And we will establish a single version of the truth in reporting and sharing information about the system.

10. In terms of **organisational structures and capabilities**:

    a. At a regional level, we will create integrated regional teams covering both NHS England and NHS Improvement functions, and led by regional directors with full responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

       The Regional Directors will play a major leadership role in the geographies that they manage, making decisions about how best to support and assure performance within their region, as well as support the development and identity of local STPs and ICSs. This is a move to a different kind of local leadership of the NHS, where Regional Directors promote, encourage and support local systems to achieve more integrated and sustainable models of care. It also means that the locus of decision-making will be centred more on the Regional Directors and their teams, with national teams generally providing support and intervention where agreed with Regional Directors.

       The Regional Directors will report to the two CEOs and be full members of the national NHS Executive Group, with responsibility for developing the overarching strategy and architecture for the NHS as well as translating that into operational plans. Through this, they will help agree where a more standardised model to policy and delivery makes sense to ensure a unified approach, alongside the areas where regional teams should have the authority and discretion to design their own approaches or to implement in a more locally specific way. Appendix Two has more detail.

    b. At a national level we will increasingly align functions across the two organisations, creating a set of new roles to support delivery:

       i. Three national director roles will be created which will report to both CEOs:
          1. A single *NHS Medical Director.*

          2. A single *NHS Nursing Director/Chief Nursing Officer for England.*

          3. A single *Chief Financial Officer* (responsibilities include leadership of the integrated financial and operational planning and performance oversight process).

       ii. Individual national directors in NHS England and NHS Improvement will take on responsibility for a number of ‘do-once’ functions supporting both organisations, with shared governance and oversight. These functions include:

1. National service programmes such as cancer and mental health; implementation of the FYFV and NHS 10 Year Plan, the move to ICSs, digital/tech, and the health/social care interface, led by the *NHS England Deputy CEO* – who will also lead NHS England's distinct responsibilities including commissioning specialised services (£17bn portfolio), primary care, oversight of CSUs, and emergency preparedness, resilience and response (EPRR) *(NHS England).*

2. Strategic programmes such as life sciences, commissioning development, primary care policy, patient choice and personalisation of care, innovation and research, led by the *National Director for Strategy and Innovation (NHS England).*

3. A new strategic approach to configuration of the provider landscape led by the *Chief Provider Strategy Officer (NHS Improvement)*.

4. NHS leadership and NHS people management, led by a new role of *Chief People Officer (NHS Improvement).*

5. System-wide improvements in quality, access and efficiency, led by a new role of *Chief Improvement Officer (NHS Improvement).*

6. A system-wide approach to improving estates, procurement and back-office services, led by a new role of *Chief Commercial Officer (NHS Improvement).*

7. A shared approach to urgent and emergency care and elective care, led by a *National Director for Emergency and Elective Care (NHS Improvement)*.

iii. A single *National Director for Transformation and Corporate Development,* who reports to both CEOs, leading most corporate operations across both organisations, including organisational development – both internally and with respect to system transformation – and people functions.

iv. For other areas of our work, where the nature of the organisation's statutory functions requires, the activity and structure will remain separate and distinct, for instance NHS Improvement's regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch; and NHS England's responsibility for tariff currency development, commissioning of specialised services and primary care, and EPRR.

v. For communications and engagement, each organisation will need its own dedicated resources to support its own distinctive functions, but we are planning further work to align our approach more closely.

vi. For analysis, we propose further work to agree where we need to establish a single team for core areas of analysis to provide 'one version of the truth'; how we develop a shared approach to professional

development across our shared analytical community; and how we develop greater agility and flexibility in deploying our collective analytical skills, knowledge and experience in ways that best support our shared business.

11. We recognise that the proposed governance and structures must operate within constraints of the existing legal framework, including the requirement that, subject to some exceptions, each body's functions must be exercised by its own committees or staff. Specific governance and decision-making arrangements will enable effective and legally compliant joint working, and provision to avoid or manage the actual or potential conflicts which may arise in relation to the exercise of different functions.

12. The net effect of these changes is that the two organisations will increasingly be working in a combined way on a shared set of system priorities, covering most key functions and capabilities:

    a. System strategy: encompassing, amongst other topics, health inequalities reduction, patient choice/personalisation, developing the provider landscape, innovation and research.

    b. Planning and performance: operational and financial planning, performance reporting and intervention.

    c. The move to integrated care systems: a single approach to supporting STPs and ICSs.

    d. Service transformation: single national service transformation programmes, for the Five Year Forward View clinical and service priorities such as mental health, cancer, learning disabilities, maternity and integrated care for older people.

    e. Improvement: a single approach to developing specialist resources that regional teams use with local health systems to deliver continuous improvement in quality, access and efficiency.

    f. NHS leadership and workforce: a single approach to developing senior leadership in the NHS and supporting the NHS in recruiting, retaining, deploying and developing today's NHS workforce.

    g. NHS information and digital technology: a single approach to transforming how the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency.

    h. NHS estates, procurement and back office services: a single approach to helping the NHS manage its estates/facilities, equipment, consumables and corporate services more efficiently and effectively.

Transforming the way we work: Creating a shared culture and managing change well

13. At its heart, this programme of work is about reshaping the culture, mind-sets and ways of working of our two organisations, so that rather than defining ourselves around the traditional boundaries between commissioners and providers, primary and secondary care, or the identity of NHS England or NHS Improvement (including Monitor and TDA), we collectively see our role and purpose as providing system leadership to the NHS.

14. A joint approach to culture and behaviours will be developed with all staff, building on their input about what should be maintained and what needs to change in our current operating styles and our leadership behaviours. We will also work with colleagues across both organisations to redesign core processes, using a continuous improvement methodology, in parallel with the redesign, to ensure what we put in place is both effective and efficient.

15. As part of managing this change well, we will provide support to colleagues through various mechanisms, including:

    a. Ensuring all 'people processes' are fair and transparent, and adhere to our existing organisational policies.

    b. Providing support on how to 'manage through change' to all colleagues who want to participate, including support to develop resilience and manage stress.

    c. Providing additional support to line leaders to ensure they can support and engage their teams effectively through this period of change and beyond.

16. In light of this, we will be launching a joint staff engagement programme, as part of the joint All Staff briefings on 25 May, under the umbrella of '*Project 70.'* This programme of work will enable us to learn from staff across our organisations and ensure that they are involved in the development and implementation of this work. Appendix Three sets out more detail.

Timeline and next steps

17. We will make the changes to the most senior roles (at a minimum, roles reporting to the two CEOs) by September and to the changed roles at the next level during the autumn. We will continue to move quickly so as to minimise the period of uncertainty for colleagues while minimising the risk to the system of a lack of continuity. We are aiming for all changes to be made by the end of this financial year.

18. We will be agile and responsive in our approach to implementation, identifying a clear set of measurable goals so we can measure success. We will also engage regularly with our staff, Trade Unions and system partners, both to involve them

in the detailed design, including the creation of a shared culture and leadership model, and to enable us to learn as we go and course correct where necessary.

Conclusion

19. The Boards are asked to endorse these proposals.

Appendix One

Refocusing NHS Improvement's Purpose and Operating Model

1.1 NHS Improvement has recently completed a major programme of work to identify how to improve organisational purpose and operating model to better drive continuous improvements in the quality and efficiency of the NHS provider sector.

1.2 The conclusions from this work represent a significant change in focus, operating model and senior structures that will need to form an integral part of how we develop and implement the proposed approach to joint working. It has significant implications for how we shape the proposed new functions that will be led by NHS Improvement or hosted by NHS Improvement on behalf of both organisations, particularly our Provider Strategy, People, Improvement and Commercial functions, and for the new integrated regional teams. This will entail significant changes both to the senior executive structure of NHS Improvement and to ways of working, including the style of our relationship with the provider sector.

Key conclusions

1.3 The key conclusions from this work are that NHS Improvement, both through its new partnership with NHS England – including integrated regional teams – and through the distinctive functions that it will in future host or lead, needs to orientate itself more fully towards supporting improvements in quality and efficiency of care, rather than acting primarily as (and being seen primarily as) a regulator.

1.4 By gathering evidence from our staff and from the providers and systems with whom we interact, this work has identified where the greatest sources of value lie in our work to support the provider sector and what this means in terms of our future operating model and senior executive structures. It has also provided valuable insight into the distinctive skills, capabilities and behaviours that will be needed to realise greater benefits for patients and taxpayers.

1.5 Our work identified seven sources of value where NHS Improvement and its national partners could have the greatest impact in supporting the provider sector to drive sustainable improvements in quality of care and efficient use of resources. All of these sources of value are reflected in the proposals set out in the main paper to align the work of NHS Improvement and NHS England. Four of these sources of value map to functions that NHS Improvement will lead or will host on behalf of both organisations:

- **Configuration of the provider landscape.** There is a clear need to be more proactive in shaping the future provider landscape, including organisational models (eg 'group' or 'chain' models for hospitals, mental health services or other services) and service models. Working with NHS England, providers and with local health systems, we need to identify changes that will best support long-term improvements in clinical and

financial sustainability, agree collectively the strategic benefits to be gained from these changes, and better manage the realisation of those intended benefits, supported by a stronger focus on clinical leadership and clinical engagement. Integrated regional teams will in future lead this agenda, supported by national work – led by NHS Improvement's proposed new Provider Strategy function – to distil evidence and best practice.

- **Quality and operational improvement.** We need to streamline and consolidate the way we support both providers and local health systems in driving continuous improvements in quality and efficiency of care. This will include developing the way we work with the most challenged providers to address persistent performance problems (taking into account the context of their wider local health system), more rigorous prioritisation of improvement priorities, and more hands-on support for providers and local health systems. The new integrated regional teams will lead work on improvement in local health systems, supported by a Chief Improvement Officer who will lead national work to develop tools, data, resources and specialist support, building on the existing work of NHS Improvement's current directorates for operational productivity and improvement.

- **NHS workforce and leadership.** While Health Education England (HEE) has a clear national role in the education and training of the future NHS workforce, there are a number of organisations working – without sufficient coordination – to support NHS organisations to recruit, retain and develop today's workforce. Our work identified a clear need to develop a more proactive and coherent approach to supporting leadership development, including talent management and succession planning, and helping the NHS to improve its people management processes. Under the proposals in the main body of the paper, NHS Improvement will host a new directorate, led by a Chief People Officer, working on behalf of both organisations to improve leadership and people management, working closely with Health Education England, NHS Employers and other national partners. This focus on leadership and people management will also be reflected in the design and resourcing of integrated regional teams.

- **NHS estates, equipment and consumables.** A further key source of value is the work we do to support the NHS in using all its physical assets more efficiently and effectively, improving quality of care and unlocking additional resources for patient care. This is already a key part of the NHS Improvement operational productivity. The proposed new Chief Commercial Officer will lead this work on behalf of both organisations, including continuing to increase our support for local health systems in managing their estates on a more system-wide basis to support new models of care and enhance value for money.

1.6 These four sources of value will be at the heart of the work undertaken by the new Provider Strategy, People, Improvement and Commercial directorates in NHS Improvement. The functions currently carried out by NHS Improvement's Regulation Directorate will in future be carried out by Provider Strategy, People, and Improvement, working with integrated regional teams.

1.7 A further key source of value identified through the work is in relation to **NHS information and digital technology**. NHS England and NHS Improvement are already jointly responsible – with DHSC and NHS Digital – for a programme of work to transform the way the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency. Our work identified the need to go further in embedding the importance of the digital agenda in all the work we do with the provider sector, so that it is an integral part of improving quality and efficiency. Under the proposed new joint working arrangements, NHS England will host the national digital programme (which will be led by the Deputy CEO of NHS England), with shared governance and oversight to help mainstream this work in all our engagement with the provider sector.

1.8 The two final sources of value identified from this work go to the heart of the proposals for joint working between the two organisations:

- **Planning and performance review.** The work identified a range of ways to support providers and local health systems in producing credible but realistic plans, allowing more productive and supportive discussions of key risks and the support needed to address them. The work identified significant opportunities to refresh the approach to monitoring and managing performance through a greater focus on understanding what improves performance, joint problem-solving (not simply upwards assurance) and using data and analysis to identify risks at an earlier stage. This work will now feed into a single programme of work between NHS England and NHS Improvement to design our future joint approach to planning and performance, including the interface between regional teams and local health systems (STPs and ICSs), trusts and CCGs.

- **System incentives and financial architecture.** We have identified a number of practical ways of simplifying and rationalising financial flows and incentives, helping us to go further in improving efficiency and quality within provider organisations and at the same time improving value across patient pathways. This will feed into a joint programme of work, led by the new Chief Financial Officer, to design and implement a new approach to managing collective NHS resources and driving value.

Conclusion

1.9 In the absence of the proposed new approach to joint working, NHS Improvement would have wanted in other ways to reflect these key conclusions in its own operating model and organisational structure. The new approach to joint working across NHS England and NHS Improvement makes it easier in some ways to make the necessary changes to our operating model, particularly in relation to financial architecture and performance management. The implementation of these changes will nonetheless require considerable change management and organisational development in relation to the new Provider Strategy, People, Improvement and Commercial functions hosted by NHS Improvement and the transition from current ways of working within NHS Improvement. This will require, in particular, the development of a strong improvement-focused and engaging culture.

Regional Teams

2.1 In March, the Boards agreed a new integrated regional model, with seven integrated regional teams each led by a single Director, working for and reporting into both NHS England and NHS Improvement. Since March, we have been working closely with the current Regional Directors and teams across our two organisations to develop proposals for a new integrated regional operating model, including the core functions that regional teams will be responsible for and the underlying principles that will guide their ways of working.

2.2 The new integrated regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the system. We see the new regional teams as playing a crucial role as 'translators' between the national level and local health and care systems, helping to ensure that all our work is responsive to local system needs.

2.3 As part of moving to joint working, we need to set up the single regions to better support local health systems. NHS England and NHS Improvement are working towards an oversight model that empowers systems to take a shared or leading role in functions that affect their populations. Under this model, STPs and ICSs will relate to a single Regional Director acting on behalf of both NHS England and NHS Improvement. As they develop and mature, we envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements.
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors; making sure they feel engaged in their system.
- Leading on provider transformation including integrated providers and primary care networks.
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed.
- Some commissioning (including current direct commissioning) not performed at national level.

2.4 Regional teams will adopt a differentiated approach as they work with local health systems at different levels of maturity. They will be agile and adaptive in their delivery of the functions outlined below, working to strengthen the leadership, capacity and capability of local systems so that they are able to becoming increasingly self-governed and require less support and oversight from regional teams.

Core functions of regional teams

2.5 We have been working across our current national and regional teams to develop the proposed core functions for the new integrated regional teams, focusing on those areas that will deliver the most value in supporting local health and care systems.

2.6 We propose that the new integrated teams deliver the following core functions:

- **Performance, improvement and intervention** – tracking performance in relation to quality of care, access, efficiency and health outcomes, developing and maintaining capacity and capability for targeted improvement support, managing regulatory interventions and promoting peer support between providers, CCGs, STPs and ICSs.

- **Strategy and system transformation** – development and oversight of STP/ICS transformation strategies, shaping national programmes and leading the regional implementation of agreed national priorities, proactively shaping the provider and commissioner landscape, and prioritising and supporting improvements in service configuration where needed.

- **Commissioning** – commissioning of specialised services, primary care services, prison healthcare, s7a public health services, and oversight of CCGs with delegated responsibility for commissioning primary medical care. There will be a clear separation between the work of these commissioning teams and NHS Improvement's regulatory oversight of those commissioning functions.

- **Operational management** – ensuring the safe and effective day-to-day running of the NHS and providing support in the face of any emerging issues (eg temporary A&E closures, cybersecurity attacks). Working with the Local Resilience Forums to support local emergency preparedness, resilience and response.

- **Finance** – oversight of local system financial planning and performance to a national framework, to manage system control totals that combine commissioning expenditure and the income and expenditure of NHS providers, oversee delivery of cost improvement programmes across local systems, support systems in the design of new payment and risk-sharing methods, and prioritise STP capital proposals.

- **Specific quality responsibilities** – professional leadership for quality improvement programmes, professional leadership for clinical staff, safeguarding, managing clinical senates and networks, the statutory duties discharged by the Medical Director (Controlled Drugs Accountable Officer, Caldicott Guardian, Performers list management), oversight and governance for patient safety and clinical support and review of reconfiguration decisions.

- **Workforce and leadership** – overseeing regional systems of leadership development, talent management and succession planning, identifying pipeline of future leaders for national leadership development, working with HEE to develop robust regional workforce strategies and improvement plans.

- **Information, digital and technology** – development and oversight of system strategies to deliver the national strategy, working with NHS Digital to ensure the robustness of local systems and local implementation programmes for care records and data sharing, and overseeing the development of services to exploit opportunities of new technology.

- **Estates and procurement** – ensuring that systems develop and implement strategies to improve the use of estates and facilities, and the efficiency of procurement and back-office services.

- **Analysis and insight** – processing and analysis of specific data to inform performance and transformation interventions, assurance of local data quality, to enhance the national core data sets.

- **Communications and engagement** – communication, engagement and partnership with regional stakeholders, including local government, MPs and patient groups, alongside relationship management with ALB and government departments where relevant.

- **Corporate functions (including HR)** – utilising and overseeing locally assigned corporate resource dedicated to the region from nationally managed functions.

Principles: interface between national and regional teams

2.7 We propose the following principles to guide the implementation of a new integrated regional operating model, relating in particular to the interaction between regional and national teams and the authority, freedoms and accountabilities of the new Regional Directors.

2.8 Regional teams will:

- Be led by Executive Directors who are part of the senior national leadership team of NHS England and NHS Improvement, together helping to design the right support and intervention for local health systems, ensuring we create maximum value and avoid unnecessary burden.

- Decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group.

- Be responsible for managing all interventions with – or seeking information/assurances from – systems, providers or CCGs, except where

the regional team ask another team to act on their behalf or where the wider national leadership team collectively agree a different approach.

- Treat performance management and improvement as a continuum, not only holding systems, providers and CCGs to account but having the right capacity and capability to help solve them complex problems and access the right improvement support.

- Help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well or where the regional team consider the system, provider or CCG has a cogent alternative approach to making performance improvements.

- Have access to all relevant data and analysis about their region, easily accessible at the right time to inform local decisions.

- Are trusted to manage their resources in a way that meets the needs of their region, subject to organisational designs and policies that are agreed collectively by the senior national leadership team.

- Be held to account for the responsibilities delegated to them.

Regional geographies

2.9 In March, based on learning from our existing regional model and the complexity of supporting systems across large geographies, the Boards agreed that we should have seven regional teams, by splitting the North and Midlands and East regions into two. Working with the Regional Directors in the North and Midlands and East, and using detailed analysis of regional populations, patient flows and performance, we developed proposals for the new regional geographies to test with staff, trade unions and local health and care systems:

Initial proposals

2.10 For the North, this was:

- **North West**: Lancashire and South Cumbria; Greater Manchester; and Cheshire and Merseyside.

- **North East and Yorkshire**: Cumbria and the North East; West Yorkshire; Humber, Coast and Vale; and South Yorkshire and Bassetlaw.

2.11 For Midlands and East region, this was:

- **Midlands**: Staffordshire; Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; and Herefordshire and Worcestershire.

- **Central and East of England**: Northamptonshire; Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.

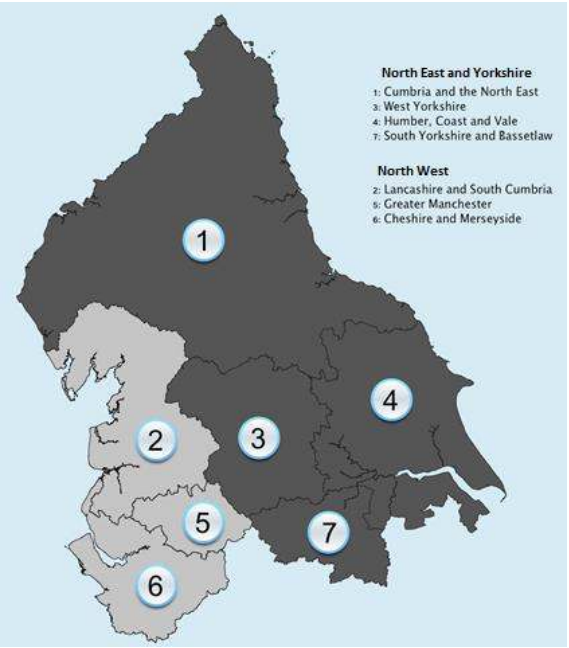
System engagement

2.12 To ensure the most appropriate decision could be made for local systems, we then engaged with our trade unions, NHS England and NHS Improvement staff, system leaders in both regions – including CCG Accountable Officers, STP leaders, Trust Chief Executives and Chairs and the Local Government Association.

2.13 We received 69 responses to our joint letters, 28% from individuals in the North region and 72% from those in the Midlands and East region. Of these, the large majority supported the split proposed for the North region, whilst concerns were raised about the Midlands and East proposal. It appears that this would significantly impact Northamptonshire's patient flows with Leicester and Warwickshire, especially direct commissioning of primary care and public health.

Revised proposals

2.14 Based on the feedback, we now would like to propose to the Boards that the North be split as initially proposed – North West; and North East and Yorkshire.

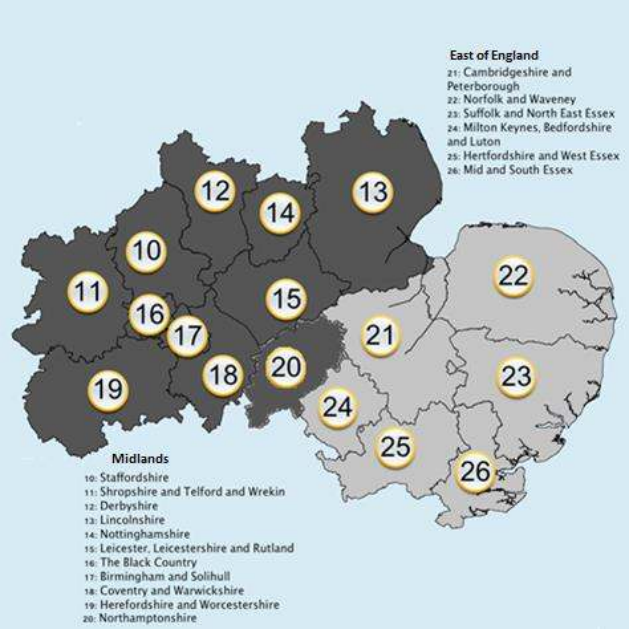


2.15 Taking into account feedback from staff and system partners, for the Midlands and East, we propose that Northamptonshire should become part of the Midlands.

2.16 This would mean that the regions would split into:

- **Midlands**: Staffordshire, Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; Herefordshire and Worcestershire, and Northamptonshire.

- **East of England**: Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.



2.17 These proposals are supported by system leaders in the two regions.

Appendix Three

Creating a shared culture

3.1 Staff have generally welcomed the direction of travel to transform how we work together, to improve the coherence and impact of our collective system leadership role. We know that working with staff to shape the implementation of these changes and agree which ways of working we want to leave behind and which we want to take forwards will be crucial to success. We are also conscious that uncertainty can be unsettling for us all and we need to take care to engage and support our staff through this process. In light of this, both organisations are committed to managing this transition well in ways that best support our staff and realise the intended benefits.

3.2 Across our two organisations, there is a wealth of knowledge on how to manage change using lessons learned from previous change programmes. We have started a dialogue with staff to hear about their experiences and ideas of how to manage this joint change programme well. In addition, we have also held a very productive initial session with both Executive teams, Chairs and Deputy Chairs, focused on agreeing what our shared change approach might look like in light of lessons learned from previous examples of leading change, both within the NHS and other sectors.

3.3 We have identified the following characteristics as key to success, and will build these into our shared change approach:

- **Clear vision and goals** – having a clear purpose and narrative of what we are trying to achieve and why, alongside a focused plan of how to get there.

- **Honesty and clarity** – communicating clearly with staff, through a frequent dialogue about what we want to achieve and how we can work together to get there. Being honest and authentic about uncertainty and sensitive to the personal impacts of change.

- **Strong leadership and transparency** – ensuring leaders at all levels authentically model the importance of this change programme and the related mind-sets, culture and ways of working. Being proactive about training leaders within our organisations to lead this programme through a network of ambassadors, with authority to identify problems and find solutions.

- **A well-managed and resourced process** – a well-resourced and well-led programme and process, with the necessary speed and agility to enable pace and the ability to course correct.

- **Stamina and perseverance** – ensuring the necessary resilience and stamina across the two organisations to ensure that lasting changes are made to culture, mind-sets and behaviours to fully transform the ways we work.

'Project 70' – our engagement and organisational development approach

3.4 On 25 May, at our two all-staff briefings, we will launch the new operating model with colleagues. This approach, called 'Project 70' will facilitate a cross-organisation dialogue with staff, about how we should transform our ways of working to provide effective system leadership for the NHS as it heads into its next 70 years. We will also be asking staff their reflections on lessons learned from previous change programmes and their views on the key success factors to get this process right. To prepare for this, we have already started to pilot a series of structured conversations across our two organisations, and staff have welcomed the chance to share honest views and shape our future ways of working.

3.5 Colleagues from our joint working programme will bring both communications and engagement and organisational development expertise to deliver 'Project 70', and we will source additional resource if required to deliver this engagement approach at the necessary scale. We see this engagement approach as a crucial part of enabling a frequent and frank dialogue with our staff, whilst also helping us to identify the building blocks of that shared culture and way of working that we want to build.

Resourcing and managing change

3.6 We have mobilised a joint programme team to support the implementation of this change programme. The team, reporting jointly to Emily Lawson and Ben Dyson, is operating as a joint resource across both organisations to coordinate the overall operating model design work alongside key enablers such as HR processes and organisational development activities. A snapshot of key activities is provided below:

- **Supporting teams through change**. Alongside implementation of our change policies and HR processes, we will be providing a bespoke offer of career transition support to teams and individuals affected by change. There will also be a broader offer of support to equip all line-managers with the resources they need to support their teams and ensure their own personal resilience.

- **Leadership and culture change**. We are developing a joint set of leadership capabilities, working with staff across both organisations to co-create a leadership model and culture fit for the future. This will be followed by development sessions for all staff, focused on:
  - equipping staff to live the new leadership model
  - equipping staff to take responsibility for improving their area of work
  - supporting staff to build resilience and adaptability so that they can deliver their best work even through periods of uncertainty and change.

- **Developing effective team working capability**. We are developing a programme of work to support the development of new joint teams and inter-team working across both organisations and with our system partners.

- **Ensuring that the right enablers are in place**. We are working to ensure that the right enablers, including the use of IT and Estates, our internal finance and budgeting processes are in place to support this transition.

- **Engaging system partners and the public.** In addition to engaging with staff, we are working closely to jointly engage our Trade Union partners at key points within this process. We will be developing a broader external engagement strategy to engage more fully with the public, patients, local systems and ALB partners through the next phase of this work.

NHS
Vale of York
Clinical Commissioning Group

Patient and Public Participation

Annual Report 2017-18

Contents

Foreword

By the Accountable Officer and the Lay Chair of the Quality and Patient Experience Committee

The engagement and involvement of patients, partners and other stakeholders are key to the commissioning of services in the Vale of York. The CCG puts quality and safety of patients at the heart of its work, with the commissioning of services informed by local need and influenced by the engagement and involvement of the community through open and honest conversations with patients, service users, our partners and other stakeholders.

In 2017-18 we created a range of engagement and involvement opportunities to gather the views of patients, service users and other stakeholders. The feedback received through our series of 'Big Conversations' events was rich in personal experience and helped to shape the coming year's plans and improvement programmes.

We launched our Commissioning Intentions in February 2018. One of the most positive features of the commissioning intentions is that they reflect the issues that the local community highlighted at our series of engagement events. These plans, alongside our important work with partners to strategically develop and deliver services in joined-up, integrated ways will help to manage the risks around delivering the local system's financial, performance and quality improvement. We aim to achieve this through the transformation of acute services, the strengthening of our primary care provision and the development of mental health services – all of which were highlighted by local patients and the public as being important to them.

Knowing what is important to the community at the planning stages has proved essential and helps with our work to develop a safer and stronger community, supporting key prevention and behaviour change initiatives that can ultimately reduce demand on more expensive interventions.

Stakeholder views also make a meaningful contribution in helping to shape services and to achieve the best possible outcomes and we will continue to ensure that wide and collective patient and public participation is embedded in the commissioning and improvement of local services.

We continue into 2018-19 with our call to the local community to be involved and tell us what is important to them about local health and care services. This document is a summary of our work and successes in the last 12 months.

Phil Mettam
Accountable Officer

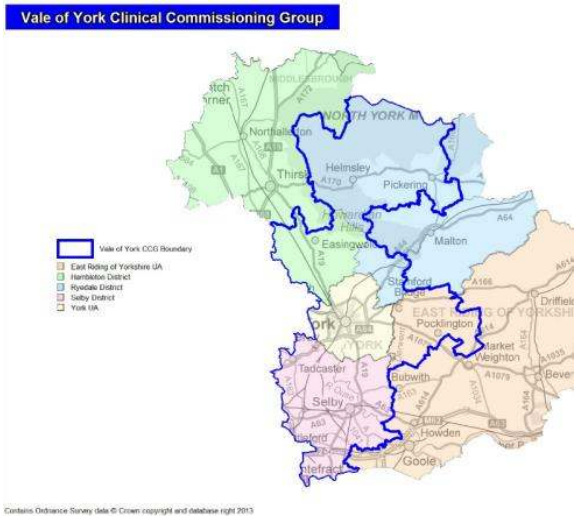
Keith Ramsay
Lay Chair of the Quality and Patient Experience Committee

1. The context: The CCG and what it does

1.1. NHS Vale of York Clinical Commissioning Group (CCG) is an NHS organisation. It is led by local GPs and other clinicians that treat patients every day and understand the needs of the community and the impact that local services have on patients' health. It is responsible for commissioning the following healthcare services in the Vale of York:

- planned hospital care
- urgent and emergency care
- community health services
- mental health and learning disability services
- services that tackle inequality, including children's health and wellbeing

1.1.1 The CCG services towns and cities including York, Selby, Easingwold, Tadcaster and Pocklington and has a population of over 350,000 people. It's vision is to achieve the best in health and wellbeing for everyone in our commmunity and it works closely with a range of partners to achieve its goal.



1.1.2 In 2017-18, the CCG had 26 member practices in its operating area and an annual commissioning budget of £455.1m. The budget is set by central government and is based upon a complex funding formula that reflects the overall health and wellbeing of the Vale of York community.

2. CCG structure

2.1. The CCG is accountable to its Governing Body, its member practices, local patients and the Vale of York community. It is overseen by NHS England, a public body that is part of the Department of Health. It engages with its public formally and informally. Public engagement and patient experience is formally reported through the Quality and Patient Experience Committee (QPEC) that meets every two months.

3. The duty to engage

3.1. The Health and Social Care Act 2012 (section 14Z2) sets out the legal duty for the CCG to involve the public in the commissioning of services for NHS patients, and in the decisions about services that will be provided to them.

3.2. As part of its statutory duty the CCG is required to implement a number of key engagement activities. However, it commits to going above and beyond the minimum requirements to ensure that patients' needs are at the heart of everything it does.

4. The CCG's engagement principles

4.1. The CCG has a set of engagement principles based on its core values. As part of this it strives to:

- Hold open, clear informed and collaborative conversations
- Ensure engagement is core to planning, prioritising and commissioning activities
- Develop innovative and interactive approaches to holding engagement conversations
- Seek and listen to views of partners, patients, carers and local citizens
- Be honest and transparent in offering opportunities and discussing constraints and challenges to the delivery of services.

5. NHS Vale of York CCG Constitution

5.1. The NHS is founded on a common set of principles and values. The CCG's Constitution sets out the rights and responsibilities of patients, the public and staff along with the plans it has committed to achieve.

5.2. The Constitution is one of the CCG's pillars of governance. It describes the arrangements in place to discharge its statutory duties and functions and includes the relationships between the Council of Representatives, the Governing Body and the organisation's core management processes.

5.3. Within the Constitution, there is specific reference to how the CCG must make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements.

6. Engagement strategy and action plan

6.1. The CCG's engagement strategy 'Involving Local Communities 2016-19' sets out its intentions for ways in which it aims to involve stakeholders and the local population. Engagement plays a vital role in achieving the local, strategic initiatives and delivering the best health and wellbeing within the resources available.

6.2. As part of its engagement work the CCG has created an engagement work plan to ensure that it carries out what is set out in the strategy. This work plan was approved at the February 2017 Quality and Patient Experience Committee and at the May 2017 Governing Body.

7. How the CCG engages and involves its population

7.1. The engagement and involvement of patients, partners and other stakeholders is intrinsic to the commissioning and procurement of services. The CCG works closely with its communities to ensure services that are commissioned on their behalf best meet the needs of our Vale of York population.

7.2. The CCG created a range of engagement and involvement opportunities to gather views. The information received is always rich in personal experience and helps to shape commissioning decisions, service specifications and improvement programmes.

7.3. The CCG believes that involvement is not just the role of an individual, or one team; but the responsibility of everyone in the organisation. It already uses a variety of mechanisms to involve the local population and gather feedback, including:

- Focus groups
- Informal discussions
- Formal consultations
- Public meetings
- Regular stakeholder newsletters
- Social media
- Surveys
- Meetings with voluntary groups

7.4. The CCG's website, newsletters and Twitter are key communications channels. It has over 5,000 followers on Twitter and followers include key stakeholders such as providers, partners, local MPs, councils and voluntary sector partners as well as members of the public.

8. Listening to the Vale of York population

8.1. This year the CCG has focused its attention on the needs of the local population by holding a series of "Big Conversations" with those living in the Vale of York area around healthcare priorities. During 2017 the CCG asked people: "What is important to you about local healthcare services?"

8.2. Over the course of 2017-18 the CCG held and attended over 100 events and forums and talked to over 1,200 people. The events focused on enabling the local community to share their views on how we can work together to ensure a sustainable health and social care system. They ranged from public events with the Accountable Officer and clinical leads, to working with the voluntary sector and local Healthwatch teams, as well as hosting library, market stall and student drop-in sessions to ensure as wide a range of views as possible were captured. Thank

you to all those who took part!

8.3. In particular, between July and October 2017 the CCG held over 40 face-to-face events specifically as part of its 'Big Conversations'. These sessions specifically focused on the current financial challenges and asked the population what their priorities for healthcare would be. The system spends more on health than it can afford and as a result the local health and care system needs to work in new ways to help improve outcomes and achieve value for money. It was important for the local population to have the opportunity to have their say about the future delivery of health and care in the Vale of York.

8.4. The focus of the engagement was around six 'Big Conversation' public events in Easingwold, Helmsley, New Earswick, Selby, York - West Offices and York - Priory Street. Two sessions were held in the afternoon, and four in the evening to allow a variety of availability for people to attend. A presentation and discussion format was adopted.

8.5. In addition to the public meetings, the CCG also went out into the community to help capture views from a range of our population**.**

8.5.1 Market stalls - Two sessions. Drop-in sessions were held at market days in Pocklington and Selby, where CCG staff and Healthwatch volunteers talked to members of the public to gather views on local health services and their thoughts on the financial challenge.

8.5.2 Library stalls - Thirteen sessions. The CCG collaborated with York Explore and North Yorkshire libraries to hold a number of drop-in stalls at local sites across York and North Yorkshire. These included Bishopthorpe, Copmanthorpe, Dunnington, Fulford, Haxby, Huntingdon, New Earswick, Pickering, Poppleton, Sherburn in Elmet, Strensall, Tang Hall and York Central.

8.5.3 Patient Participation Groups. Several GP practices have Patient Participation Groups (PPGs) that meet on a regular basis to discuss primary care based health and care and how improvements can be made for the benefit of patients and the practice. The CCG has attended and presented at PPGs across the Vale of York. Twelve of the sessions we specifically focused on priorities and the financial challenge.

8.5.4 Forums - Seven sessions The CCG presented at several voluntary sector forums and groups including the Learning Difficulty Forum, Voluntary Sector Forum, the Carers' Advisory Group in East Riding and York and the local Ageing Well and Mental Health Forums.

8.5.5 Student events - During September, the CCG teamed up with local university, York St. John, and York College to ask students and young people about what was important to them when accessing healthcare. Information stalls and a session

about health at the Student Experience Zone were engagement methods used at these events.

9 Commissioning on behalf of the community

9.1 The feedback and comments collated from events throughout 2017-18 have provided the foundations for the CCG's Commissioning Intentions – the organisation's strategic direction over the next two years. Listening to the population's views and experiences – including the need to improve access to GPs, calls to place more focus on mental health and provide more joined-up services, along with the requests for information and support to help people to stay healthy and well have been reflected in CCG's future priorities.

9.2 Collecting these views at the draft planning stage has proved essential and this will help to develop:

- a safer and stronger community
- support key prevention and behaviour change initiatives and
- reduce the demand on expensive healthcare interventions.

9.3 The feedback collated from these events has proved vital in the development of our commissioning intentions for 2018/19. A two-page summary of the Commissioning Intentions is also available.

10 Working with stakeholders and partners

10.1 Working in partnership with health colleagues, local government, voluntary organisations and the wider community is vital for helping to achieve best outcomes for the Vale of York population.

10.2 We work closely with our voluntary sector representatives to ensure that as many groups as possible are represented in our work with our patients and the public. The CCG could not engage with and care for its population without the continued support of the community and voluntary sector partners. Thank you also goes to the organisations that supported the most vulnerable members of the local population to be involved.

10.3 An extensive list of stakeholders and a proactive approach to networking ensures the CCG provides up to date information on its work and enables their involvement. The CCG regularly attends a wide range voluntary sector forums, assemblies and events.

10.4 Close partnerships with Healthwatch York, Healthwatch East Riding of Yorkshire and Healthwatch North Yorkshire as well as local voluntary and third sector organisations and working with them on projects and having these present at meetings and committees to mutually share news and information is also a very important part of the CCG's work

10.5 The CCG also plays an active role in formally approved forums and channels where patients and members of the public are represented, involved and informed, including:

- Attendance of voluntary and patient groups at committee meetings – such as the Maternity Services Liaison Committee (MSLC), the Quality and Patient Experience committee (QPEC) and the local Wheelchair and community equipment service user group.
- Quarterly meetings between the CCG's Accountable Officer and MPs with constituencies in the Vale of York to discuss citizens' needs.
- Regular attendance at Practice Patient Participation Groups (PPGs) where volunteer patients, practice management and GPs meet on a regular basis to discuss the primary care based services and the opportunities for improvement to benefit patients and the practice.
- Updates on the 'Get involved' section of the CCG's website to highlight areas where patients and the public can become involved in the work of the CCG.

10.6 Bi-monthly Governing Body meetings are held in public and advertised via the CCG's website, media releases, newsletters and social media channels. Members of the public are able to attend and written questions can be submitted in advance. These are addressed in the first part of the Governing Body meeting.

10.7 Every year the CCG holds an Annual General Meeting (AGM) where it presents its Annual Report and Accounts. The event is advertised to the public. Previous AGM events have included a market place of information stall holders. Local organisations that took part were also invited to chat with the Governing Body and the CCG's Clinical Leads.

10.8 The CCG's staff regularly attend and get involved in many of the above activities.

11 Providing quality assurance and listening to patient feedback

11.1 Under the organisation's statutory duty to secure continuous improvement within the services it commissions, and as part of its work to pursue assurance of safety and quality, the CCG has a Quality Assurance Strategy. This is built upon the recommendations of reports by Francis, Keogh, Berwick and others, defining the CCG's vision for 'quality' and how the CCG will assure itself, and its stakeholders, that people within the local community will receive high quality care.

11.2 Quality is everyone's business and the CCG is committed to working with partners across the system to ensure the best possible outcomes and experience for patients and their carers and families. The CCG is committed to openness and transparency when developing or assuring services and seek to hear the voice of the local population and the impact of its decisions on people.

11.3 Engagement activities are just one way the CCG establishes what the local population's opinion about local services. It also collates feedback through a range of other methods including national surveys, such as the Friends and Family Test and GP Patient Survey; local patient feedback surveys such as Care Opinion and information provided through complaints and incidents. These are reported through the Quality and Patient Experience Committee that meets bi-monthly.

12 The CCG's commitment to equality, diversity and health inequalities

12.1 The CCG remains committed to addressing health inequalities in the Vale of York and it understands that some groups of people, including people with Protected Characteristics experience different access and outcomes when they use NHS services.

Characteristic	Protection for
Age	A person belonging to a particular age or age group. People of different ages including children, younger and older people.
Disability	People who have a disability or a physical or mental impairment and it has substantial and long term adverse effect on an individual's ability to carry out normal daily living activities.
Gender reassignment	People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other physical attributes of sex.
Marriage and civil partnership	People who are married or in a civil partnership.
Pregnancy and maternity	Women who are having or have recently had a baby.
Race	People characterised by shared ethnicity, colour, nationality (including citizenship) ethnic or national origins.
Religion or belief	People with or without a religion or belief.

Sex	Men and women.
Sexual orientation	People whose sexual orientation is towards people of the same sex as themselves (gay or lesbian); people of the opposite sex (heterosexual); or people of both sexes (bisexual).

12.2 A toolkit has been developed to assist staff that play a lead role in engagement to help them to define and scope involvement activities around the CCG's commissioning and improvement work. This process includes stakeholder mapping processes, guidance for completing equality impact assessments and templates to establish the appropriate application of the legal Duty to Involve.

12.3 The CCG takes a holistic approach to reducing health inequalities by:

- considering the impact on health inequalities in every decision it makes and every policy it delivers;
- allocating resources to where they are needed most;
- working in an integrated way for individuals and communities who suffer poorer health outcomes;
- working with individuals/communities to develop community based solutions to improving the health and wellbeing of the local population.

12.4 More information can be found in our Equality, Diversity and Human Rights Strategy (see document pages 235 – 244).

13 NHS Vale of York CCG in numbers 2017-18

Events	
Events attended	100+
Patient participation groups	20
Voluntary sector forums	7
Libraries stalls	13

Twitter	
Tweets sent	1,335
Number of followers	5,438
New followers on 2018/18	501
Retweets and likes	2,940

Website and media	
Total users	24,793
Total user sessions	48,285
Page views	120,428
Media releases	59

14 Highlights – a year in brief

A few key moments from conversations with the community during 2017-18:

April 2017	The CCG enjoyed meeting with Healthwatch and local carers organisation to find out what matters to them, listening to their feedback at their regular sessions. The CCG also surveyed patients and the public about their experience of using non-emergency transport. This was used to help inform the service specification and procurement of a new medical non-emergency transport service.
May 2017	The CCG met patient representatives and practice staff at Milfield, Tollerton and Pickering PPGs to find out more about patient experience and the pressures within primary care. The engagement action plan was launched at the Governing Body meeting on 4 May 2017.
June 2017	The CCG supported Carers Week attending events in York and promoting information through its staff engagement channels. Stakeholders, voluntary sector and the public joined the CCG for an interactive session on tackling the issues of health language and communications. The Wheelchair and Community Equipment Service user group met with providers to share feedback from those using services. The CCG's Chief Nurse and one of the Joint Medical Directors presented to 40 residents of Pocklington about commissioning and current health topics.
July 2017	The series of Big Conversations was launched. Hosting 40 events over between July and October, the CCG visited communities in areas such as Easingwold, Selby, New Earswick, Helmsley and York to talk with them and gather views.. The Student Health Needs Assessment (SHNA) report was presented at the York Health and Wellbeing Board, following conversations and

	feedback from over 1,800 students within York. The SHNA was commissioned following recognition that students form a significant proportion (around 15%) of the York population and have a specific set of health needs, with a particular focus on mental health concerns of York students.
August 2017	The CCG continued to tour around the Vale of York patch as part of the 'Big Conversations' to listen to the views of the local population. This month the CCG also visited libraries and market stalls to ask local communities for their thoughts on local health services.
September 2017	During September the CCG attended a number of events hosted by York St. John University and York College to talk to students about how the younger generation accesses health care and what they do if they were unwell. Work began with members of the local community with attendance at a learning disabilities forum to learn more about overcoming barriers that may be associated with accessing GP services and cervical screening. The CCG held its Annual General Meeting to present the Annual Report and Accounts 2016-17. Stakeholders and voluntary organisations were invited to have a stall at the event and chat with local GPs.
October 2017	Filming of the CCG's first patient story began and patient stories became a standing item at the beginning of each Quality and Patient Experience Committee. The CCG met with staff and members of the public at the Pickering and Sherburn's one-stop-shop library service.
November 2017	Attendance at Haxby and Millfield surgery Patient Participation Groups this month allowed the CCG to capture feedback about GP services. The PPG received a presentation on the financial position of the CCG and information about its transformation policies.

	The CCG began a formal consultation around the prescribing of Gluten Free Foods. Members of the CCG attended the St Leonard's Hospice 'Vision Board Development Day, and give a presentation on 'Palliative and End of Life Care – Commissioning Vision and Strategy', opening up discussions around collaborative working.
December 2017	The first patient story of a parent carer was shown and was well received at the Quality and Patient Experience Committee. The 'Stay Well This Winter' campaign was launched. Created by engaging with partners and the voluntary sector the series of videos are designed to help people in the Vale of York self-treat common illnesses such as cold and flu at home.
January 2018	Dr Kev Smith (Executive Director for Primary Care and Population Health) updated the York Healthwatch Assembly about the CCG's priorities and commissioning intentions. The focus was how the CCG can help people to support themselves and delivering services that meet the needs of the Vale of York population. The City of York Youth Council and the Children in Care Council (CiCC) met with one of the CCG's mental health commissioners. Discussion included the Child and Adolescent Mental Health Services' (CAMHS) Local Transformation Plan and capturing the voices and priorities for mental health from young people.
February 2018	The CCG launches its Commissioning Intentions that were shaped and built upon conversations with local communities. The 2018-19 priorities reflect the views of local people who attended the CCG's series of 'Big Conversation' engagement events. Topics including cancer, dementia, mental health, health prevention and education and access to primary care services were identified by participants and remain a focus for the year ahead. The CCG also visited several care homes and forums to speak to staff and residents about what matters most to them. These important

	conversations fed into the care homes strategy and have ensured that the focus is on person-centred care and quality.
March 2018	Improving access to GP services survey was launched. The CCG asked the Vale of York population to complete a short survey to help shape how this additional service is delivered events at train stations, colleges and with partners made it possible to capture thoughts and feedback from a wide selection of the local population around the introduction of weekend and evening appointments.

15 Getting out and about with the community

15.1 The CCG aims to listen to the local population and ensure that it makes the most of the patient feedback it receives and use it to improve local services. In addition to the 'Big Conversations' the CCG has worked closely with its communities and local vulnerable people on a number of projects. Below is a selection of the actions that the CCG has undertaken as a result of listening to what local people have said. A selection of these projects has been chosen below.

15.1.1 Working with learning disability partners

In September 2017 GPs and nurses from the Quality and Nursing Team attended a local forum to discuss the potential barriers of attending health screening appointments and accessing primary health care services. Discussions highlighted that the length of a GP appointment was not always long enough to communicate issues. It also raised the need for more accessible information for patients and health professionals, and the requirement for easy read invitation to screening letters to encourage uptake.

15.1.2 In response to the feedback the CCG worked on action plan to address potential barriers and updates and feedback was provided at the York LD forum in December 2017 and to a local advocacy group member in January 2018. Some of the key areas include:

- Design of a template for a patient to complete prior to seeing their GP or nurse. This included a list of concerns, accompanied by an easy read body map and visual pain score.
- Work on a central repository for links to easy read leaflets, patient information and guidance for health professionals.
- A survey to establish baseline figures across primary care to determine current cancer screening uptake for patients with a learning disability.
- Improving communications with primary care and raising awareness of LD support available for healthcare professionals.

15.2 Patient stories at committee meetings - As part of the CCG's commitment to ensure the voices of patients, service users, carers and the public are heard the CCG began to collect and present patient stories in 2017-18 and this is now a regular item on the Quality and Patient Experience Committee agenda.

15.2.2 A patient story is an account of an individual's experience of health or care and enables the CCG and service providers to have a better understanding of the impact from the individual's perspective. Patient stories help to bring experience to life and help the CCG to focus on the person rather than clinical conditions or

patient outcomes.

15.2.3 Patient stories are presented at the beginning of each Quality and Patient Experience Committee and either spoken in person, shown via video or read out on behalf of the individual involved. Committee discussions that immediately follow stories are used to foster a culture of learning from experience and to influence policy direction and service improvements.

15.3 Care home engagement - the CCG is working with its Partners in Care members to promote quality and improve joint working between the NHS and the care home sector. Regular Partners in Care meetings take place bi-monthly. Care home managers and staff, facilitated by the CCG, share experiences and best-practice and receive updates. The forums are well attended and provide the space for information sharing and bringing stakeholders together to discuss delivering high quality care to residents. Examples of key themes that have been discussed over the year include the introduction of a Care Home Bed State Tool to identify the number of beds that are available within the Vale of York, recognition of deteriorating residents, pressure ulcer identification and training, celebrating successes and reducing falls and risks through safety huddles. More than 40 Partners in Care members attend the meetings where they focus on quality and patient care and have the opportunity to network and share best practice. .

15.3.1 Focused engagement events with care home staff and residents have also taken place and the outcomes of these have fed into the care homes work and strategy throughout 2018.

15.3.2 In February 2018 the CCG visited William Wilberforce Residential Home in Pocklington to talk to staff and residents about what matters most to them. Strong themes around person-centred compassionate care, leadership and supporting staff to do their job well were captured at the event.

15.4 Working with children in care - During 2017-18 the CCG's Safeguarding Leads made it possible to engage with children in care to better understand their perspective and perceptions of healthcare services. The Designated Nurse for Safeguarding, on behalf of the CCG, worked with children in care in the City of York to develop resources that support children, young people and their carers understanding of how statutory health assessments can be.

15.4.1 The CCG's Nurse Consultant for Primary Care also spent time with young people in care to gain a greater understanding of what they need from local GP services. Feedback from the sessions was shared as part of GP and primary care staff safeguarding training. It was also used to raise general awareness of the particular health needs of children and young people in care. The response from primary care has been has been very positive.

15.5 Working with carers groups - Following a number of meetings with carers groups, it was suggested that the CCG could help increase awareness of carers within GP practices. The CCG has worked with a local Carer's Centre to provide free training to GP practice based healthcare professionals to help raise awareness of identifying and supporting unpaid carers. Four training sessions took place in 2017-18 and provide the opportunity for professionals to learn more about the support available for unpaid carers across the city.

16. Supporting our staff with engagement

16.1 To ensure that engagement is embedded throughout its work, the CCG launched an internal engagement toolkit to support a more consistent delivery of engagement activities across the organisation. This toolkit helps staff leading on engagement to define and scope involvement activities.

16.2 The CCG also publishes weekly communication and engagement newsletter containing information on future events, feedback from our population and links to useful articles, documents and videos about patient and public participation.

16.3 Opportunities to attend and help at engagement events are also offered by to CCG staff. To date more than 30 people have participated in engagement activities

17. CCG consultations

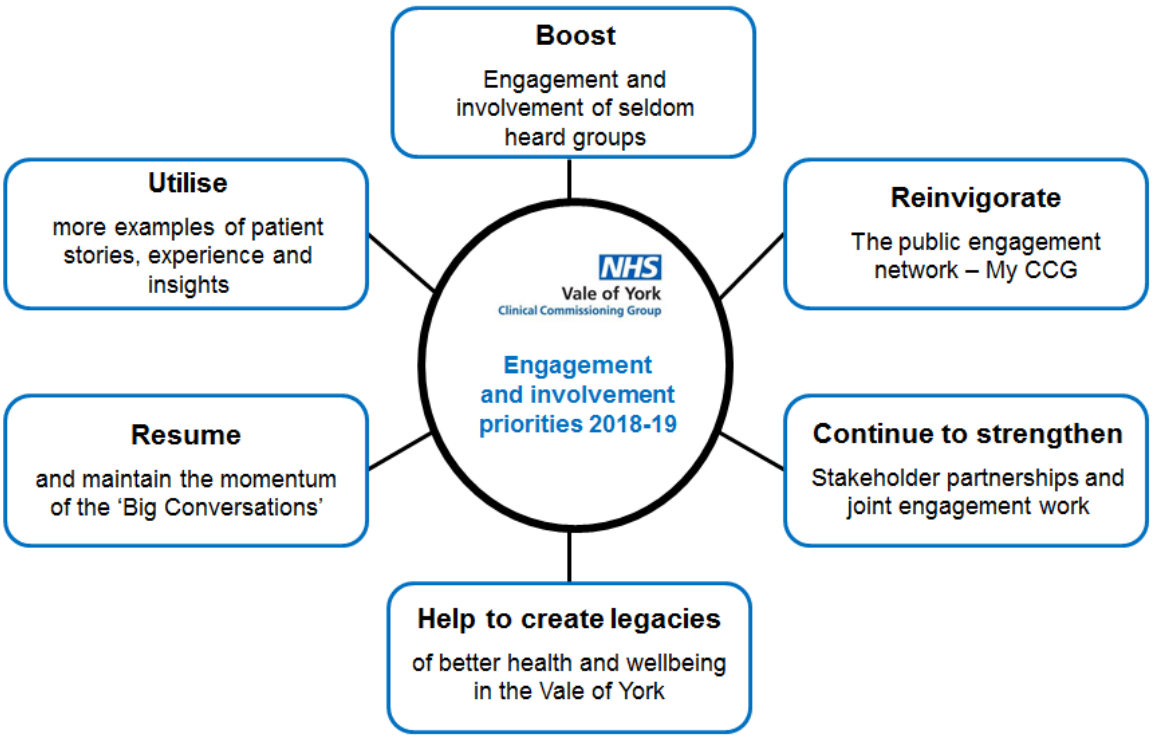
17.1 The CCG actively encourages patients, residents and community organisations to take part and contribute to its work. Taking part in consultations and public engagement exercises is an important way for the local community to give feedback on issues that may affect them.

17.2 In 2017-18 the CCG asked for formal feedback on several areas of its work. These included:

- Gluten Free Foods prescribing
- Improving access to General Practice through evening and weekend appointments
- Non-emergency transport services
- Perinatal mental health services

18. The next steps

18.1 Building on the engagement strategy and engagement action plan the CCG will continue to involve its patients, service users, partners and the wider community in its work. The priorities for 2018-19 are listed below and are described in the following diagram.



18.1.2 Close partnership working with stakeholders - Continuing to work in partnership with key partners such as Healthwatch, patient participation group (PPGs) and voluntary organisations and identify how the CCG uses their experience and networks to involve patients and the public.

18.1.3 Conversations with our population about our new strategy - The CCG will ask the local community and key stakeholders to inform the new patient and public engagement strategy for 2020.

18.1.4 NHS Vale of York CCG engagement network - We will look to further grow the CCG patient network – a group which supports patients and the public to learn about healthcare in the Vale of York community, feeds into CCG priorities and quality improvement and takes key messages back into its communities.

18.1.5 Identification of groups who are 'seldom heard' and ensuring that they have the opportunity to be involved - The CCG will establish the methods that communities and groups prefer to be involved. It will further explore new communication methods – e.g. SMS text messaging and aim to produce more materials in alternative formats.

18.1.6 Patient experience and insights - The CCG endeavours to continue to develop a system to record patient experiences and insights to provide feedback to CCG. It aims to improve on how it listens, reviews, and acts upon patient feedback. It will continue to capture patient stories and ensure that they are incorporated into meetings, briefings and events to put the patient at the heart of everything it does.

18.1.7 NHS 70 - The NHS is turning 70 on 5 July 2018. Across the country there will be celebrations And the CCG will work with its partners, service users, patients and the wider public to create a series of local celebrations that help to raise awareness of the CCG's priorities of preventative measures to improve health, self-care methods to stay well, the importance of tackling loneliness and isolation whilst it showcases an innovative and sustainable NHS.

Item Number: 6

Name of Presenter: Abigail Combes

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Risk Update Report

Purpose of Report
To Receive

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

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

All risks were reviewed by the relevant lead w/c 25 June 2018.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☒Legal
☒Primary Care
☒Equalities

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

Emerging Risks (not yet on Covalent)

No emerging risks are noted this month.

Recommendations
The Governing Body is requested to: • review risks arising and to consider risk appetite for events and high scoring risks.

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

Events Report

NHS Vale of York Clinical Commissioning Group

CCG REGISTER OF NEW EVENTS

Code & Title	Description	Potential Effect	Operational Lead	Lead Director	Latest Note	Note Last Updated	Impact	Status	Trend
JC.29 Changes to services offered by The Retreat	The Retreat recently advised stakeholders of changes to the services it offers which will significantly reduce the inpatient bed base.	Patient experience compromised and financial burden on CCG	Jenny Brandom; Paul Howatson	Executive Director Transformation	The CCG continues to work with The Retreat regarding their plans to change their service delivery model and impact on clients funded by the CCG.	14 June 2018	4		

CCG REGISTER OF ON-GOING EVENTS

Code & Title	Description	Potential Effect	Operational Lead	Lead Director	Latest Note	Note Last Updated	Impact	Status	Trend
ES.17 There is a potential risk that the CCG will fail to deliver a 1% surplus in-year.	The scale of the financial challenge for the organisation is such that the CCG will not deliver a 1% surplus in-year or cumulatively in the short term and will likely require a number of years to reach this point.	Failure to retain a surplus of 1% will not have an overall impact on patient care.	Michael Ash-McMahon	Executive Director Chief Finance Officer	The CCG has submitted a 2018/19 plan that delivers the required in-year control total deficit of £14m against which it will be measured and for which it would then be able to access Commissioner Sustainability Funding of £14m, a technical adjustment that would mean an in-year break-even position. Therefore the CCG will not deliver a 1% surplus in-year and local modelling for the latest Financial Recovery Plan does not anticipate this being delivered until around 2020/21.	28 June 2018	4		
JC.26a CAMHS: long waiting lists for assessment and treatment that significantly extend beyond national constitutional standards	Long waiting lists may adversely affect response to treatment and outcomes. CYP and families experience longer periods of stress and anxiety waiting for appointments and treatment. Poorer or reduced outcomes may have effects on longer term emotional and mental health. There is potential detriment to reputation, and effects on partnerships, e.g. local authority.	Delays in assessment and diagnosis leading to delays in treatment and support options. Poor patient experience.	Susan De Val; Paul Howatson	Executive Director Transformation	1 June 2018: The CCG and TEWV are each investing £50K in to support children and young people on the emotional pathway, which has very long waiting lists at present: the monies will be used to increase numbers of staff assessing and treating patients and are expected to reduce waiting times and improve patient flow. TEWV is putting in place group sessions from June 2018 to increase access to support for those with mild to moderate difficulties. The capacity and demand gap analysis will be finalised by end of June. At CMB the CCG agreed to invest an additional £120k into children's services during Q1 of 18/19. Clinical priority areas are to be agreed by TEWV clinical director based on risk assessment. Improvement to waiting times to be mapped based on the investment.	26 June 2018	4		
JC.26c Children and young people eating disorders. Non-compliance with national access and waiting time standards	Higher than anticipated referral rates into the NYY eating disorder service in York means TEWV does not meet access and waiting time standards. These patients are usually very ill, and require intensive long term care and support. Although patients are seen outside the national waiting time standard, they generally do not wait long periods, but the high volume means patients are in treatment for longer than national standards recommend, and outcomes may be poorer and take longer to be apparent.	Delays in assessment and diagnosis: high referral rate leads to longer periods in treatment with potential for poorer outcomes.	Susan De Val; Paul Howatson	Executive Director Transformation	1 June 2018: a workshop with TEWV will be held on 28 June to settle an action plan and discuss how to improve therapeutic management of children and young people referred into service. The issue remains a standing exception at CMB, and QPEC is sighted on the issue. Finance and Performance Committee received a detailed report in May 2018.	06 June 2018	4		
JC.26b Childrens Autism Assessments:	For the 5-18 pathway there is a long waiting list. For both the	Delays in assessment and diagnosis mean families wait longer for	Susan De Val; Paul Howatson	Executive Director Transformation	1 June 2018: waiting lists remain long, and a higher number of referrals in 2017/18 means that	06 June 2018	3		

Code & Title	Description	Potential Effect	Operational Lead	Lead Director	Latest Note	Note Last Updated	Impact	Status	Trend
long waiting lists and non-compliance with NICE guidance for diagnostic process	0-5 and 5-18 pathways, the diagnostic process does not comply with NICE guidance. Children and families can wait for long periods for assessment and diagnosis, with consequent strain and anxiety, and do not receive support from other agencies pending diagnosis. There are concerns around the pathway for formal diagnosis because of limited input across professional input into assessment.	specialist support in school and other settings.			waiting lists may increase. The waiting list initiative has taken an additional 36 patients off the waiting list. TEWV is now examining the pathway around integration of Autism and ADHD referrals to reduce waiting times. The action plan for autism is included in the SDIP for CAMHS and is expected to be approved at CMB in June.				
JC.30 Dementia - Failure to achieve 67% coding target in general practice.	Non delivery of mandatory NHS England targets Lack of sufficient providers in some areas resulting in delayed transfers of care or limited choice available to patients meeting new standards	Further pressure from NHS England to rectify this. Service users may not be appropriately flagged and therefore on-going referrals from primary care will not have the relevant information to make reasonable adjustments for their carers support.	Paul Howatson	Executive Director Transformation	Work continues to be undertaken to identify cases in care homes and to reconcile registers held in the specialist MH service with GP QOF registers. Also a further GP education evening was held on 12th June 2018 led by the Clinical Network Lead from Yorkshire and the Humber. Analysis of out of area placements underway. Rerun of TEWV data to provide better diagnostic information to GPs to support coding.	26 June 2018	3		

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Item Number: 7

Name of Presenter: Kev Smith

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Healthier You: NHS Diabetes Prevention Programme

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

Reason for Report

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

From July 2018 this programme will be rolled out across the Vale of York CCG. The NHS DPP is funded nationally and commissioned by NHS England until June 2020.

The purpose of this report is to provide the Vale of York CCG Governing Body with an overview of the programme and the service model that will be available to the Vale of York population identified as at risk of Type 2 diabetes. Individuals going through the programme will reduce their risk of a range of conditions related to being overweight and obese, poor nutrition and a sedentary lifestyle.

The roll out of the Healthier You: NHS Diabetes Prevention Programme is a positive opportunity that has been welcomed by our local GPs and which we will support to get the best impact for the Vale of York CCG.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks	Covalent Risk Reference and Covalent Description
☒Financial ☐Legal ☒Primary Care ☒Equalities	
Emerging Risks (not yet on Covalent)	
Recommendations Governing Body to note content of report	

Responsible Executive Director and Title	Report Author and Title
Dr Kevin Smith Executive Director of Primary Care and Population Health	Alex Kilbride Commissioning and Transformation Manager

Healthier You: NHS Diabetes Prevention Programme

Background

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

Diabetes treatment currently accounts for around 10 per cent of the annual NHS budget. Many cases of Type 2 diabetes are preventable and there is strong international evidence that behavioural interventions can significantly reduce the risk of developing the condition, through reducing weight, increasing physical activity and improving the diet of those at high risk[1].

The long-term aims of the NHS DPP are[1]:

- To reduce the incidence of Type 2 diabetes;
- To reduce the incidence of complications associated with diabetes - heart, stroke, kidney, eye and foot problems related to diabetes; and
- Over the longer term, to reduce health inequalities associated with incidence of diabetes.

In the short-term a stronger focus on identifying people who are at risk of diabetes is likely to increase incidence of diabetes as more undiagnosed cases are uncovered.

Individuals going through the programme will reduce their risk of a range of conditions related to being overweight and obese, poor nutrition and a sedentary lifestyle.

The NHS DPP is funded nationally and commissioned by NHS England. NHS England has recently approved a further investment of £80 million. They expect to have this in place from April 2019 and funding will cover the years 2019/20, 2020/21 and 2021/22[2].

What is the intervention?

The NHS DPP behavioural intervention is underpinned by three core goals[1]:

- Achieving a healthy weight
- Achievement of dietary recommendations
- Achievement of CMO physical activity recommendations

Whilst models between providers vary slightly, all programmes must be made up of at least 13 sessions, with at least 16 hours face to face contact time, spread across a minimum of 9 months, with each session lasting between 1 and 2 hours. People will be supported to set and achieve goals and make positive changes to their lifestyle in order to reduce their risk of developing Type 2 Diabetes[1]. Details of the Humber, Coast and Vale STP provider programme can be found in appendix a.

Who is eligible to go on the programme?

- Over 18 years of age
- Registered with a GP Practice in one of the following areas:
    - East Riding of Yorkshire
    - Hull
    - North East Lincolnshire
    - North Lincolnshire
    - Scarborough and Ryedale
    - Vale of York
- HbA1c between 42-47 mmol/mol (6.0%-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmols/l within the last 12 months
- Not pregnant
- Able to take part in light to moderate physical activity

Referral Routes

Referral routes into the programme vary according to local case finding pathways. Three primary mechanisms for referral are[1]:

- Those who have already been identified as having an appropriately elevated risk level (HbA1c or FPG) in the past and who have been included on a register of patients with high HbA1c or FPG;
- The NHS Health Check programme, which is currently available for individuals between 40 and 74. NHS Health Checks includes a diabetes filter, those identified to be at high risk through stage 1 of the filter are offered a blood test to confirm risk; and
- Those who are identified as at risk of developing Type 2 diabetes through opportunistic assessment as part of routine clinical care.

How many people will go through the programme?

In June 2016 the process for roll out of the Healthier You: NHS Diabetes Prevention Programme (NHS DPP) began with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. In April 2017 the programme mobilised across a further 13 sustainability and transformation partnerships (STP), achieving 75% nationwide coverage[3].

By April 2017 over 48,000 people had been referred to the service with 18,000 people commencing on programmes to date. During 2018 roll out of the service to all remaining areas in England will commence. The programme will roll out to the whole country by 2020[3].

Outcomes of Wave One and Wave Two roll out

Early outcome data and provisional analyses suggest that over 50% of the individuals that started the intervention completed it. Completion is defined as attendance to 62% or more of the Programme sessions, which is 8 out of 13 sessions in the curricula of most providers, aligning to the financial incentives for providers to retain participants on the programme[4].

https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes

https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes

Sefton CCG (Wave One) patient impact

- Average weight loss per patient 3.2kg

- Improved blood pressure readings 29%
- Average reduction in waist circumference 3.4cm
- Between sessions 1-6, 65% of patients lost weight

Programme Impact (long-term benefits)

- If 390,000 people receive the NHS DPP intervention over 5 years
- 15,000-24,000 cases of Type 2 diabetes prevented or delayed by year six
- Approximately £1.1bn of health benefits and by year 12, the programme will become cost saving
- 26% reduction in risk of developing diabetes over 12-18 months (as modelled by PHE)

STP Implementation

The local provider for Humber, Coast and Vale STP (HCV STP) is Pulse Healthcare Limited trading as ICS Health. The places available for the HCV STP area are modelled until June 2020 in line with the original Memorandum of Understanding.

Across our STP area (Hull CCG, East Riding of Yorkshire CCG, North East Lincolnshire CCG, North Lincolnshire CCG, Scarborough & Ryedale CCG and Vale of York CCG) there are **5357** places available on the behavioural intervention programme. This is based on population sizes and the various uptake levels wave one and wave two have experienced so far.

The modelled profile below is an indication of how this will be achieved. The initial assessment modelling is based on 50% of the STP total referral profile.

STP Monthly Initial Assessment Modelling

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19			39	189	193	193	193	193	193	193	193	193
2019/20	193	196	265	266	266	266	266	266	266	266	266	266
2020/21	267	270										

STP Monthly Referral Modelling

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19			81	377	385	386	386	386	386	386	386	386
2019/20	386	392	530	532	532	532	532	532	532	532	532	532
2020/21	534	539										

The referral profile is a guide for required volumes of referrals that may be required to deliver this volume of initial assessments in partnership with the provider. It is likely that this will need to vary as the uptake rate that is being seen across the partnership becomes clear.

It is important to note that the numbers added are lower than our projected prevalence as an NHSE requirement. If we exceed the overall number for the STP, prior to the end of the contract, the service provision will cease.

North Lincolnshire and North East Lincolnshire were originally part of the wave one Greater Lincolnshire roll out. As part of the wave three roll out they have joined the Humber Coast and Vale STP. The transition has been completed and the two CCGs are continuing to refer their eligible patients into the programme which means mobilisation of the Humber, Coast and Vale STP has started in line with the June 2018 plan.

The trailblazer practices for Hull CCG, East Riding of Yorkshire CCG, Scarborough and Ryedale CCG and the Vale of York CCG will start going live during July 2018.

In the Vale of York CCG we have 10 practices who volunteered to be trailblazer practices for the NHS DPP. These practices have been split into two mobilisation phases based on locality.

Phase	Locality	Practice	List Size	Current at Risk Register
1	South	Tadcaster Medical Centre	8591	409
1	South	Sherburn Group Practice	9364	249
1	South	Posterngate Surgery	16958	660
1	South	Scott Road Medical Centre	10690	245
2	Central	MyHealth	19208	606
2	Central	Pocklington Group Practice	16222	180
2	Central	York Medical Group	44117	525
2	Central	Priory Medical Group	57284	2,015
2	Central	Haxby Group Practice	32686	854
2	North	Kirbymoorside Surgery	5958	215
		TOTAL	**221,078**	**5,958**

The phase one practices will go live first during July 2018. The South practices fall under North Yorkshire County Council (NYCC) and therefore run NHS health checks within their practices. The process for referral to the NHS DPP from an NHS health check is already established across the STP area.

The phase two practices will go live during August and September 2018 if roll out across the phase one practices is successful during July 2018. The Vale of York CCG are working closely with City of York Council (CYC) during July 2018 to finalise the process for those practices whose health checks are carried out by CYC.

<u>Practice Preparation for mobilisation of the NHS DPP</u>

All practices are asked to:

- Code patients already identified as at risk of developing Type 2 diabetes in line with the national coding guidance
- Run searches for patients not currently coded as at risk of developing Type 2 diabetes using the eligibility criteria and code accordingly.
    - Over 18 years of age

    - Registered with a GP Practice in one of the following areas:
        - East Riding of Yorkshire
        - Hull
        - North East Lincolnshire
        - North Lincolnshire
        - Scarborough and Ryedale
        - Vale of York
    - HbA1c between 42-47 mmol/mol (6.0%-6.4%) or Fasting Plasma Glucose between 5.5-6.9 mmols/l within the last 12 months
    - Not pregnant
    - Able to take part in light to moderate physical activity
- Provide the Vale of York CCG with the number of patients at that practice identified as at risk of Type 2 diabetes
- Provide or recommend a venue location either at the practice itself of within the community
- Provide ICS with an email address so quarterly reports can be sent to the practice. The report will advise on the outcomes of their patients referred onto the programme and these need to be coded accordingly in line with the national guidance.

A GP mobilisation pack is being developed which includes a wealth of information to help practices get mobilised. It includes:

Information sharing agreement with ICS Health and Wellbeing
Presentation explaining the programme
Referral form and how to integrate to system
Promotional materials
Contact details ICS Healthcare and Wellbeing
Referral pathway information sheets
Guidance to aid identification of eligible cohort
National read codes
Scripts for text messages and emails / letters
Signposting to other support services

Feedback from the trailblazer practices across the STP area will help develop FAQs which will complete the mobilisation pack for roll out across the remaining practices.

The Vale of York CCG has provided ICS Health and Wellbeing with signposting links to our local services that already encourage a healthy lifestyle. These will be recommended to people during and after the programme to increase awareness and build on the engagement the Diabetes Prevention Programme will have created with people.

Benefits to the local healthcare system

- Equity of access to an intervention programme across our CCG footprint.
- Encourage people to take ownership of their health through structured education programmes.

- Type 2 diabetes is heavily linked to obesity. This programme can be an effective intervention and part of the solution to tackling obesity across the Vale of York CCG.
- Individuals going through the programme will reduce their risk of a range of conditions related to being overweight and obese, poor nutrition and a sedentary lifestyle.
- Increased opportunities to signpost to other 'healthier living' services creating greater awareness amongst the Vale of York population.
- Re-launch of the City of York Council health checks programme to re-engage with practices and the public and encourage increased attendance.
- Develop a greater understanding of the scale of our local population at risk of developing Type 2 diabetes. Practices are encouraged to actively search for people at risk using the Leicester risk score tool or PRIMIS chart application.
- Earlier diagnosis of those at risk will in time have a positive impact on the prevalence rates of diabetes in the Vale of York as intervention can be offered earlier and in turn reduce the number of people developing Type 2 diabetes.

References

1) NHS Diabetes Prevention Programme Overview and FAQs (2016): https://www.england.nhs.uk/wp-content/uploads/2016/08/dpp-faq.pdf
2) Public Health England (2018) Health Matters – Evaluation and next steps for the NHS Diabetes Prevention Programme: https://publichealthmatters.blog.gov.uk/2018/06/13/health-matters-evaluation-and-next-steps-for-the-nhs-diabetes-prevention-programme/
3) NHS England (2017) Roll Out of the Programme: https://www.england.nhs.uk/diabetes/diabetes-prevention/roll-out-of-the-programme/
4) Public Health England (2018) Health matters: Preventing Type 2 Diabetes https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes

Appendix a

ICS Referral Pathway Steps for Practices

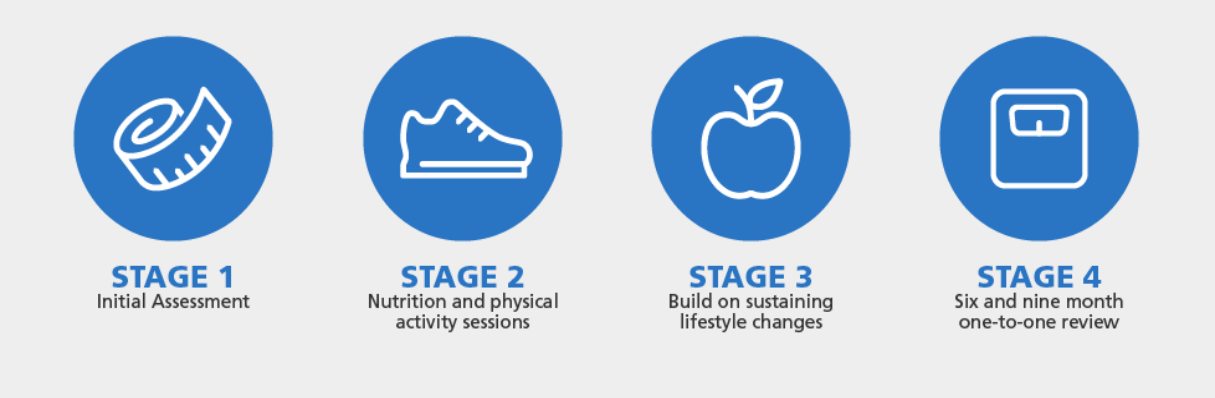
Ethnicity Check

As per the pathway diagram, patients within certain ethnic groups have a higher risk of diabetes before the age of 40. Diabetes UK have an excellent screening tool https://riskscore.diabetes.org.uk/start that can be done with the patient to determine whether they should be added to the High Risk Register and monitored annually.

2. High Risk of Diabetes Register

The register is a list of people who are at high risk of diabetes and require annual HbA1c testing. The only reason that a patient should come off the list is if they are diabetic.

Service Model



Stage 1: Initial Assessment

60 minute 1:1 appointment with trained Health Coach

- Anthropometric measurements
- Point of Care testing
- Smoking status
- Wellbeing measure
- Goal setting
- Signposting onto other services

Stage 2: Core: Healthy Foundations

7 x weekly group session (2 hours each)

- Week 1 - What is pre-diabetes & diabetes
- Week 2 - Physical Activity (chair based resistance exercises)
- Week 3 - Carbohydrate awareness
- Week 4 - Food labels
- Week 5 - Long-term health complications related to impaired glucose regulation
- Week 6 -- Energy balance and fat awareness

- Week 7 - Physical Activity session and progress review

Stage 3: Maintenance: Prevention Plus

4 x monthly group sessions (2 hours each)

- Session 1-Barriers to change, health values, habits and goals
- Session 2- Stress, emotional eating and mindfulness
- Session 3- Habitual thoughts, triggers, inner critic and self-compassion
- Session 4- Gaining control of your health, willpower and review

Stage 4: 6 & 9 Month Reviews

4 x monthly group sessions (2 hours each)

- Session 1-Barriers to change, health values, habits and goals
- Session 2- Stress, emotional eating and mindfulness
- Session 3- Habitual thoughts, triggers, inner critic and self-compassion
- Session 4- Gaining control of your health, willpower and review

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Item Number: 8

Name of Presenter: Michael Ash-McMahon

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Report Month 2

Purpose of Report
For Information

Reason for Report

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

To provide details and assurance around the actions being taken.

Members are asked to note that this is the first Financial Performance Report since agreement on the Aligned Incentives Contract; work is now taking place on priorities for system wide cost reduction programme and appropriate assignment of resources.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

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

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

Responsible Executive Director and Title	**Report Author and Title**
Michael Ash-McMahon, Acting Chief Finance Officer	Natalie Fletcher, Acting Deputy Chief Finance Officer Caroline Goldsmith, Acting Head of Finance

Finance and Contracting Performance Report – Executive Summary

April 2018 to May 2018

Month 2 2018/19

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

IMPROVEMENTS IN PERFORMANCE

Issue	Improvement	Action Required
Aligned Incentive Contract	An Aligned Incentive Contract has now been agreed with Scarborough and Ryedale CCG, East Riding CCG and York Teaching Hospital NHS Foundation Trust. This allows commissioners and Trust teams to work collaboratively on a system wide cost reduction programme.	Agree priorities for system wide cost reduction programme and assign resources appropriately. Joint programme to be presented to System Transformation Board on the 16th July.
Month 2 financial position	Overall the CCG is £300k better than the planned £3.5m deficit as at the end of May.	On-going monitoring of expenditure trends, in particular around Prescribing and CHC in particular.

Financial Performance Headlines

DETERIORATION IN PERFORMANCE

Issue	Deterioration	Action Required
Prior Year Pressures	Currently the CCG is forecasting a year end position in line with its submitted financial plan. Within this position is a £61k pressure relating to prior year adjustments – this has been offset from the CCG's contingency. There are still some outstanding areas to finalise for 2017/18 (most significantly, NHS Property Services) so the overall prior year impact may change over the next few months.	Finalise all outstanding agreements for 2017/18.

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. Continuing Healthcare – Work is continuing to validate the data transferred from the PCU. This data cleanse process may have a financial impact, although until the work is completed it is not possible to assess whether this is likely to be a positive or negative impact and of what magnitude. The CCG does have an agreement in principle with the other North Yorkshire CCGs to manage this collectively should any individual CCG be materially adversely impacted by this work.

2. NHS Property Services – Work is on-going to agree a year end deal for 2017/18. The 2017/18 year end position included a prudent assessment of this as far as possible.

3. SRBI – Invoice payments for SRBI for the four North Yorkshire CCGs transferred to the CCG from 1st April 2018. It is possible that this may have an adverse impact on the Better Payment Practice Code.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation					7.5	6.8	0.8	G
In-year total expenditure does not exceed total allocation (Programme and Running costs)					463.9	477.9	(14.0)	R
Better Payment Practice Code (Value)	95.00%	99.30%	4.30%	G	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	96.60%	1.60%	G	95.00%	>95%	0.00%	G
Cash balance at year end is within 1.25% of monthly drawdown								
CCG cash drawdown does not exceed maximum cash drawdown					477.1	477.9	(0.8)	R

- 'In-year total expenditure does not exceed total allocation' – outturn expenditure is forecast to be £14.0m higher than the CCG's in-year allocation, in line with the financial plan submitted to NHS England on 31st May 2018. However, this is expected to be offset by receipt of the £14.0m Commissioner Sustainability Fund (CSF), resulting in an in-year break even position.
- 'Maximum cash drawdown' – the target is calculated by NHS England and includes an arbitrary value for depreciation. This will be corrected later in the year on the basis of returns submitted by the CCG.

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
Running costs spend within plan	1.1	1.1	(0.0)	G	6.8	6.8	0.0	G
Programme spend within plan	79.6	79.3	0.3	G	471.1	471.1	0.0	G
Actual position is within plan (in-year)	(3.5)	(3.2)	0.3	G	(14.0)	(14.0)	0.0	G
Actual position is within plan (cumulative)					(57.8)	(57.8)	0.0	G
Risk adjusted deficit					(14.0)	(14.0)	0.0	G
Cash balance at month end is within 1.25% of monthly drawdown (£k)	402	106	296	G				
QIPP delivery (see section 9 of detailed narrative)	1.4	1.4	0.0	G	14.5	14.5	0.0	G

QIPP Summary

QIPP Summary	£m
QIPP Target	14.5
Delivered at Month 2	1.4
QIPP gap (included in overall gap)	13.1

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

Report produced: June 2018

Financial Period: April 2018 to May 2018 (Month 2)

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1. Month 2 Supporting Narrative

The plan at Month 2 was for a deficit of £3.5m; however the actual deficit is £3.2m, £300k better than planned. This is explained in further detail in the table below.

QIPP delivery at Month 2 is reported in line with the financial plan - £1.4m from a target £14.5m. Actual QIPP delivery will be reported from Month 3 onwards when acute and prescribing data is available (only one month of flex data for acute expenditure is available at Month 2 and no prescribing data for the current financial year).

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust (YTHFT)	(£0.99m)	At the time of reporting, negotiations relating to the Aligned Incentive Contract (AIC) with YTHFT were at an advanced stage but the contract variation had not been signed. The reported position reflects the worst case scenario under AIC. Month 1 flex data indicates that under a traditional Payment by Results contract the YTD spend would be c£0.7m higher – this has been reported as a risk to the financial position, with agreement of the AIC contract as an offsetting mitigation.
Contingency	£0.39m	0.5% contingency provided for in plan.
Ramsay and Nuffield Health	£0.22m	Ramsay is currently under trading by £0.25m however this is partly offset by an over-trade with Nuffield of £0.03m.
Other variances	£0.08m	
Total impact on YTD position	**£0.30m**	

2. Reported forecast outturn

The forecast outturn of £14.0m deficit is in line with the plan submitted to NHS England on 31st May 2018.

3. Gap and key delivery challenges

In the Month 2 non-ISFE submission, the CCG reported risks totalling £3.26m which are offset in full as follows:

Pressures

Description	Expected Value	Commentary
Acute SLAs	£0.70m	Contract risk from estimated PbR over-trade
QIPP under-delivery	£2.56m	In-year QIPP slippage relating to timing
Total	**£3.26m**	

Proposals and contingencies

Description	Expected Value	Commentary
Acute SLAs	£0.94m	Aligned incentives contract
Contingency	£2.32m	0.5% contingency provided for in plan
Total	**£3.26m**	

4. Allocations

The allocation at Month 2 is as follows:

Description	Recurrent / Non-recurrent	Category	Value
18/19 Opening position	Recurrent	Programme	£412.87m
18/19 Opening position	Recurrent	Delegated commissioning	£43.89m
18/19 Opening position	Recurrent	Running costs	£7.51m
18/19 Opening position – HRG 4	Recurrent	Programme	(£2.98m)
18/19 Opening position – IR	Recurrent	Programme	£0.42m
2017/18 Brought Forward Deficit	Non-recurrent	Prior year deficit	(£43.83m)
18/19 Paramedic Allocations	Non-recurrent	Programme	£0.11m
Market rent adjustment	Non-recurrent	Running costs	£0.03m
Market rent adjustment	Recurrent	Programme	£1.92m
HSCN	Non-recurrent	Programme	£0.11m
Total allocation at Month 2			**£420.05m**

5. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31st May 2018. One of the CCG's statutory requirements is that the cash drawdown in year must not exceed the Maximum Cash Drawdown as determined by NHS England. This is currently showing as red on the RAG rating however this is due to the NHS England calculation which includes an arbitrary value for depreciation and will be corrected later in the year.

6. QIPP programme

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
PLANNED CARE							
Biosimilar high cost drugs gain share	016	Apr-17	105	105	632	632	
Commissioning for Value (PNRC)	006	Apr-17	77	77	2,188	2,188	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	167	167	1,000	1,000	
RightCare - Circulation (Heart Disease)	008	Oct-17	0	0	400	400	
RightCare - Gastroenterology	009	Apr-18	0	0	622	622	In plan from 2018/19
Other Schemes (Ophthalmology, Neurology, General Medicine and ENT)		Apr-18	0	0	780	780	In plan from 2018/19
RightCare - Orthopaedics / MSK	011	Oct-17	110	110	1,323	1,323	
UNPLANNED CARE							
Community Podiatry	IC4	May-17	4	4	26	26	In contract, delivery on track
Review of community inpatient services - Phase II	019a	Apr-17	0	0	700	700	
Out of Hospital Programme - System Opportunity Cost including Frail Elderly, Long Term Conditions, Telehealth, Social Prescribing, Health Navigator	017	Apr-18	322	322	1,934	1,934	In plan from 2018/19
Patient Transport project - re-procurement	190b	Apr-18	0	0	150	150	In plan from 2018/19
PRIMARY CARE							
GP IT - NYNET	003	May-17	19	19	113	113	
Roll out indicative budgets to other specialities	020	Jul-17	0	0	125	125	
PRESCRIBING							
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	13	13	75	75	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	250	250	1,500	1,500	
CCG wide: Continence & Stoma Care	199	Oct-17	0	0	53	53	
COMPLEX CARE							
Complex Care - CHC and FNC benchmarking	024d	Oct-17	208	208	2,500	2,500	
Recommission MH out of contract expenditure	025	Apr-17	42	42	500	500	
BACK OFFICE							
Commissioning support (eMBED) contract savings	004	Apr-17	37	37	223	223	In contract, delivery on track
Vacancy control	027	Apr-17	90	90	537	537	
Total identified QIPP			1,444	1,444	15,382	15,382	
Adjustment for identified schemes above in-year QIPP requirement			-143	-143	-859	-859	
Total QIPP requirement			1,301	1,301	14,523	14,523	

Note that QIPP is reported in line with plan as at Month 2. Actual QIPP figures will be calculated from Month 3 onwards when acute and prescribing data is available.

7. Contracting Update

7.1. 2017/18 Year End Positions

Positions have been finalised for the remaining contracts where year-end outturns were not agreed as detailed in the table below.

Description	Annual Accounts Position	Final Position	Difference
Leeds Teaching Hospitals	8,383,676	8,272,464	111,212
Ramsay - Clifton Park Hospital	4,867,749	4,910,115	(42,366)
Nuffield - York Hospital	3,271,947	3,250,966	20,982
Northern Lincolnshire & Goole	496,351	487,824	8,527
GP Out of Hours	3,136,480	3,157,169	(20,689)
Harrogate and District Hospital - Acute	2,195,060	2,248,738	(53,678)
Harrogate and District Hospital - Podiatry	1,204,500	1,201,677	2,823
Harrogate and District Hospital - MIU	706,137	701,618	4,519
			31,329

Overall, the final position provides a benefit of £31k compared to the annual accounts position.

Although the Ramsay position is higher than anticipated, there was an underspend of £2.2m against plan. The financial position for the Yorkshire Doctors GP Out of Hours contract deteriorated due to higher levels of activity than anticipated over Easter. The Harrogate Acute contract overtraded due to increased Critical Care activity during Quarter 4.

As highlighted in previous contracting performance reports, financial agreements were reached in advance of the year end to offset financial risk. The final positions based on cost per case methodology are detailed in the following table and have provided a small benefit to the final financial position.

Description	Annual Accounts Position	Final Posiion	Difference
York Teaching Hospitals - Community	20,555,000	20,569,105	(14,105)
Hull & East Yorkshire Hospitals	3,080,000	3,070,000	10,000
Mid-Yorkshire Hospitals	2,356,000	2,366,126	(10,126)
South Tees Hospitals	1,400,000	1,384,853	15,147
			916

7.2. Month 1 Positions: Acute Contracts

At Month 1 (flex), there is minimal to report on the trading positions. A brief update is provided below.

- York Teaching Hospitals: An Aligned Incentive Contract (AIC) has now been agreed for the acute, community and MSK services. Reporting mechanisms are currently being developed which moves away from the traditional approach of monitoring based on

Payment by Results (PbR) towards system level demand, productivity and cost reduction monitoring.

- Leeds Teaching Hospitals: An under spend of £73k is noted primarily related to a low level of day case activity.

- Ramsay – Clifton Park: The phasing of the current plan is currently being reconsidered. The expectation is that activity will begin to rise over the latter part of the year as patients currently subject to the BMI threshold pass the 12 month waiting period. Currently, the contract is reporting an under spend of £57k including on-going adjustments related to outpatient ratios.

- Nuffield – York Hospital: An under spend of £22k is noted primarily related to a low level day case and elective activity. Nuffield, with the CCG's support, have recently introduced telephone base pre-assessments. These should generate a small reduction in cost as they are charged at a lower tariff.

- Hull and East Yorkshire: An under spend of £29k is noted primarily related to lower than planned non-elective activity. An adjustment related to the critical care 70/30 risk share have not been applied to this figure but would reduce the underspend by £4k.

- Mid Yorkshire Hospitals: An over spend of £5k is noted primarily related to a higher than planned level of non-elective activity which is offset by a lower than planned level of elective activity.

- Harrogate and District: Coding continues to be an issue and therefore the position is prone to movement. An under spend of £38k is noted with no particular highlights.

- South Tees: Errors were identified in the SLAM report so no position was reported.

- Northern Lincolnshire and Goole: Due to IT issues no SLAM report was submitted in Month 1 by this organisation.

7.3. Other Contracting Updates

Medequip Community Equipment – On the 7th June a workshop was undertaken attended by commissioners and providers and lead by Hambleton, Richmondshire and Whitby CCG. This was required to address the significant governance and process issues which are affecting the service across the patch. The day was extremely positive and generated a lively discussion. Governance arrangements are now being finalised based on the intelligence gathered at the meeting and further meetings will follow. One of the key outcomes of this redesign is to move to activity based charging. This would allow a better understanding of the community equipment needs of each commissioner. However on the basis of early analysis, using a simplistic methodology (which requires significant refinement and further discussion) the current expectation is the funding requirement from health commissioners will increase.

Harrogate - Community Podiatry: There is a slight overspend (£3k) against the planned contract but this is well below the agreed ceiling. Discussions have been held with the service to better understand current trends and on-going activity expectations. The service has identified a 30% increase in referrals which has led to a 20% increase in first attendances above activity procured

in the first year and have raised this as a concern. At this juncture the fact that the contract ultimately stayed below the ceiling in 2017/18 seems fortuitous rather than being representative of a downward trend in attendances. There are further issues regarding the agreed activity plan, the impact of the BMI threshold and GP referral outliers that require further investigation

Northern Doctors – GP Out of Hours: The contract was renegotiated for 2018/19 and the commissioned activity reduced to a position more in line with prior year outturns. Therefore, it is unlikely this contract will regularly report an underspend position as it had previously. At Month 1 activity was marginally above the ceiling to generate a £4k over spend.

Appendix 1 – Finance dashboard

	YTD Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioned Services						
Acute Services						
York Teaching Hospital NHS FT	32,715	33,699	(985)	191,609	191,609	0
Yorkshire Ambulance Service NHS Trust	2,185	2,185	(0)	13,110	13,110	0
Leeds Teaching Hospitals NHS Trust	1,434	1,329	105	8,604	8,604	0
Hull and East Yorkshire Hospitals NHS Trust	529	495	34	3,173	3,173	0
Harrogate and District NHS FT	381	335	46	2,283	2,283	0
Mid Yorkshire Hospitals NHS Trust	394	391	3	2,365	2,365	0
South Tees NHS FT	226	226	0	1,358	1,358	0
North Lincolnshire & Goole Hospitals NHS Trust	76	76	0	456	456	0
Sheffield Teaching Hospitals NHS FT	34	34	0	202	202	0
Non-Contracted Activity	714	714	0	4,282	4,282	0
Other Acute Commissioning	171	169	2	1,028	1,028	0
Ramsay	990	803	187	5,939	5,939	0
Nuffield Health	526	491	36	3,159	3,159	0
Other Private Providers	207	242	(35)	1,245	1,245	0
Sub Total	**40,582**	**41,188**	**(606)**	**238,815**	**238,815**	**0**
Mental Health Services						
Tees, Esk and Wear Valleys NHS FT	6,824	6,751	73	40,946	40,946	0
Out of Contract Placements	954	1,207	(253)	5,473	5,473	0
SRBI	282	193	89	1,689	1,689	0
Non-Contracted Activity - MH	69	69	0	412	412	0
Other Mental Health	231	193	39	1,388	1,388	0
Sub Total	**8,360**	**8,413**	**(53)**	**49,908**	**49,908**	**0**
Community Services						
York Teaching Hospital NHS FT - Community	3,122	3,122	0	18,031	18,031	0
York Teaching Hospital NHS FT - MSK	386	386	0	2,356	2,356	0
Harrogate and District NHS FT - Community	429	434	(5)	2,571	2,571	0
Humber NHS FT - Community	337	258	79	2,019	2,019	0
Hospices	212	212	0	1,271	1,271	0
Longer Term Conditions	70	73	(3)	422	422	0
Other Community	472	351	122	2,833	2,833	0
Sub total	**5,027**	**4,835**	**193**	**29,503**	**29,503**	**0**
Other Services						
Continuing Care	4,486	4,486	(0)	25,667	25,667	0
CHC Clinical Team	309	168	142	1,856	1,856	0
Funded Nursing Care	722	661	61	4,334	4,334	0
Patient Transport - Yorkshire Ambulance Service NHS Trust	344	344	1	1,915	1,915	0
Voluntary Sector / Section 256	84	86	(2)	503	503	0
Non-NHS Treatment	97	112	(15)	582	582	0
NHS 111	149	149	0	894	894	0
Better Care Fund	1,882	1,886	(4)	11,293	11,293	0
Other Services	310	267	43	1,861	1,861	0
Sub total	**8,384**	**8,159**	**225**	**48,905**	**48,905**	**0**

	YTD Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care						
Primary Care Prescribing	7,888	7,920	(33)	47,272	47,272	0
Other Prescribing	277	305	(28)	1,661	1,661	0
Local Enhanced Services	336	280	56	2,013	2,013	0
Oxygen	53	55	(3)	318	318	0
Primary Care IT	149	169	(20)	895	895	0
Out of Hours	531	580	(49)	3,184	3,184	0
Other Primary Care	191	193	(2)	1,471	1,471	0
Sub Total	**9,424**	**9,503**	**(79)**	**56,813**	**56,813**	**0**
Primary Care Commissioning	**7,291**	**7,165**	**127**	**43,751**	**43,751**	**0**
Trading Position	**79,068**	**79,263**	**(194)**	**467,695**	**467,695**	**0**
Prior Year Balances	0	61	(61)	0	61	(61)
Reserves	37	0	37	223	223	0
Contingency	386	0	386	2,318	2,257	61
Unallocated QIPP	143	0	143	859	859	0
Reserves	**567**	**61**	**506**	**3,401**	**3,401**	**0**
Programme Financial Position	**79,635**	**79,324**	**311**	**471,096**	**471,096**	**0**
In Year Surplus / (Deficit)	(3,507)	0	(3,507)	(14,000)	0	(14,000)
In Year Programme Financial Position	**76,128**	**79,324**	**(3,196)**	**457,096**	**471,096**	**(14,000)**
Running Costs	**1,131**	**1,143**	**(12)**	**6,784**	**6,784**	**(0)**
Total In Year Financial Position	**77,259**	**80,466**	**(3,208)**	**463,880**	**477,880**	**(14,000)**
Brought Forward (Deficit)	(7,305)	0	(7,305)	(43,831)	0	(43,831)
Cumulative Financial Position	**69,953**	**80,466**	**(10,513)**	**420,049**	**477,880**	**(57,831)**

Note: the Finance Dashboard will include month-on-month movement analysis from Month 3 reporting.

Appendix 2 – Running costs dashboard

Directorate	YTD Position			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Chief Executive / Board Office	36	168	(132)	215	398	(183)
Primary Care	120	82	37	717	670	47
System Resource & Planning	198	206	(9)	1,187	1,181	6
Planning and Governance	175	182	(7)	1,052	1,060	(8)
Joint Commissioning	86	68	18	518	500	18
Medical Directorate	20	(0)	20	120	100	20
Finance	198	165	33	1,189	1,148	42
Quality & Nursing	122	94	28	731	622	109
Planned Care	175	173	3	1,052	1,077	(25)
Risk	0	5	(4)	3	28	(26)
Reserves	0	0	0	0	0	0
Overall Position	**1,131**	**1,143**	**(12)**	**6,784**	**6,784**	**(0)**

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Item Number: 9

Name of Presenter: Michael Ash-McMahon

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Financial control, planning and governance assessment

Purpose of Report
To Receive

Reason for Report

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

The self-assessment is designed to consider the overall control environment and covers financial control, planning and governance.

The questionnaire has been discussed amongst at the CCGs Executive Committee and has been signed off by the CCG Accountable Officer as required by NHS England. However, the assessment also needs to feature as part of the next available Governing Board meeting and so it is presented here in full as an Appendix with key exception areas as follows:

Assessment Criteria	Y/N/P/NA	Please explain key reasons where not met	Actions to address issues identified
Is year to date QIPP delivery in line with planned profile?	Not Applicable	The CCG has not yet reported against its QIPP plan at the time of completing this assessment.	Regular monthly reporting processes will begin from Month 3 onwards.
The CCG can confirm, all contracts signed for 2018-19 including; any MOUs, secondment agreements, BCF, pool agreements etc and any contract variations required for 2018-19	Partial	The East Riding BCF and the associated S75 agreement has not been updated and signed for 2018-19. The contract with Medequip for community equipment is not signed.	The CCG is working with East Riding Council to finalise and sign the S75 agreement. The Medequip contract will be signed by the end of July after finalising CQUIN details.

The CCG can confirm that any debtor or creditor balances (Non-NHS) over 120 days have all been fully provided for?	No	The CCG has two key outstanding creditors, which have not been provided for as they are in formal dispute. These largely relate to Harrogate Foundation Trust and NHS Property Services.	Harrogate CCG are taking forward the historic invoices with Harrogate Foundation Trust. As part of the 2017/18 year-end process the CCG agreed a full and final settlement figure with NHS Property Services for 2015/16 and 2016/17 debts. This exercise continues with senior engagement for the 2017/18 onwards bills.
The CCG manages cash balances effectively and has not required any supplementary cash drawdowns in the last 12 months? If no, confirm how many instances and actions being taken to avoid reoccurrence?	No	The CCG has made two supplementary cash draw downs in the last 12 months. The first at the 2017/18 year-end in line with additional allocation received and recently for Month 3 of 2018/19 as a result of increased CHC invoicing.	The first draw down was a business as usual adjustment. The second is a result of the recent in-housing of this service and it is anticipated this will improve throughout the year as the CCG gets to more accurately understand manage the associated expenditure flows.
CCG to confirm finance roles are all filled by substantive appointments? If no, state % WTE vacancy and proportion covered by interim staffing arrangements	Partial	The CCG's CFO post has been appointed to substantively, however the new CFO is not due to start in post until 1st August. Acting up arrangements are in place for the CFO, Deputy CFO and Head of Finance role.	No further action required - all permanent staff will be in post from 1st August
Can the CCG confirm that all QIPP schemes have associated, risk assessed business cases with key milestones identified for delivery?	Partial	Where relevant, schemes have business cases in place, however all schemes have a 'plan on a page' document with a project plan and key milestones.	
CCG can confirm that QIPP performance is monitored at least monthly at individual initiative level with QIPP performance figures reconciling to reported I&E performance?	Partial	The CCG monitors QIPP performance monthly from month 3 as prior to this acute and prescribing data is not sufficient to commence scheme level reporting.	Regular monthly reporting processes will begin from Month 3 onwards.

Strategic Priority Links

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

Local Authority Area

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

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

Emerging Risks (not yet on Covalent)

N/A

Recommendations

The Governing Body is asked to receive and note the CCG's self-assessed CCG Financial Control Planning and Governance Self-Assessment_18-19_v4 in full, with specific awareness of the exceptional items noted above.

Responsible Executive Director and Title	**Report Author and Title**
Michael Ash-McMahon, Acting Chief Finance Officer	Michael Ash-McMahon, Acting Chief Finance Officer Natalie Fletcher, Acting Deputy Chief Finance Officer

CCG Financial Control, Planning and Governance Self-Assessment | **Annual criteria**

Domain	#	Assessment Criteria	Frequency	Y/N/P/NA	Please explain key reasons where not met	Actions to address issues identified
Detailed Financial Planning and Budget Setting	1	Is the CCG planning to meet all business rules in 2018 - 19 as set by NHS England? *(In-year control total compliant, achieving 1% cumulative surplus, contingency set aside for unforseen events, Admin spending contained within technical limits, Mental Health Investment Standard compliant)*	Annual	Partial	The CCG will not meet the 1% cumulative surplus requirement.	The CCG has constructed and submitted a Financial Recovery Plan that demonstrates when this will be achieved.
	2	Is the CCG planning compliance with all additional expectations in 2018 - 19 as defined by NHS England? *(Meeting Mental Health Investment expectations accross all metrics (e.g. C&YP Year on Year growth), Compliant with requirement to invest £3per head in primary care over 2 years (2017-19), Meeting requirement to reinvest Non-Elective Marginal rate benefit, reinvesting readmissions penalties (where levied)).*	Annual	Yes	Under the CCG's aligned incentive contract with its main acute provider, non-elective marginal rate and readmissions penalties will not be levied.	
	3	Is the CCG plan meeting good practice expectations in preparation of 2018 - 19 financial plans? *(underlying position maintained (balanced or in surplus - e.g. by deploying some expenditure on a non-recurrent basis), Plan is realistically profiled, QIPP target is ambitious but not unrealistic (i.e. >2% and <4% of CCGs total allocation and in line with historic delivery), QIPP plan is not unduely profiled towards the last quarter of the year (i.e. <65% of QIPP is due to be delivered in months 7-12), plan templates analysed and completed in required level of granularity (new requirement for 18/19 Acute PODs & MH).*	Annual	Partial	The CCG has an underlying deficit and will continue to do so in 2018/19	The CCG has constructed and submitted a Financial Recovery Plan that demonstrates when this will be achieved.
	4	Has the CCG utilised and modelled year on year assumptions as per NHS England Planning Guidance? including activity growth broadly in line with National trend assumptions, tariff efficiency and inflation etc. If not, please clearly specify rationale and impact of alternative assumptions.	Annual	Yes		
	5	Is the CCG unidentified QIPP less than 15%? if no, state value, % of allocation and process/timescales to close this gap	Annual	Yes		
	6	CCG can confirm key risks are identified and quantified with clear and credible mitigations in place?	Annual	Yes		
	7	Can the CCG confirm it has reasonable contingencies or reserves set aside to respond to **unforeseen** events and they are phased appropriately?	Annual	Yes		
	9	Budgets are prepared with involvement of trained budget holders with guidance on assumptions (e.g. growth, efficiencies and inflation provided by CCG CFO); budgets are formally agreed / signed off including any budget adjustments/virements	Annual	Yes		
	10	All areas of expenditure are budgeted at a sufficiently detailed level to facilitate understanding of actual performance and enable robust financial control?	Annual	Yes		
	11	Is the finance function actively involved in service developments, procurements and wider commissioning agenda?	Annual	Yes		
	12	Is the CCG within 5% above/below target funding?	Annual	Yes		
In year Financial Performance	20	The CCG has robust process in place to provide timely realistic forecasts?	Annual	Yes		
Financial Control & Process	31	The CCG can confirm Prime Financial Policies and the underpinning detailed financial policies and procedures are regularly reviewed and updated.	Annual	Yes		
	32	All staff including committee staff are trained on financial governance and training record is fully documented?	Annual	Yes		
	33	Delegated authorities (as set out in the CCG scheme of delegation) are built into ISFE and are regularly reviewed and updated?	Annual	Yes		
	34	The CCG has clear guidance documents in place for key processes of financial control such as procurement and recruitment?	Annual	Yes		
	35	All Journals are fully documented and approved by appropriate level supervisor?	Annual	Yes		
	43	CCG can confirm it received a 'No material issues' opinion in the last Internal Audit report rating for "Financial Control"?	Annual	Yes		

CCG Financial Control, Planning and Governance Self-Assessment | **Annual criteria**

Domain	#	Assessment Criteria	Frequency	Y/N/P/NA	Please explain key reasons where not met	Actions to address issues identified
Audit	49	The CCG Audit Committee Chair is a qualified accountant or is supported by an appropriately qualified Lay member?	Annual	Yes		
	50	Audit Committee receives and follows up all internal audit reports and approves internal audit plan?	Annual	Yes		
	51	Audit chair regularly meets with internal and external auditors without management present?	Annual	Yes		
	52	Audit chair can confirm that lay members training needs are regularly reviewed and appropriately addressed?	Annual	Yes		
	53	Where applicable, Audit Committee can confirm that service auditor reports are received from outsourced service providers and assurance is sought that the overall control environment of the CCG is not negatively impacted through the arrangement?	Annual	Yes		
	57	CCG can confirm it has no adverse external audit findings and recommendations in the last 12 months?	Annual	No	Except for the incurrence of expenditure in excess of specified targets due to its financial position the CCG has had no such reports.	The CCG's Operational and Financial Recovery Plan is the response to this position and builds on the stabilisation of the financial position in 2017/18.
Finance & Investment Committee	58	Has the CCG a separate Finance & Investment Committee in place, if no what is in place to ensure strong financial governance?	Annual	Yes		
	59	Is the Chair of the Finance & Investment Committee independent?	Annual	Yes		
	61	Is there a robust process for investment decisions and monitoring of investment implementation and delivery?	Annual	Yes		
	62	Does the investment process include a Post Implementation review stage that allows lessons learnt to be factored in to future investment proposals?	Annual	Partial	Although the CCG reviews procurements and investments through its Executive Committee and Finance and Performance Committee, this is not part of a formal post implementation review process.	
	64	The Finance & Investment Committee chair/s report to the governing body following each meeting and have an annual review of the committee's performance?	Annual	Yes		
Governing Body (GB)	68	CCG to confirm there is sufficient finance skills within the GB including lay members?	Annual	Yes		
Capability and Capacity	71	Do all staff have clear roles and responsibilities that are supported by an process of performance development? i.e. including having had PDPs within the last 12 months, a clear training and development plan with CPD up to date for all applicable staff members?	Annual	Yes		
PMO Function (QIPP)	76	Where QIPP Schemes require consultation, the CCG confirms consultation guidance has been followed?	Annual	Yes		
	77	Has the CCG agreed QIPP plans with its main providers as part of its agreed contract with clearly defined risk management?	Annual	Yes		

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Item Number: 10

Name of Presenter: Caroline Alexander

Meeting of the Governing Body

Meeting Date: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Integrated Performance Report Month 1 2018/19

Purpose of Report
For Information

Reason for Report

This document provides a triangulated overview of CCG performance across all NHS Constitutional targets and then by each of the 2018/19 programmes.

The report captures validated data for Month 1 for performance and should be read alongside the Month 2 Finance Report (which incorporates planned QIPP targets).

The CCG is currently reviewing delivery in 2017/18 against the NHS England Improvement Assurance Framework (IAF) indicators based on available national and local data and this will inform the performance improvement priorities the CCG will focus on in 2018/19.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☒Equalities

Covalent Risk Reference and Covalent Description

Risks are currently being refreshed by the CCG programme leads and Exec Leads for 2018/19.

Emerging Risks (not yet on Covalent)

n/a

Recommendations
n/a

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

Integrated Performance Report

Validated data to April 2018

Month 01 2018/19

NHS
Vale of York
Clinical Commissioning Group

CONTENTS

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

A&E 4 hr **Target: 95%**	York Trust's performance against the 4 hour target continued to improve in April 2018, rising to 85.1% from 81.2% in March. Type 1 performance alone increased 6% from 68.2% to 74.2%. There were 13 x 12 hour breaches in April, all at the Scarborough Hospital site. Unvalidated May performance is 90.1%, meaning the monthly trajectory of 85% April and 86% May has been met.	Both ED sites have seen a recent increase in attendances, and as in previous years May was a busier month than April. Nurse staffing vacancies remain a significant operational pressure in ED at YFT. Work is ongoing at the York site to target recovery actions and inform the recovery plan for 2018/19. A rapid improvement plan is in place for the Scarborough site based on the external reviews completed at both sites.
Cancer 2 Week Wait **Target: 93%**	Vale of York CCG met the 93% two week wait target for the sixth consecutive month in April 2018, with performance of 95.9%. This is a further improvement from 95.6% in March 2018. York Trust's performance also improved in April 2018, remaining above target with 93.9% compared to 93.7% in March.	York Trust are delivering a number of targeted actions in April including: • The NHSI Intensive Support Team were on site throughout April providing support to implement key recommendations • The Cancer Training Strategy has been completed for approval by the Cancer Board • Weekly Patient Tracking List meetings have been re-established and teams have visited Gateshead and Hull to learn from best practice and strengthen communication with specialist centres • The HCV STP Cancer Alliance has prioritised funding for diagnostics, additional cancer patient trackers and community based cancer champions

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

Dementia **Target : 66.7%**	Diagnosis increased from 60.2% in April to 60.7% in May 2018. 45 patients were added to the register (Haxby +15, Priory + 8) offset by 10 due to patient deaths however the estimated prevalence increased from 4,410 to 4,430 which reduced the impact of this increase.	The CCG continues to support primary care with coding and identification. Lists of patients with a recorded diagnosis in TEWV's services have been sent to GP practices to reconcile with practice QOF registers. The CCG are undertaking case finding in care homes and a GP education event took place on 12 June attended by 20 GPs. There were presentations from the Yorkshire & Humber GP dementia lead, Dementia Forward and the memory service.

Performance Headlines

DETERIORATION IN PERFORMANCE :

Diagnostics 6 Week Wait **Target: 99%**	Performance for Vale of York CCG in April 2018 fell to 95.6% from 96.6% in March 2018. This represents 186 patients waiting over 6 weeks from a cohort of 4,202. MRI and CT were the specialties with the highest number of breaches in April with 44 each. This is followed by Colonoscopy with 26, Flexi Sigmoidoscopy with 18, Sleep Studies with 16 and Gastroscopy with 15. York Trust's performance also deteriorated, falling to 96.1% in April 2018 compared to March at 97%.	York Trust have reported that sleep studies and MRI GA radiology delays have continued to affect their position, as well as significant capacity challenges in Endoscopy. The initial impact of the reduction of WLIs in previous months has not been recovered as anticipated and has been further affected by a surge in referrals for colorectal seen in March and April. The Trust have provided details of a number of targeted actions in April which are covered in more detail in the Diagnostics section of this report. Diagnostics demand and capacity work has also been under taken by the HCVSTP Cancer Alliance.
Cancer 62 day Treatment **Target: 85%**	Both Vale of York CCG and York Trust saw a significant decrease in performance in April 2018 compared to March 2018. The CCG's performance against the 85% target was 78.7% in April, compared to 86.8% in March. York Trust's performance fell to 78.0% in April, compared to 86.0% in March.	YFT Cancer Board have refreshed their programme of performance recovery and the HCV STP Cancer Alliance has prioritised funding for diagnostics and additional cancer patient trackers across providers (HEYHT/YFT). Flash reports on the key Cancer Alliance workstreams supporting delivery of 62 day performance have been produced including for Vague Symptoms, Colorectal and Lung.

Performance Headlines

DETERIORATION IN PERFORMANCE :

RTT 18 Week

Target: 92%

Vale of York's performance against the 92% target has improved slightly in April 2018 at 85.0% compared to 84.5% in March 2018. In 2018/19 the key target set by NHS England is to maintain the waiting list so that in March 2019 the list is no larger than March 2018. The waiting list increased in April 2018 to 16,815 compared to 16,473 in March 2018.

York Trust are in a very similar position to the CCG in that their performance against the 92% target improved from 83.3% to 83.8%, however their total waiting list increased from 26,303 to 26,967.

The specialties with the most breaches for Vale of York CCG patients were Ophthalmology (652), General Surgery (301), ENT (254) and Thoracic Medicine (208).

There were 3 x 52 week breaches for Vale of York CCG patients in April 2018, 1 in Ophthalmology at NLAG and 2 in T&O at Leeds. The data published by NHS England for March and April 2018 also shows 2 x 52 week breaches per month in T&O at Nuffield York, however these have been confirmed by Nuffield as data errors and have been removed from the data in this report despite still appearing in the public data.

Ophthalmology services at YFT are a key area of focus for both CCGs due to the pressures on the capacity to manage the current waiting list for both new and follow-up patients.

Although York Trust's waiting list increased in April, the backlog did reduce from the previous month. The Trust DNA rate reduced to 5.7% and 5% at York Hospital specifically, which reflects the impact of the text messaging service and directorate work to address DNA rates.
Long waits at the Trust continue to be a concern with one declared 52 week breach for April in Head and Neck services (not a VOY patient). This was due to incorrect recording of the clock stop as a patient transferred between specialties.
Additional validation support has been provided to support the directorate in improving recording.

The number of patients waiting over 40 weeks is monitored weekly, however there is a significant risk for further 52 week breaches in some specialties with capacity pressures. The CCG is working with YFT and S&R CCG to jointly develop recovery plans which support performance recovery as a system and focus on managing demand on services more effectively, including the development of a new expert consulting pathway between primary and secondary care and outpatient transformation.

The Trust have provided a number of targeted actions in April which are covered in more detail in the RTT section of this report.

Performance Headlines

DETERIORATION IN PERFORMANCE :

IAPT : Prevalence **Target : 15%**	The local position for May is 11.2% down from 14.2% in April. 294 patients have entered treated in May against a level of need of 2,617.	Concerns were flagged formally at last CMB regarding lack of maintenance of 15% in Month 1 plus GP referral slow down and lost slots. CMB informed action plan regarding GP referrals is being developed but reduction below 15% is largely to do with bank holidays. Month 2 position has worsened further, the CCG will formally escalate concerns through TEWV Performance sub group which will consider whether a contract notice is required.

Performance Headlines

SUGGESTED ISSUES FOR DISCUSSION:

1. Performance issues in the Ophthalmology and proposed next steps across YFT, VoY CCG and S&R CCG

2. For note: Long Stay Reduction letter from National Director of Urgent and Emergency Care [see Annex 2]

3. For information: latest draft system Winter/ Resilience Plan (A&E Delivery Board)

4. For note: initial feedback from HCV STP Cancer Alliance Diagnostics demand and capacity review
 - shortfalls in radiology and pathology capacity are significant
 - there is a need for 3 additional CT scanners for MRI to meet the projected demand over the next 5 years across the STP
 - reporting capacity is also insufficient
 - a sustainable model for endoscopy is required for the STP and a new workstream is being established to support this

Performance Summary:
All Constitutional Targets 2018/19

Validated data to April (Month 01)

NHS
Vale of York
Clinical Commissioning Group

VoY CCG - NHS Constitution - 2018/19

Generated on: 25 June 2018

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

EMBED HEALTH CONSORTIUM

Indicator	Level of Reporting	Target/ Actual	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Q1 2018/19	2018/19	Q4 2017/18	2017/18	Direction of Travel (last 12 Months)	3 Month Trend
Planned Care																				
Referral to Treatment																				
Referral to Treatment pathways: incomplete	CCG	Actual	90.2%	90.2%	89.7%	89.3%	88.8%	89.2%	89.2%	88.1%	87.5%	86.6%	84.5%	85.0%	85.0%	85.0%	86.2%	88.6%		↓
		Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		
Number of >52 week Referral to Treatment in Incomplete Pathways	CCG	Actual	2	0	1	0	0	0	0	3	5	6	4	10	10	10	15	23		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Diagnostic test waiting times	CCG	Actual	3.49%	2.83%	2.18%	1.63%	1.60%	1.99%	1.85%	2.06%	3.42%	3.87%	3.40%	4.43%	4.43%	4.43%	3.40%	3.40%		↑
		Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		
Cancer																				
All Cancer 2 week waits	CCG	Actual	89.6%	90.4%	85.9%	85.2%	88.1%	86.8%	96.4%	93.5%	96.1%	97.2%	95.6%	95.9%	95.9%	95.9%	96.2%	91.3%		↓
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Breast Symptoms (Cancer Not Suspected) 2 week waits	CCG	Actual	95.5%	96.6%	96.8%	96.8%	100.0%	97.6%	91.3%	93.0%	93.2%	98.6%	98.4%	96.9%	96.9%	96.9%	96.6%	95.7%		↓
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Cancer 31 day waits: first definitive treatment	CCG	Actual	98.9%	97.8%	97.4%	97.4%	96.6%	95.2%	98.2%	98.3%	98.3%	97.6%	98.9%	98.4%	98.4%	98.4%	98.3%	97.5%		↑
		Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		
Cancer 31 day waits: subsequent cancer treatments-surgery	CCG	Actual	93.8%	96.9%	88.1%	97.7%	95.5%	85.1%	94.2%	97.1%	92.9%	100.0%	100.0%	95.0%	95.0%	95.0%	96.7%	94.3%		↓
		Target	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
Cancer 31 day waits: subsequent cancer treatments-anti cancer drug regimens	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		-
		Target	96.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%		
Cancer 31 day waits: subsequent cancer treatments-radiotherapy	CCG	Actual	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	97.7%	95.9%	98.1%	98.1%	98.1%	97.4%	99.1%		↑
		Target	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
% patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer (inc 31 day Rare cancers)	CCG	Actual	74.3%	76.6%	82.0%	87.3%	74.1%	72.5%	87.5%	87.0%	85.1%	81.8%	86.7%	78.7%	78.7%	78.7%	84.8%	81.5%		↓
		Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	CCG	Actual	100.0%	100.0%	88.2%	100.0%	94.4%	88.9%	90.0%	86.7%	100.0%	90.9%	94.7%	92.9%	92.9%	92.9%	92.3%	92.6%		↑
		Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	CCG	Actual	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	Nil Return	Nil Return	100.0%	100.0%	100.0%	100.0%	100.0%		
		Target																		
Cancelled Operations																				
Cancelled Operations - York	YFT (Trust Wide)	Actual		1.9%			1.1%			0.4%			6.1%				6.1%	3.0%		↑
		Target		11.7%			1.4%			1.0%			7.8%		11.7%	5.1%	7.8%	5.1%		
No urgent operations cancelled for a 2nd time - York	YFT (Trust Wide)	Actual	0	0	0	0	0	0	0	0	0	0	0				0	0		
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Mixed Sex Accommodation																				
Mixed Sex Accommodation (MSA) Breaches (Rate per 1,000 FCEs)	CCG	Actual	0	0	0	0	0	0	0	0	1.2	0.1	0	0	0	0	0.4	0.1		↓
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Number of MSA breaches for the reporting month in question	CCG	Actual	0	0	0	0	0	0	0	0	14	1	0	0	0	0	15	15		↓
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

Unplanned Care

A&E

A&E waiting time - total time in the A&E department, SitRep data	% of YFHT activity (CCG weighted)	Actual	88.1%	91.9%	87.1%	88.2%	83.2%	86.7%	91.7%	83.0%	81.5%	81.9%	81.3%	85.2%	85.2%	85.2%	81.5%	86.6%	
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
A&E - % Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	79.6%	86.1%	77.6%	79.1%	71.2%	77.1%	86.3%	72.0%	69.4%	70.3%	68.4%	85.2%	85.2%	85.2%	69.3%	77.1%	
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
A&E Attendances - Total, SitRep data	% of YFHT activity (CCG weighted)	Actual	8,466	8,201	8,755	8,599	8,024	8,319	7,611	8,157	7,388	6,890	7,957	8,220	8,220	8,220	22,234	96,448	
A&E waiting time -% of patients seen and discharged within 4 hours -CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	84.53%	89.22%	83.18%	85.53%	82.20%	85.80%	87.72%	78.66%	79.22%	81.29%	78.98%	85.84%	85.84%	85.84%	79.77%	83.93%	
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	

Trolley Waits

12 hour trolley waits in A&E - Scarborough & Ryedale CCG	CCG	Actual	1	0	2	0	0	0	0	3	0	3	4	2	2	2	7	13	
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
12 hour trolley waits in A&E - York	YFT (Trust Wide)	Actual	3	0	2	1	1	2	0	5	14	15	40	13	13	13	69	83	
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Ambulance performance - YAS

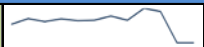
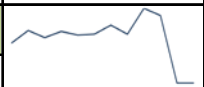
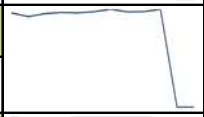
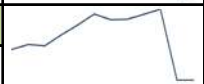
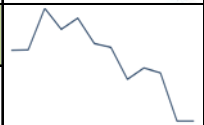
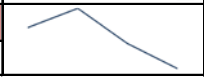
Category 1 - Response within 8 Minutes	YAS (Region)	Actual	74.1%	68.2%	71.4%	66.8%												69.5%	
		Target	75.0%	75.0%	75.0%	75.0%												75.0%	
Category 1 - Mean	YAS (Region)	Actual					00:07:14	00:07:11	00:07:27	00:08:12	00:08:10	00:08:07	00:08:17	00:08:02	00:08:09	00:08:02	00:08:11	00:07:46	
		Target					00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	00:07:00	
Category 1 - 90th Centile	YAS (Region)	Actual					00:13:27	00:13:17	00:13:21	00:14:19	00:13:56	00:13:57	00:14:15	00:13:44	00:14:00	00:13:44	00:14:03	00:13:49	
		Target					00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	00:15:00	
Category 2 - Mean	YAS (Region)	Actual					00:22:07	00:20:28	00:21:20	00:27:58	00:26:57	00:25:08	00:25:38	00:21:39	00:23:38	00:21:39	00:25:54	00:24:26	
		Target					00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	00:18:00	
Category 2 - 90th Centile	YAS (Region)	Actual					00:47:16	00:43:56	00:45:18	01:00:47	00:59:30	00:55:13	00:57:34	00:45:53	00:51:44	00:45:53	00:57:26	00:24:26	
		Target					00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	00:40:00	
Category 3 - 90th Centile	YAS (Region)	Actual					01:52:18	01:33:56	01:45:02	02:41:47	02:31:51	02:24:28	02:25:24	00:54:00	01:39:42	00:54:00	02:27:14	02:06:56	
		Target					02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	02:00:00	
Category 4 - 90th Centile	YAS (Region)	Actual					03:15:04	02:57:47	02:46:03	04:22:05	03:45:02	03:33:15	03:17:37	01:06:51	02:12:14	01:06:51	03:31:58	03:22:45	
		Target					03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	03:00:00	

Ambulance Handover Time

Ambulance handover time - % Delays over 30 minutes (Scarborough General Hospital)	Trust Site	Actual	18%	15%	17%	22%	31%	30%	8%	32%	33%	33%	30%	26%	26%	26%	32%	23%	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	Trust Site	Actual	6%	5%	5%	6%	13%	14%	2%	12%	16%	17%	15%	14%	14%	14%	16%	9%	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	CCG	Actual	11%	7%	11%	11%	14%	10%	7%	27%	18%	18%	16%	8%	8%	8%	17%	13%	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Ambulance handover time - % Delays over 30 minutes (York Hospital)	CCG	Actual	4%	1%	4%	3%	5%	3%	2%	14%	8%	9%	7%	3%	3%	3%	8%	5%	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

Mental Health/ IAPT

IAPT

Proportion of people that enter treatment against the level of need in the general population	CCG	Actual	0.72%	0.94%	0.82%	0.93%	0.86%	0.88%	1.04%	0.88%	1.34%	1.22%					2.56%	10.27%		↑
		Target	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%			1.33%	6.65%		
% of people who are moving to recovery	CCG	Actual	54.17%	42.31%	40.91%	37.93%	41.67%	53.85%	46.81%	40.00%	46.34%	40.91%					43.53%	44.47%		↓
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%		
Number of people who receive psychological therapies	CCG	Actual	225	295	255	290	270	275	325	275	420	380					800	3210		↑
		Target	208	208	208	208	208	208	208	208	208	208	208	208			416	2080		
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	96.15%	92.59%	95.65%	96.77%	96.15%	97.62%	100.00%	97.37%	97.73%	100.00%					98.90%	97.47%		↑
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%		
The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	100.00%	98.31%	98.04%	98.28%	100.00%	100.00%	100.00%	100.00%	100.00%	98.68%					99.38%	99.38%		↓
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%		
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	80.77%	77.78%	82.61%	80.65%	84.62%	76.19%	70.00%	76.32%	75.00%	82.98%					79.12%	79.29%		↑
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%		
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	42.22%	49.15%	47.06%	62.07%	75.93%	90.91%	83.08%	83.64%	90.48%	97.37%					93.75%	74.92%		↑
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%		
Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment enter treatment in the reporting period.	CCG	Actual	84.62%	85.19%	134.78%	109.68%	123.08%	92.86%	88.00%	50.00%	63.64%	57.45%					60.44%	81.57%		↑
		Target	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%		
% of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	CCG	Actual		96.2%			98.8%			94.0%			90.6%				90.6%	94.8%		↓
		Target		95.0%			95.0%			95.0%			95.0%		95.0%	95.0%	95.0%	95.0%		

Dementia

Estimated diagnosis rate for people with dementia.	CCG	Actual	58.3%	58.7%	59.1%	59.4%	59.6%	60.2%	61.0%	60.7%	60.9%	60.6%	60.5%	60.2%	60.2%	60.2%	60.5%	60.5%		↓
		Target	62.8%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%		

HCAI and Quality

Hospital Infections

Incidence of healthcare associated infection (HCAI): MRSA	CCG ATTRIBUTED	Actual	1	1	2	2	2	0	1	0	0	0	0	3	3	3	0	10		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile).	CCG ATTRIBUTED	Actual	4	6	5	6	14	12	10	6	9	9	6	8	8	8	24	91		↓
		Target	6	8	4	7	6	7	5	9	7	6	6	7	21	24	19	25		
Incidence of healthcare acquired infections (HCAI): MRSA - York FT	YFT TRUST APPORTIONED	Actual	1	0	0	1	1	0	0	0	0	0	0	3	3	3	0	3		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile) - York FT	YFT TRUST APPORTIONED	Actual	2	5	2	3	5	7	4	3	5	4	3	9	9	9	12	45		↑
		Target	1	3	3	2	1	3	2	8	10	5	5	3	71	45	20	46		
Incidence of healthcare acquired infection (HCAI) measure - Escherichia Coli infections	CCG ATTRIBUTED	Actual	21	24	20	23	19	33	25	33	26	15	23	34	34	34	64	293		↑
		Target	21	24	20	27	25	20	26	27	25	26	19	26	71	286	70	286		

Smoking at time of Delivery

Maternal smoking at delivery.	CCG	Actual		10.1%			12.0%			7.5%			11.9%				11.9%	10.4%		↑
		Target		12.1%			12.1%			12.1%			12.1%		12.1%	12.1%	12.1%	12.1%		

Programme Overview
- Planned Care
- Cancer Care
- Diagnostics

Validated data to April (Month 01)

Executive Lead:
Simon Cox, System Transformation Chief Officer

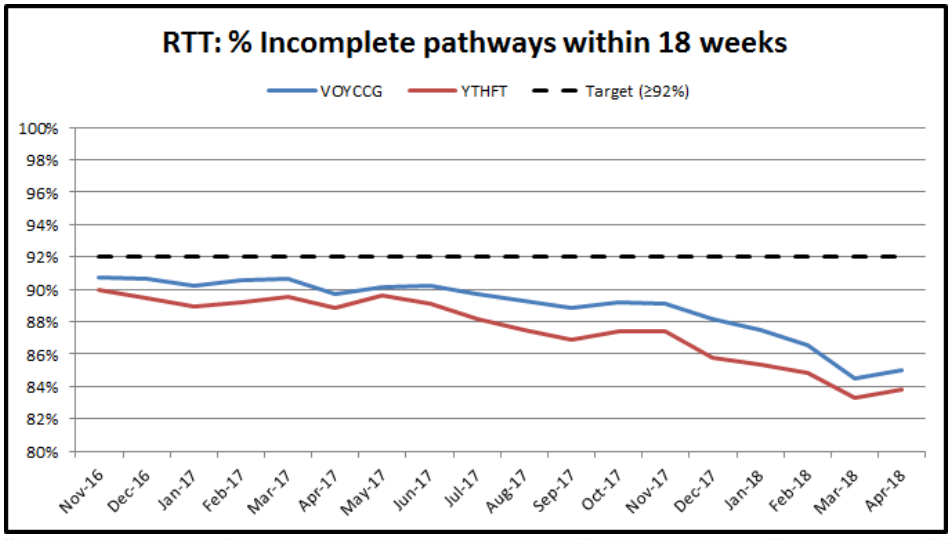
Clinical Lead:
Shaun O'Connell, Medical Director, CCG

Programme Leads:
Andrew Bucklee, Head of Commissioning and Delivery
Laura Angus, Lead Pharmacist
Fliss Wood, Performance Improvement Manager (Cancer)
Michaela Golodnitski, Senior Delivery Manager Cancer Alliance

NHS
Vale of York
Clinical Commissioning Group

PERFORMANCE PLANNED CARE: REFERRAL TO TREATMENT (RTT)

RTT: % Incomplete pathways within 18 weeks (Target ≥92%)					
Vale of York CCG			York Trust		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
84.5%	85.0%	↑	83.3%	83.8%	↑



Treatment Function	Total VOYCCG Incomplete Pathways	No. of 18 week breaches	% VOYCCG pathways within 18 weeks	52 week breaches
Neurosurgery	13	-	100.0%	0
General Medicine	204	2	99.0%	0
Geriatric Medicine	100	5	95.0%	0
Neurology	545	39	92.8%	0
Cardiology	990	76	92.3%	0
Other	1,573	127	91.9%	0
Rheumatology	465	49	89.5%	0
Gastroenterology	938	113	88.0%	0
Trauma & Orthopaedics	1,564	197	87.4%	2
Gynaecology	864	112	87.0%	0
Dermatology	993	135	86.4%	0
General Surgery	2,139	301	85.9%	0
Ear, Nose & Throat (ENT)	1,693	254	85.0%	0
Urology	1,044	199	80.9%	0
Ophthalmology	2,794	652	76.7%	1
Plastic Surgery	172	46	73.3%	0
Thoracic Medicine	718	208	71.0%	0
Cardiothoracic Surgery	6	2	66.7%	0
Grand Total	**16,815**	**2,517**	**85.0%**	**3**

Vale of York CCG's performance improved slightly from 84.5% in March to 85% in April 2018. This equates to 2,517 breaches of the 18 week target, from a cohort of 16,815. There were 3 x 52 week breaches for Vale of York patients in April – 2 T&O at Leeds and 1 Ophthalmology at NLAG.

York Trust's RTT performance in April 2018 also improved slightly to 83.8% which is above the planned trajectory of 83.3%. The final waiting list position at the end of March 2018 was 26,303 and this is required to be maintained (or reduced) by March 2019. The non-admitted backlog, which has been growing expediently in recent months was lower in April than in March and the DNA rate has reduced to 5% at York Hospital, reflecting the impact of the text messaging service and directorate work to address DNA rates.

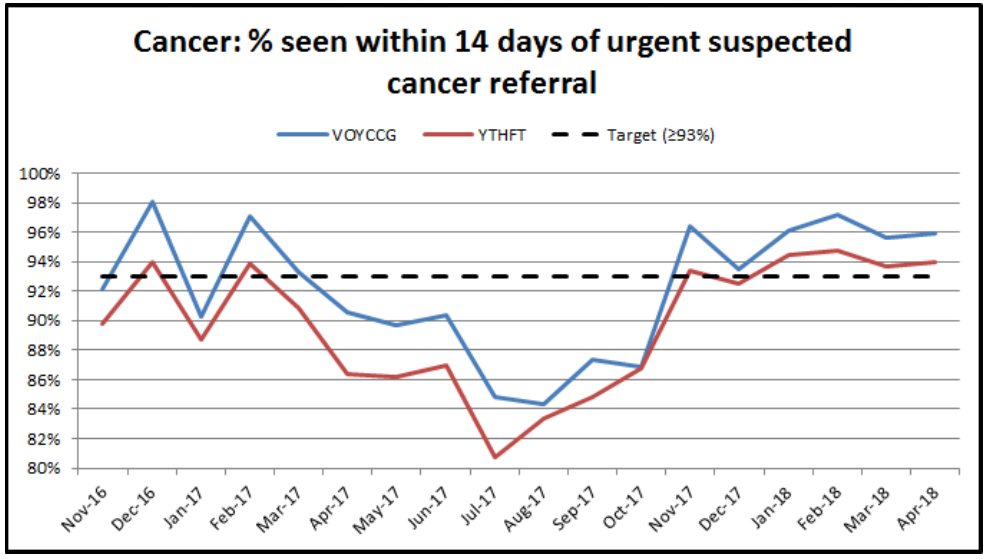
Long wait patients on the incomplete waiting list continue to be a concern. There are currently 191 patients waiting over 40 weeks for treatment and consequently there is a significant risk for further 52 week breaches.

Targeted actions for YTHFT in April 2018 included:-

- E-learning training package to support validation and improve data quality
- In-depth validation and review within the Head & Neck directorate.
- External analytical support to review theatre productivity.
- Trust finalised the modelling for the Operational Plan during April setting an expectation of elective delivery over 10 months to allow for winter pressures.
- Planned Care Steering Group has refreshed the priorities to understand the impact of the proposed CCG QIPP schemes.

PERFORMANCE PLANNED CARE: CANCER TWO WEEK WAITS

Cancer: % 2WW referrals seen within 14 days (Target ≥93%)					
Vale of York CCG			York Trust		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
95.6%	95.9%	↑	93.7%	93.9%	↑



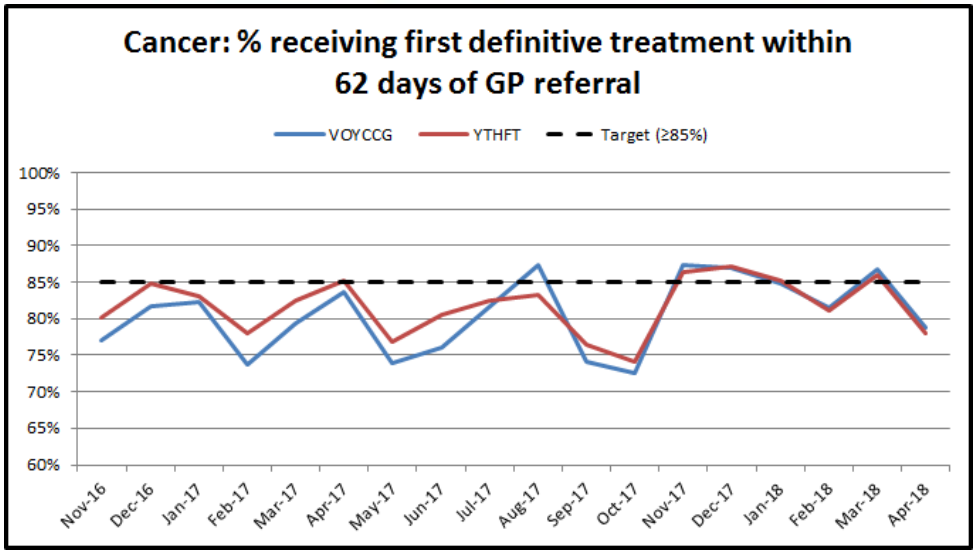
Vale of York CCG again achieved the 2WW Cancer Standard in April 2018 with performance of 95.9% against the 93% target. York Hospital also achieved the 2WW target in April with 93.9% performance.

April Cancer breach data is not yet available from eMBED but the majority of the 2WW breaches relate to Skin patients. YTHFT are working with the CCG to provide alternative models to reduce wait times for Skin patients particularly on the East Coast.

The Trust has seen a significant increase in prostate and colorectal two week fast track referrals in March 2018 which will impact on 2WW performance.

PERFORMANCE PLANNED CARE: CANCER 62 DAYS

Cancer: % treated within 62 days of urgent GP referral (Target ≥85%)					
Vale of York CCG			York Trust		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
86.8%	78.7%	↓	86.0%	78.0%	↓



Vale of York CCG failed to meet the 62 Day Cancer Standard in April 2018 achieving 78.7% against the 85% target. York Trust also failed to meet the 62 Day Cancer Standard in April 2018 with performance at 78.0%.

Breach analysis data is not yet available from eMBED but York Trust advised that their breaches were due to delays in Urology biopsies and robotics.

York Trust targeted actions in April include:-

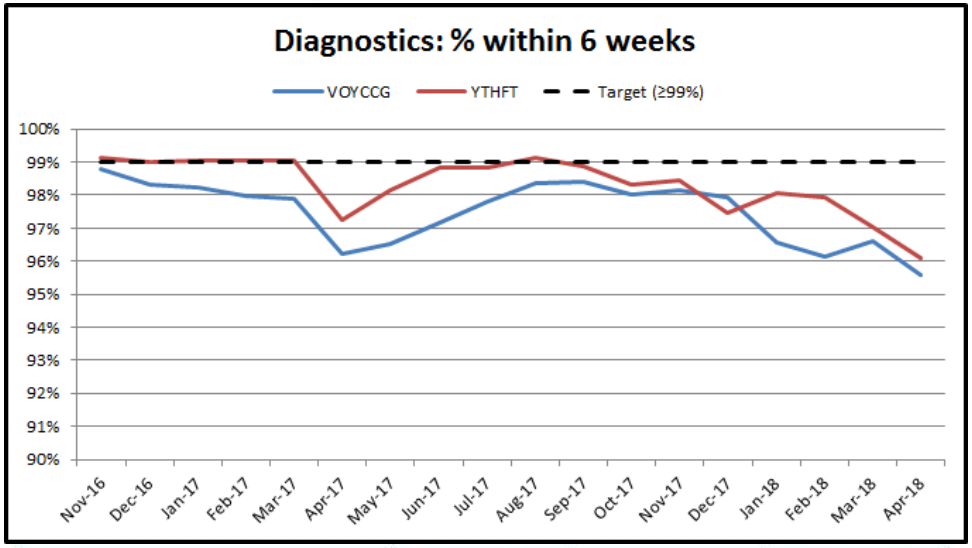
- The NHSI Elective Intensive Support Team have been on site and their work focused on finalising the approach to Clinical Harm Reviews, pathway analysis on key tumour sites and reviewing the workload of the MDT Co-ordinator Team.
- Cancer Training Strategy was approved by the YTHFT Cancer Board
- Patient Tracking teams have visited Gateshead and Hull hospitals to learn from best practice and strengthen communication with the specialist centres.

HCV Cancer Alliance has prioritised funding for diagnostics procurement of a networked radiology system to work across the three acute organisations in the STP. The Cancer Alliance team are currently working on the specification and will go out to tender in July 2018 with contract award scheduled for January 2019.

HCV Cancer Alliance advised that the HCV STP is unlikely to meet the 62 Day Cancer Standard for the months of May, June & July 2018 and consequently are forecasting receiving 75% of the budget for 80% target.

PERFORMANCE PLANNED CARE: DIAGNOSTICS

Diagnostics: % within 6 weeks (Target ≥99%)					
Vale of York CCG			York Trust		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
96.6%	95.6%	↓	97.0%	96.1%	↓



Diagnostic Type	Total VOYCCG Waiting List	Total >6 weeks	% within 6 weeks
BARIUM_ENEMA	11	0	100.0%
URODYNAMICS	8	0	100.0%
ECHOCARDIOGRAPHY	285	0	100.0%
NON_OBSTETRIC_ULTRASOUND	1037	6	99.4%
AUDIOLOGY_ASSESSMENTS	247	4	98.4%
MRI	1070	44	95.9%
GASTROSCOPY	335	15	95.5%
DEXA_SCAN	109	6	94.5%
CYSTOSCOPY	68	4	94.1%
PERIPHERAL_NEUROPHYS	41	3	92.7%
CT	595	44	92.6%
COLONOSCOPY	215	26	87.9%
FLEXI_SIGMOIDOSCOPY	118	18	84.7%
SLEEP_STUDIES	63	16	74.6%
ELECTROPHYSIOLOGY	0	0	
Grand Total	**4202**	**186**	**95.6%**

Vale of York CCG achieved 95.6% against the 99% target for patients waiting less than 6 weeks for a Diagnostic Test in April 2018. There were a total of 186 breaches out of 4202 on the waiting list.

CT breaches at Hull and East Yorkshire Hospitals NHS Trust (HEY) increased with 42 breaches for Vale of York CCG patients and a further 23 breaches for Scarborough and Ryedale CCG patients. CT scans have been subcontracted out to Spire but there are still on-going CT capacity issues at Hull.

The number of MRI breaches at York Trust increased to 39 in April 2018. 30 breaches related to children who require general anaesthetic. They have all now been offered treatment at Sheffield - 14 patients have accepted but 15 declined and want to wait for treatment at York, however, this should help to reduce the backlog.

There were 16 Sleep Studies breaches in April 2018 at York Hospital. The new equipment has arrived and staff are being trained to use it which will improve efficiency from July onwards and the Trust hope to clear the backlog by the end of August 2018.

York Teaching Hospitals Foundation Trust's overall performance was 96.1% in April 2018 and did not meet the diagnostic target of 99%.

KEY QUESTIONS: PERFORMANCE PLANNED CARE

Are targets being meet and are you assured this is sustainable?	What mitigating actions are underway?
Diagnostics – No **Cancer 2 week waits – Yes** **Cancer 62 day standard – No** **RTT – No**	**Diagnostics:** CT Scanner has been replaced at HEY and staff training on the new equipment. HEY also outsourced CT scans to SPIRE. Sleep Studies – New equipment arrived. Backlog should be cleared by end of August 2018. MRI GA cases – Children requiring GA have been offered treatment at Sheffield. YHFT are outsourcing work to address radiology reporting backlog whilst a medium term plan is developed. **Cancer:** HCV Cancer Alliance is currently undertaking a Demand & Capacity exercise to understand current and future demand for services across Humber, Coast & Vale STP. Workshop on 20 June 2018 to present the outcomes and agree way forward. HCV Alliance is also looking to procure a new networked radiology system which will allow the sharing of images and reporting across the STP footprint. NHSI Intensive Support Team are working with York Trust to improve 62 Day process and clinical pathways for Lung and Haematology. YTHFT's Cancer Board has been reconfigured with 4 work groups focused on: timed pathways, diagnostics, quality surveillance and patient outcomes, living with and beyond cancer. 3 additional radiographers trained to report plain film by June 2018, reporting 3000 plain film per annum and releasing consultant radiologist time to report an additional 6,000 complex radiographs. 2 WTE radiographers in post to support additional workload HCV Alliance have recruited Cancer Champions to promote cancer awareness and encourage people to self-refer.
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
YHFT Transformational Plan to be shared with Sub-CMB July 2018	HCV Alliance have advised that it is unlikely that the STP will meet the 62 Day Cancer Standard in May, June and July and consequently are planning on 75% of the budget for 80% target.

Programme Overview - Unplanned and Out of Hospital Care

Validated data to April (Month 01)

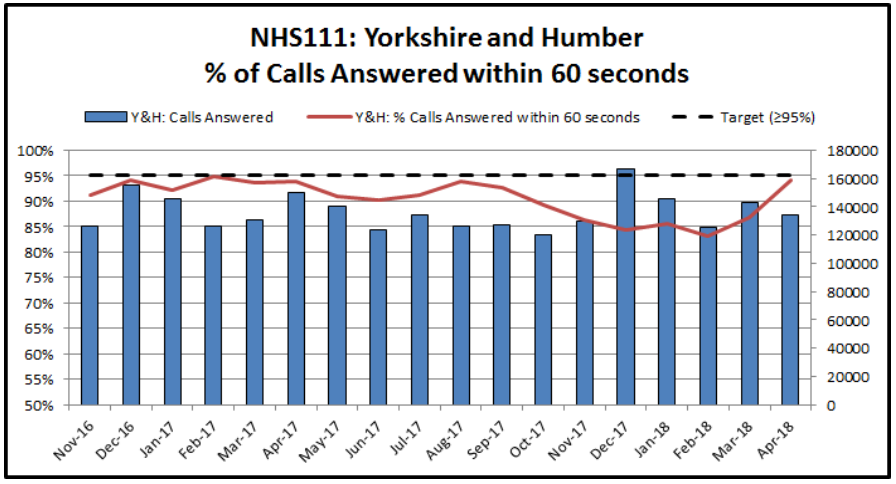
Executive Leads:
Kev Smith (Out of Hospital care), Simon Cox (Urgent & Emergency Care) and Denise Nightingale (DTOCs)
Programme Leads :
Fiona Bell, Assistant Director of Transformation & Delivery
Becky Case, Head of Transformation and Delivery
Locality leads: Shaun Macey and Heather Marsh
Clinical Leads:
Andrew Phillips, Medical Director VoY CCG
Peter Billingsley, GP, S&R CCG

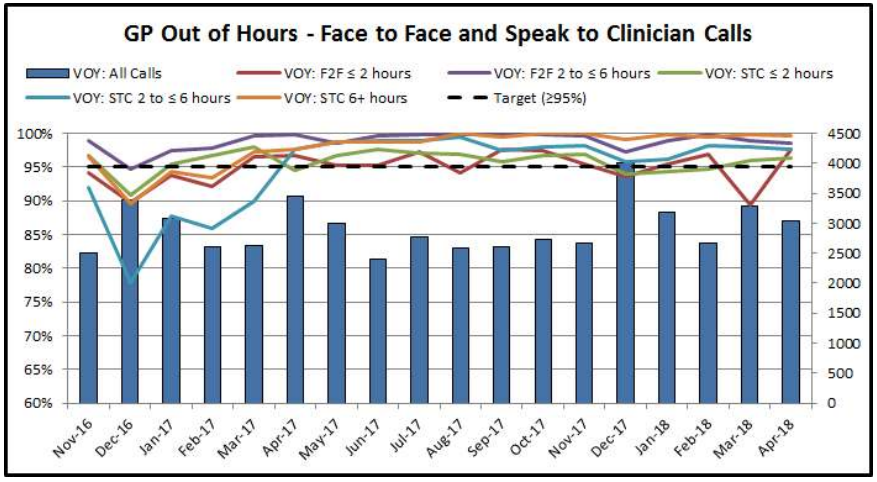
NHS
Vale of York
Clinical Commissioning Group

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

NHS111: Yorkshire and Humber					
Calls Offered			% Answered within 60 seconds		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
143,271	134,003	↓	86.9%	94.2%	↑

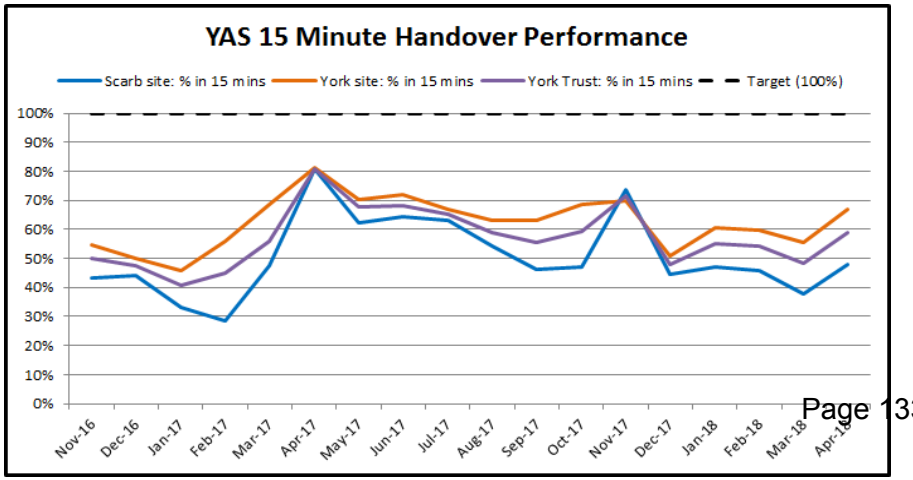
GP Out of Hours - Face to Face and Speak to Clinician Calls					
F2F calls within ≤2 hours (Target 95%)			STC calls within ≤2 hours (Target 95%)		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
89.3%	97.6%	↑	96.0%	96.4%	↑

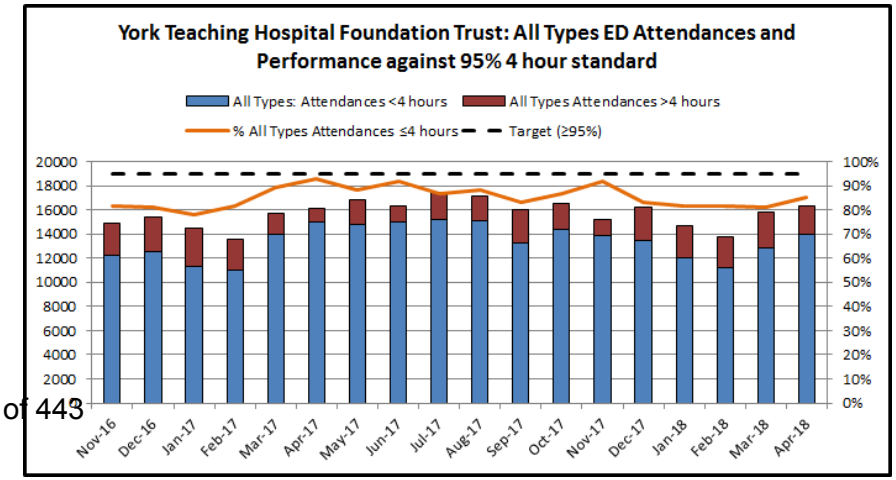




YAS 15 Minute Handover Performance					
Scarborough site (Target 100%)			York site (Target 100%)		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
37.8%	47.9%	↑	55.7%	66.8%	↑

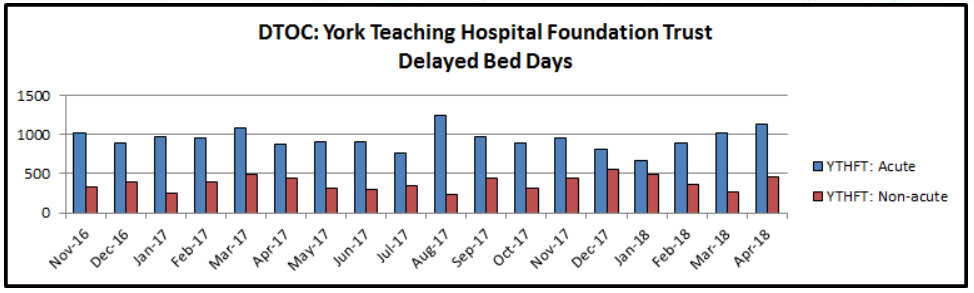
York Teaching Hospital Foundation Trust: ED 4 hour standard					
All Types Attendances			All Types % within 4 hours		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
15,845	16,374	↑	81.2%	85.1%	↑



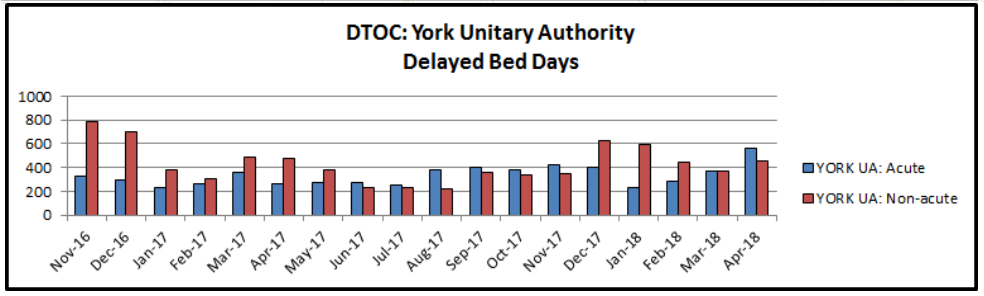


PERFORMANCE UNPLANNED CARE: DELAYED TRANSFERS OF CARE

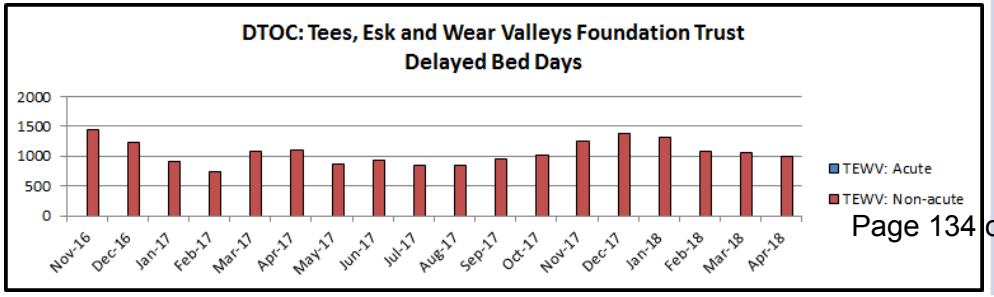
DTOC: YTHFT Delayed Bed Days					
Acute			Non-acute		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
1010	1134	⇧	266	464	⇧



DTOC: York UA Delayed Bed Days					
Acute			Non-acute		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
375	565	⇧	366	457	⇧



DTOC: TEWV Delayed Bed Days					
Acute			Non-acute		
Mar-18	Apr-18	DoT	Mar-18	Apr-18	DoT
N/A	N/A	N/A	1069	1003	⇩



The number of bed days for acute DTOCs at York Trust increased from 1010 in March to 1134 in April 2018. There was also a significant increase in the bed days for non-acute DTOCs from 266 in March to 464 in April 2018. This may in part be due to Fastrack delays now being counted in the DTOC numbers.

April was very busy for the first 2 weeks of the month and bed occupancy at York Hospital ranged from 82 – 98%. The number of patients delaying in York Hospital has significantly increased due to NHS delays with increases in nursing home and intermediate/rehabilitation delays. This is being further explored through the Complex Discharge working group.

Actions to address DTOCs include:-

- Daily review of discharges by YTHFT Discharge Liaison Team and CYC/NYCC
- Weekly SitRep meetings to support timely discharge
- YHFT are holding daily 8.30am operations meeting to identify 'gold ' patients and expedite patient discharges earlier in the day
- Social Workers and Discharge Liaison Team are working 7 days per week to facilitate discharges.
- Pilot with Fulford Nursing Home – 2 'time to think' beds for self-funders

Main reasons for DTOC delays are:-

- Shortage of reablement and long-term home care packages in City of York
- Providers are unable to fulfil the demand for home care packages and consequently patients are unable to move off re-ablement care resulting in long delays from acute beds
- Shortage of dementia nursing and residential placements in both York and North Yorkshire
- Patient choice delays

KEY QUESTIONS : PERFORMANCE UNPLANNED CARE

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

- **4-hour standard:** As expected, performance in April 18 shows an improvement in the ECS and a year on year improvement against April 17.
- **Ambulance Handovers**: These have improved in April with York similar to the regional trend, but continued poorer performance at Scarborough.
- **YAS response times:** The reporting discrepancies have been found across the area. April's ARP data shows a significant improvement for the lower priority journeys; the responsible commissioner has been asked for an explanation, and details as to sustainability.
- **OOH GP**: April data shows the expected improvement and the data in May also met the majority of targets. There are still a larger than usual number of 2-hour urgent calls being transferred – NHS111 have been asked to validate.
- **EDFD:** There has been no improvement.
- **NHS111:** April/May data shows improvement against the March average.
- **DTOC**: non-acute DTOCs continue to improve but domiciliary support capacity remains tight across CYC and NYCC.
- **Utilisation review**: Key elements of E&R review will be examined at the winter planning meetings now commenced.
- **NHS111 50% clinical booking target:** this is applicable to the STP and the region is currently at 48.8% and on trajectory to reach target by end July '18

What mitigating actions are underway?

- **4-hour standard:** continued work on internal flow (via SAFER) and weekend patient management has the current focus for mitigation.
- **Ambulance Handovers:** 'Action on A&E 2018' work will focus on this; fortnightly meetings and action plan now established. Next regional meeting is on 20/06. All partners engaged.
- **YAS response times:** continued working with the responsible commissioner will provide information for mitigation.
- **OOH GP:** No mitigating actions required at present; monitoring continues.
- **EDFD:** The review of this area has commenced.
- **NHS111:** No mitigating actions required at present; monitoring continues.
- **DTOC:** Work ongoing on joint commissioned forward plan between CCG and CYC.
- **Utilisation review:** now combined with winter planning.
- **NHS111 50% clinical booking target:** NHSE dental contribution to be added from October '17: 1.7%, local CAS alignment (NELincs): 2.1%

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

- **4-hour standard:** action plans against applicable projects have been shared with Complex Discharge Group and A&E Delivery Board as appropriate.
- **Ambulance Handovers:** key actions have been described against Action on A&E timeline and metrics will be agreed 18/06 and 20/06.
- **YAS response times:** CCG performance review to take place when possible from data.
- **OOH GP:** not applicable at present.
- **EDFD**: not applicable at present.
- **NHS111**: not applicable at present.
- **DTOC**: discussions around executive/senior leadership for this system issue are still ongoing. This is vital to ensure the trajectory designed as part of CCG QIPP will be achievable. Complex Discharge Group to continue to meet as a strategic group.
- **NHS111 50% clinical booking target:** as above – July date for recovery

Is further escalation required?

- **4-hour standard:** continued monitoring takes place with escalation calls established when required. Recovery is now usually within 24 hours.
- **Ambulance Handovers**: No
- **YAS response times**: No
- **OOH GP**: No
- **EDFD**: No
- **NHS111**: No
- **DTOC**: Continued focus from Complex Discharge Group and associated programmes. AEDB aware of issues.
- **NHS111 50% clinical booking target:** No

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

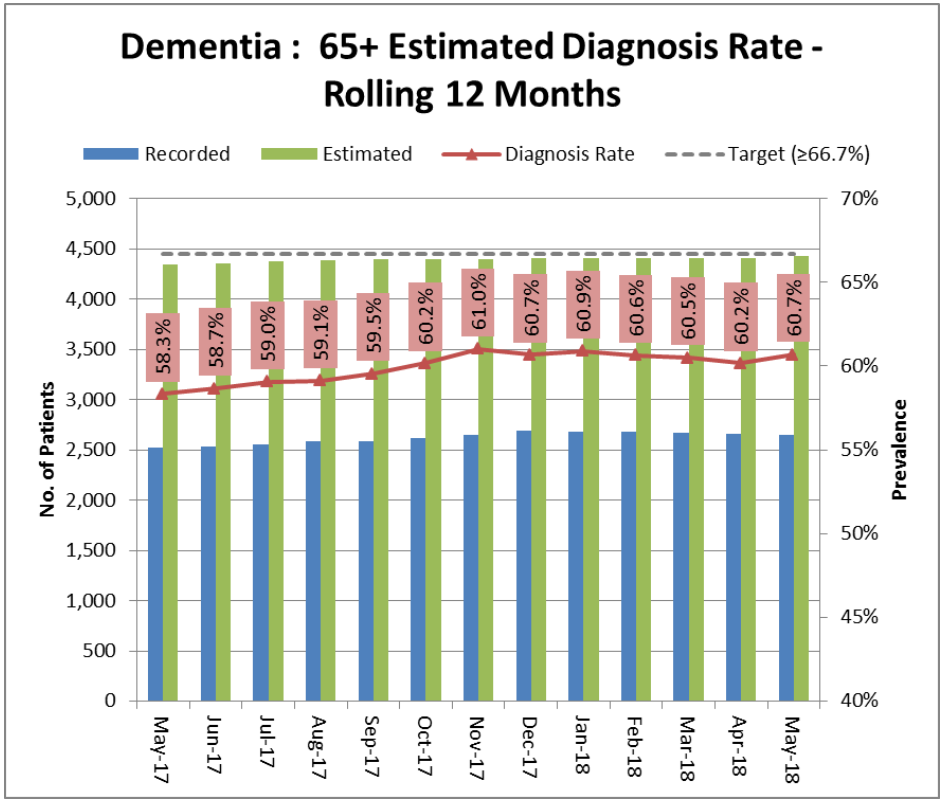
Executive Lead:
Denise Nightingale, Executive Director of Transformation & Delivery (MH/LD/CHC)

Programme Leads :
Paul Howatson, Head of Joint Programmes
Bev Hunter, Head of Mental Health Commissioning

Clinical Lead:
Louise Barker, GP

PERFORMANCE : MENTAL HEALTH – DEMENTIA

Dementia				
ientia : 65+ Estimated Diagnosis Rate - Rolling 12 Mo				
Feb-18	Mar-18	Apr-18	May-18	DoT
60.6%	60.5%	60.2%	60.7%	↑

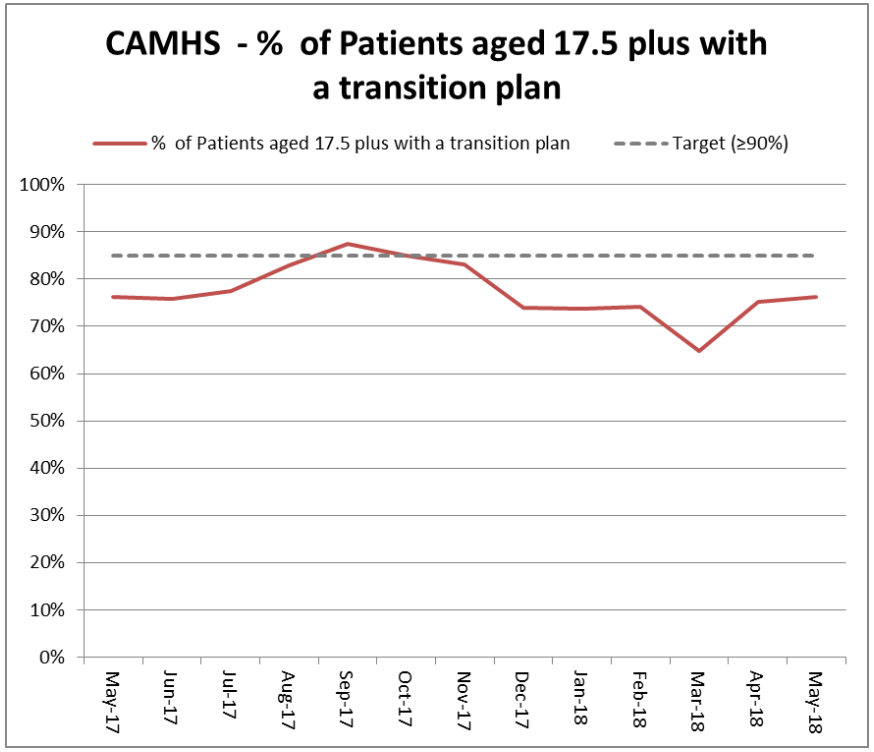


Diagnosis increased from 60.2% to 60.7%. 45 patients were added to the register (Haxby +15, Priory + 8) offset by 10 due to patient deaths however the estimated prevalence increased from 4,410 to 4,430 which reduced the impact of this increase.

Practice Name	Movement	Prevalance
BEECH TREE SURGERY	(1)	74.8%
DALTON TERRACE SURGERY	1	40.4%
EAST PARADE MEDICAL PRACTICE	1	48.7%
ELVINGTON MEDICAL PRACTICE	3	79.5%
ESCRICK SURGERY	0	61.3%
FRONT STREET SURGERY	3	40.0%
HAXBY GROUP PRACTICE	15	95.0%
HELMSLEY SURGERY	(2)	43.6%
JORVIK GILLYGATE PRACTICE	(2)	70.7%
KIRKBYMOORSIDE SURGERY	2	58.8%
MILLFIELD SURGERY	0	63.3%
MY HEALTH GROUP	1	56.9%
PICKERING MEDICAL PRACTICE	1	54.2%
POCKLINGTON GROUP PRACTICE	0	53.8%
POSTERNGATE SURGERY	(2)	58.3%
PRIORY MEDICAL GROUP	8	64.8%
SCOTT ROAD MEDICAL CENTRE	2	83.8%
SHERBURN GROUP PRACTICE	0	74.0%
SOUTH MILFORD SURGERY	2	45.0%
STILLINGTON SURGERY	0	51.0%
TADCASTER MEDICAL CENTRE	(2)	50.0%
TERRINGTON SURGERY	0	42.9%
THE OLD SCHOOL MEDICAL PRACTICE	1	57.5%
TOLLERTON SURGERY	0	31.8%
UNITY HEALTH	(1)	52.9%
YORK MEDICAL GROUP	5	47.7%
Based on Primary Care Data (Mar 15)	**35**	**62.5%**
Based on NHS Digital Data	**35**	**60.7%**

PERFORMANCE : MENTAL HEALTH

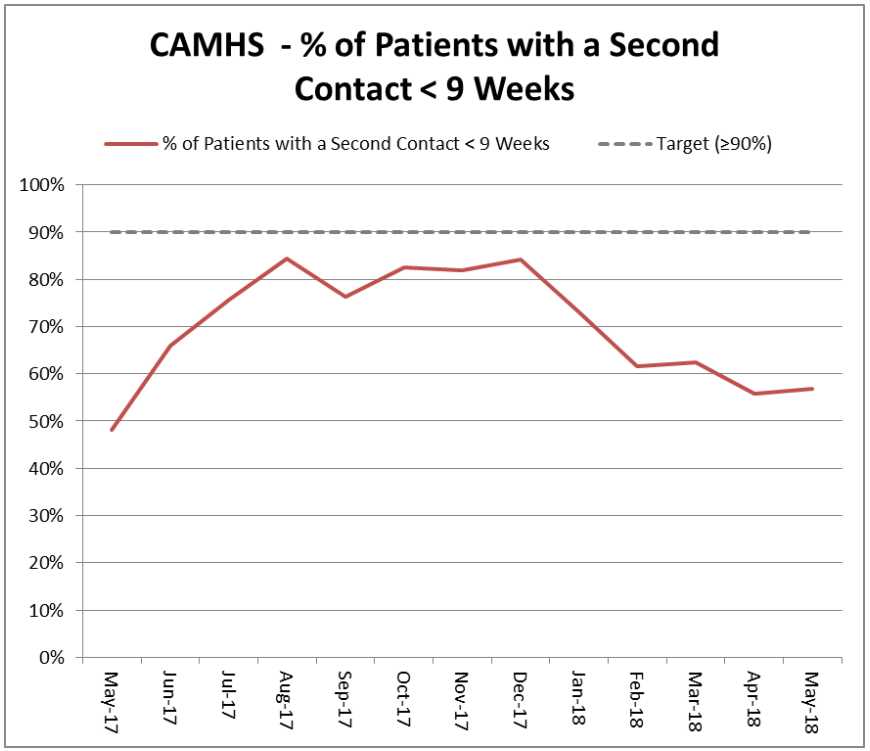
CAMHS				
% of Patients aged 17.5 plus with a transition plan				
Feb-18	Mar-18	Apr-18	May-18	DoT
74.1%	64.8%	75.3%	76.1%	↑



The position for May is 76.1%, which is attributable to 21 breaches out of 88 patients.

Reason	Count
New to Service	3
Emotional Wellbeing Pathway	6
Did Not Attend / Cancelled by Service User	5
Discharged / Due to be Discharged	3
Other	4
	21

CAMHS				
% of Patients with a Second Contact < 9 Weeks				
Feb-18	Mar-18	Apr-18	May-18	DoT
61.5%	62.4%	55.9%	56.8%	↑

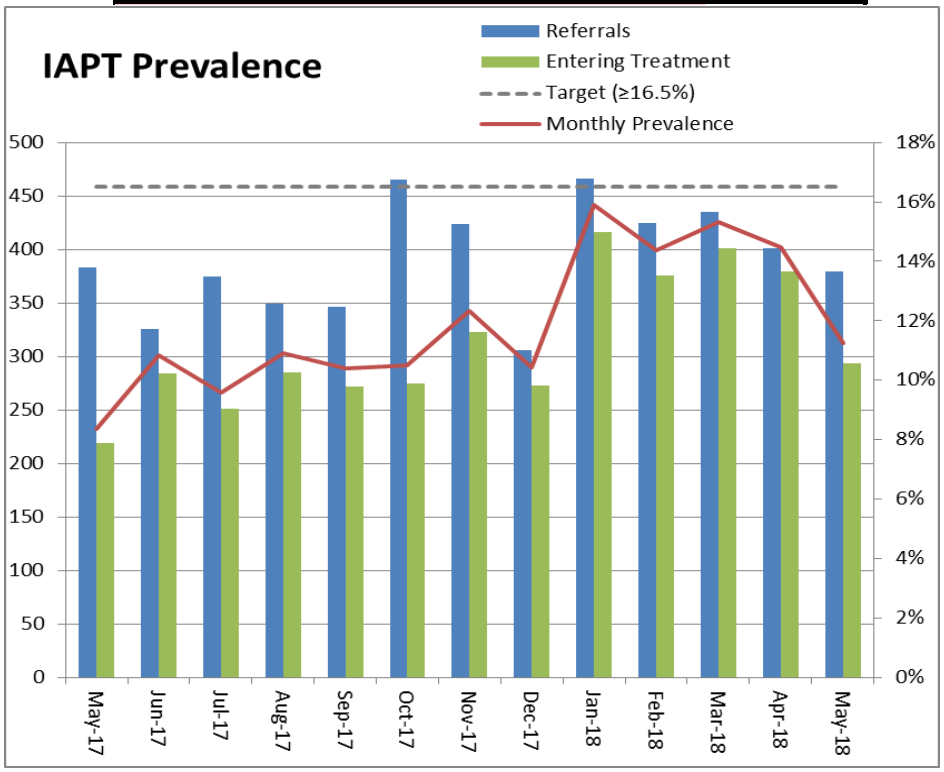


The position for May is 56.8%, which is attributable to 37 breaches out of 68 patients.

Reason	Count
Staff Capacity	29
Patient Choice	3
Other	5
	37

PERFORMANCE : MENTAL HEALTH

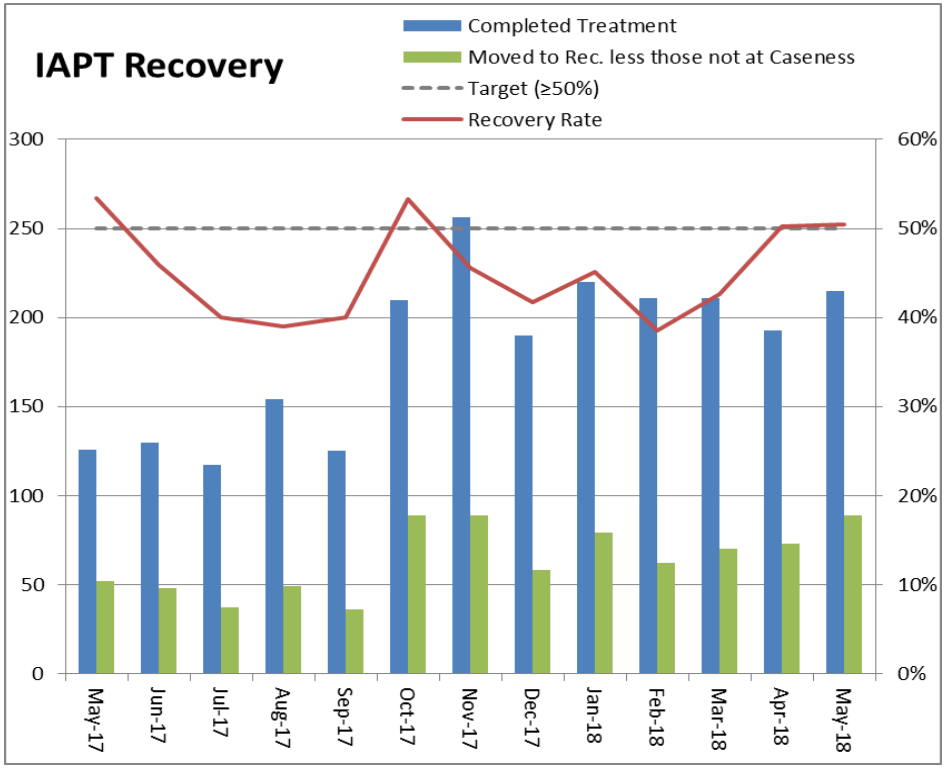
IAPT Prevalence				
Feb-18	Mar-18	Apr-18	May-18	DoT
14.4%	15.3%	14.5%	11.2%	↓



The local position for May is 11.2%.

294 patients have entered treated in May against a level of need of 2,617.

IAPT Recovery				
Feb-18	Mar-18	Apr-18	May-18	DoT
38.6%	42.6%	50.3%	50.5%	↑

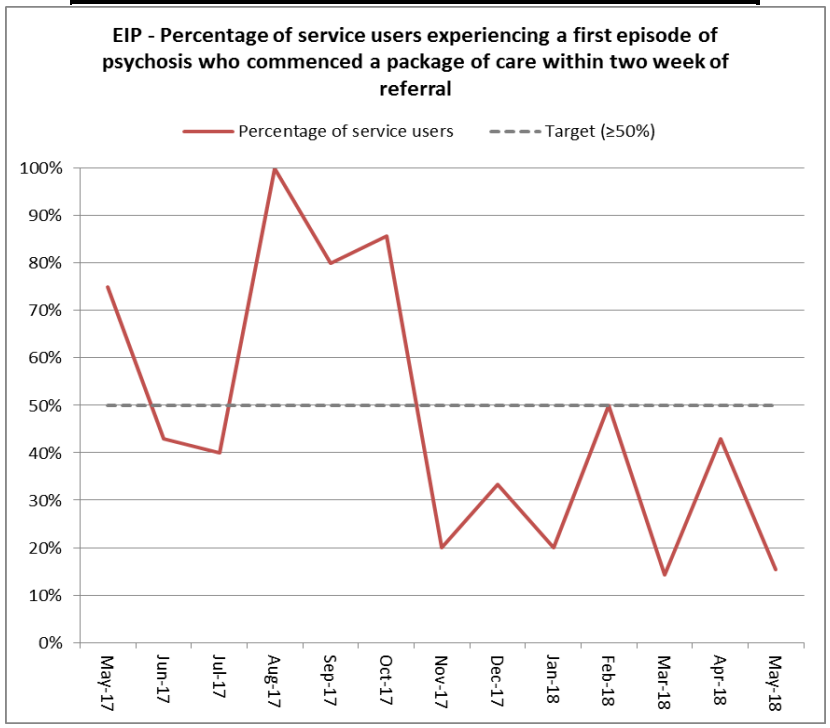


The local position for May is 50.9%.

Of the 215 patients who completed treatment : 102 moved to recovery and of the 113 patients who did not recover, 13 were not at clinical caseness at treatment commencement.

PERFORMANCE : MENTAL HEALTH / CONTINUING HEALTHCARE

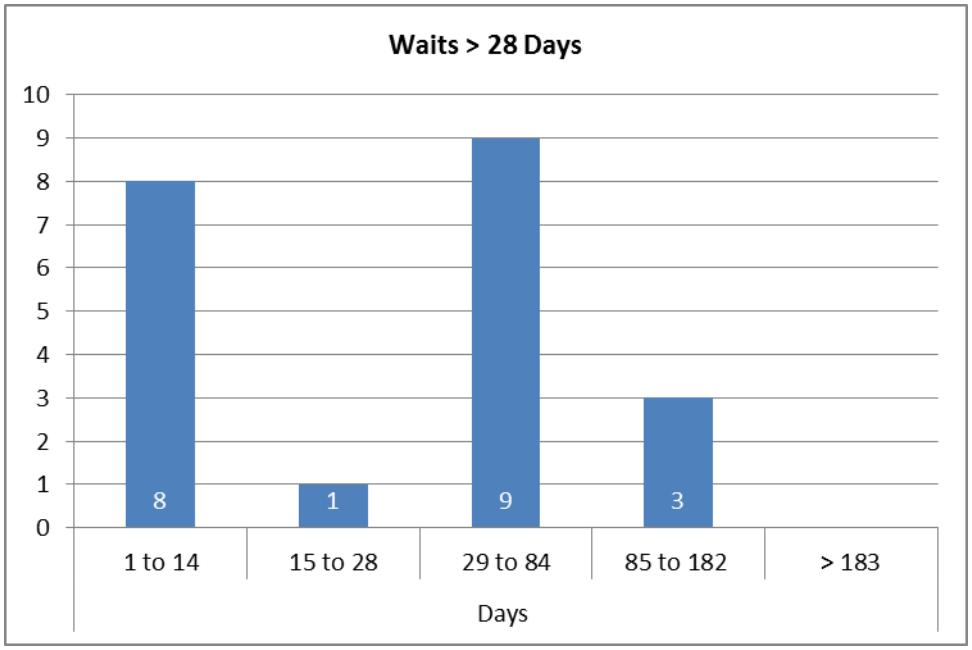
EIP				
Percentage of service users experiencing a first episode of psychosis who commenced a package of care within two week of referral				
Feb-18	Mar-18	Apr-18	May-18	DoT
50.0%	14.3%	42.9%	15.4%	↓



The position is attributable to 11 breaches out of 13 patients.

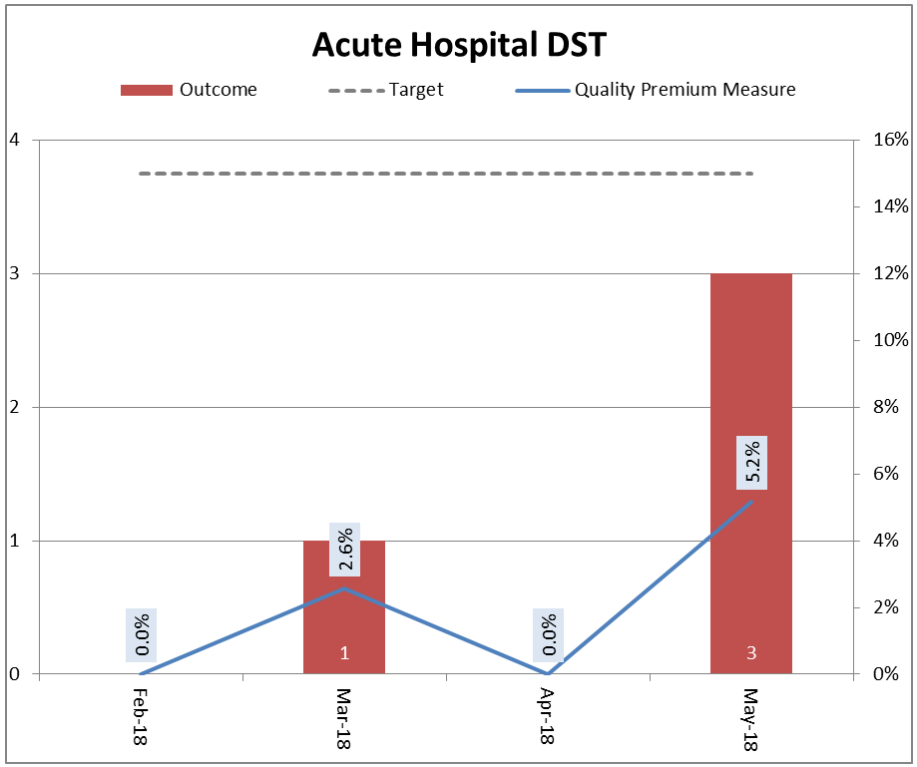
- Service is seeing a high number of referrals so staff are operating with a high case load.
- Service currently has 3 vacancies and a staff member off long term sick. Vacancies have been recruited to but will not be filled until September.

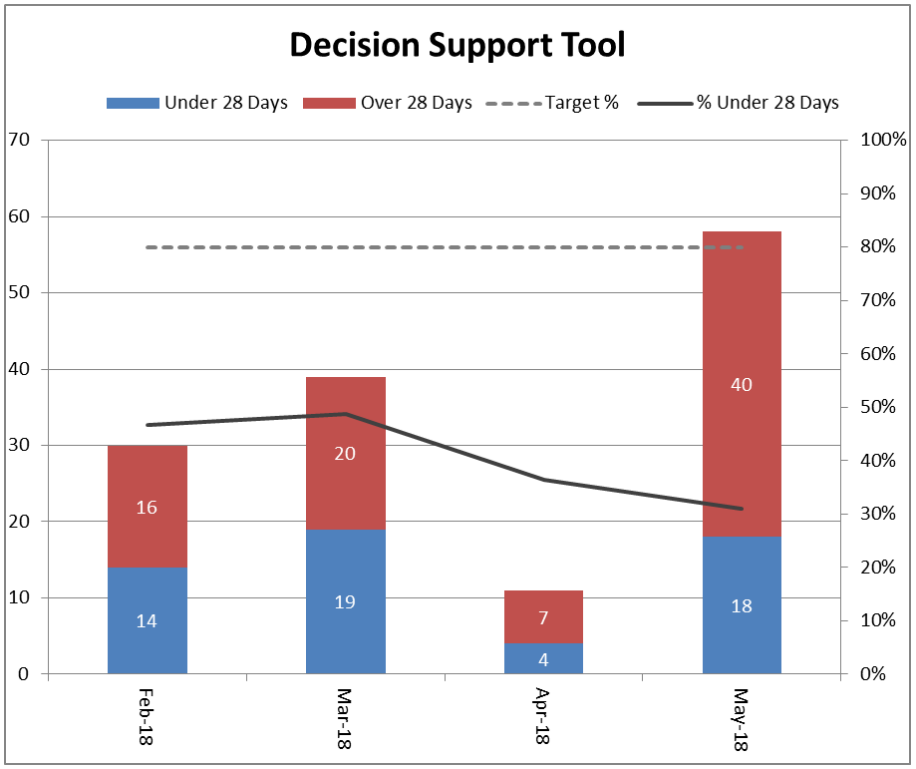
Continuing Health Care



A number of these clients had a DST and have been to panel but panel were unable to make a decision and outstanding information is await from CYC.

PERFORMANCE : MENTAL HEALTH / CONTINUING HEALTHCARE





Implementation of the discharge to assess approach has continued to deliver this target.

DSTs done in hospital are approved and based on location e.g. specialised care or complexity which would not suit a discharge to assess bed

80% of DSTs undertaken from referral to decision within 28 days not achieved

This demonstrates an increase in DSTs undertaken and productivity however challenges remain with obtaining social care assessors and the manual tracking of each case due to systems disconnect.

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

Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
Mental Health: **IAPT :** No **Dementia :** No **CAMHS :** No **EIP:** No **Psych Liaison**: No **CHC :** **Monthly Acute Hospital DST Activity :** Yes **Decision Support Tool :** No	**IAPT-** Concerns were flagged formally at last CMB regarding lack of maintenance of 15% in Month 1 plus GP referral slow down and lost slots. CMB informed action plan regarding GP referrals is being developed but reduction below 15% is largely to do with bank holidays. Month 2 position has worsened further, the CCG will formally escalate concerns through TEWV Performance sub group which will consider whether a contract notice is required. **Dementia** :The CCG continues to support primary care with coding and identification. Lists of patients with a recorded diagnosis in TEWV's services have been sent to GP practices to reconcile with practice QOF registers. The CCG are undertaking case finding in care homes and a GP education event took place on 12 June attended by 20 GPs. There were presentations from the Yorkshire & Humber GP dementia lead, Dementia Forward and the memory service. **CAMHS: Detailed papers provided over the last two months to F&P.** A further £120k (recurrent) is being made available. TEWV & the CCG discussions at CMB over where to invest. Awaiting decision. **EIP** : £54k (recurrent) increase has been allocated to TEWV to cover new roles. CMB clarified that delivery of this target is a TEWV priority as well. **Psychiatric Liaison :**Service still recruiting into this newly recurrent funded service **CHC:**. QA system roll out and data cleanse has begun.
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
IAPT : Trajectory agreed but is below national target. **Dementia :** The tasks in the action plan support progress towards delivery of the national target **CAMHS :** Action plan developed with TEWV to support meeting required performance targets. New trajectory requested following confirmation of £120k investment. **EIP** : Trajectory and investment for 18/19 agreed **Psychiatric Liaison :** Performance is being monitored monthly at CMB **CHC** : 28 day performance compliance anticipated by end of Quarter 2.	**IAPT recovery:** Verbal update to F & P Committee. **Dementia :** Verbal update to F & P Committee. **CAMHS :** Update papers to F & P in both May and June **EIP** : No further escalation at present, awaiting recruitment of new posts **Psychiatric Liaison :** No escalation required at this stage. **CHC :** Verbal update to F & P Committee

Acronyms

2WW	Two week wait: Urgent Cancer Referrals Target
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactive Disorder
AEDB	A and E Delivery Board
AHC	Annual Health Check
AIC	Aligned Incentive Contract
CAMHS	Child and Adolescent Mental Health Services
CC	Continuing Care
CEP	Capped Expenditure Process
CGA	Comprehensive Geriatric Assessment
CHC	Continuing Healthcare
CIP	Cost Improvement Plan
CMB	Contract Management Board
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (framework)
CRUK	Cancer Research UK
CT	Computerised Tomography Scan
CWTs	Cancer Waiting Times
CYC	City of York Council
CYP	Children & Young People
DEXA	Dual energy X-ray absorptiometry scan
DNA	Did not attend
DQIP	Data Quality Improvement Plan (in standard acute contract)
DTOC	Delayed Transfer of Care
ECS	Emergency Care Standard (4 hour target)
ED	Emergency Department

Acronyms continued

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

Acronyms continued

MNET	Medical Non Emergency Transport
MSK	Musculo-skeletal Service
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NYCC	North Yorkshire County Council
NYNET	NYNET Limited (created by North Yorkshire County Council, provides WAN connectivity and broadband services to private and public sector sites)
ONPOS	Online Non Prescription Ordering Service
OOH	Out of hours
PCH	Primary Care Home
PCU	Partnership Commissioning Unit
PIB	Permanent Injury Benefit
PID	Project Initiation Document
PLCV	Procedures of Limited Clinical Value
PM	Practice Manager
PMO	Programme Management Office
PNRC	Procedures Not Routinely Commissioned
POD	Point of Delivery
QIPP	Quality, Innovation, Productivity and Prevention
RRV	Rapid Response Vehicle
RSS	Referral Support Service
RTT	Referral to treatment
S&R / SRCCG	NHS Scarborough and Ryedale CCG
SRBI	Special Rehabilitation Brain Injury
STF	Sustainability and Transformation Fund

Acronyms continued

STP	Sustainability and Transformation Plan
STT	Straight to Triage
SUS	Secondary Uses Service (data)
TEWV	Tees, Esk and Wear Valleys NHS Foundation Trust
T&I	Trauma and Injury
T&O	Trauma and Orthopaedics
TIA	Transient Ischaemic Attack
ToR	Terms of Reference
UCC	Urgent Care Centre
UCP	Urgent Care Practitioner
VoY	Vale of York
VoY CCG	NHS Vale of York CCG
VCN	Vale of York Clinical Network
WLIs	Waiting List Initiatives
YAS	Yorkshire Ambulance Service
YDUC	Yorkshire Doctors Urgent Care
Y&H	Yorkshire & Humber (region)
YTHFT/York Trust	York Teaching Hospital NHS Foundation Trust
YDH	York District Hospital
YHEC	York Health Economics Consortium

York Teaching Hospital NHS
NHS Foundation Trust

Public Performance Report

May 2018

Our ultimate objective: To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Performance Report
Chapter Index

Chapter	Sub-Section
Performance	Trust Performance Index
	STF Trajectory
	Performance Benchmarking
	Trust Unplanned Care - Emergency Care Standard
	Trust Unplanned Care - Adult Admissions
	Trust Length of Stay & Delayed Transfers of Care
	Trust Paediatric Admissions
	Trust Planned Care Outpatients
	Trust Planned Care - Elective Activity & Theatre Utilisation
	Diagnostics & 18 Weeks RTT Incomplete
	Cancer

Activity Summary: Trust

Operational Performance: Unplanned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Emergency Care Attendances			16834	16330	17438	17134	15979	16570	15158	16236	14712	13719	15845	16374
Emergency Care Breaches			2018	1328	2268	2033	2697	2222	1263	2766	2728	2499	2983	2439
Emergency Care Standard Performance	95%	95%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%	85.1%
ED Conversion Rate: Proportion of ED attendances subsequently admitted			37.0%	36.8%	35.9%	36.5%	37.7%	37.7%	39.0%	40.8%	40.9%	40.0%	39.0%	38.6%
ED Total number of patients waiting over 8 hours in the departments			378	158	323	274	528	371	152	791	833	668	872	607
ED 12 hour trolley waits	0	0	3	0	2	1	1	2	0	5	14	15	40	13
ED: % of attendees assessed within 15 minutes of arrival			72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%	63.9%
ED: % of attendees seen by doctor within 60 minutes of arrival			40.1%	43.3%	36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%	40.2%	41.1%
Ambulance handovers waiting 15-29 minutes	0	0	272	335	360	446	469	745	649	823	702	679	784	671
Ambulance handovers waiting 30-59 minutes	0	0	164	150	215	258	331	368	172	537	424	360	471	313
Ambulance handovers waiting >60 minutes	0	0	92	75	96	106	207	257	55	548	390	367	419	297
Non Elective Admissions (excl Paediatrics & Maternity)			4378	4476	4421	4411	4251	4411	4304	4575	4515	4092	4525	4447
Non Elective Admissions - Paediatrics			664	607	616	495	673	790	800	934	736	654	844	706
Delayed Transfers of Care - Acute Hospitals			908	902	806	1238	965	932	958	865	660	885	1010	1134
Delayed Transfers of Care - Community Hospitals			313	298	352	234	445	312	439	506	483	357	266	464
Patients with LoS >= 7 Midnights (Elective & Non-Elective)			1109	1013	1063	1015	1048	1057	1045	1130	1153	1034	1108	1004
Ward Transfers - Non clinical transfers after 10pm	300 per Qtr	100	90	60	110	70	84	67	57	113	99	106	94	106
Emergency readmissions within 30 days			800	815	772	745	712	738	796	876	768	756	2 months behind	2 months behind

Operational Performance: Planned Care	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Outpatients: All Referral Types			17604	18568	17686	16977	16599	18088	17966	14977	17804	15711	17026	16772
Outpatients: GP Referrals			9208	10097	9386	9134	9044	9751	9758	7794	9672	8637	9452	9191
Outpatients: Consultant to Consultant Referrals			2209	2283	2286	2240	2007	2314	2215	1894	2143	1936	1968	1971
Outpatients: Other Referrals			6187	6188	6014	5603	5548	6023	5993	5289	5989	5138	5606	5610
Outpatients: 1st Attendances			12318	12517	11979	11741	11721	12797	12665	10091	12309	10091	12666	11171
Outpatients: Follow Up Attendances			27794	27820	26708	26558	26826	28311	29312	24019	29717	24019	29845	25553
Outpatients: 1st to FU Ratio			2.26	2.22	2.23	2.26	2.29	2.21	2.31	2.38	2.41	2.38	2.36	2.29
Outpatients: DNA rates			7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%	5.7%
Outpatients: Cancelled Clinics with less than 14 days notice	180	180	163	147	129	121	188	176	167	133	210	213	194	168
Outpatients:Hospital Cancelled Outpatient Appointments for non-clinical reasons			891	942	834	823	817	862	780	702	949	757	844	886
Diagnostics: Patients waiting <6 weeks from referral to test	99%	99%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%	96.1%
Elective Admissions			749	758	715	721	683	790	790	597	568	604	531	637
Day Case Admissions			6216	6364	5896	6047	5846	6254	6151	5179	6069	5538	5827	5532
Cancelled Operations within 48 hours - Bed shortages			57	10	23	12	38	27	2	74	118	129	168	62
Cancelled Operations within 48 hours - Non clinical reasons			154	57	64	57	84	91	65	169	191	189	205	115
Theatres: Utilisation of planned sessions			86.9%	89.3%	88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%	84.0%	88.9%
Theatres: number of sessions held			621	633	629	590	619	704	718	542	599	543	520	565
Theatres: Lost sessions < 6 wks notice (list available but lost due to leave, staffing etc)			84	71	72	56	77	57	54	76	74	50	105	76

Activity Summary: Trust

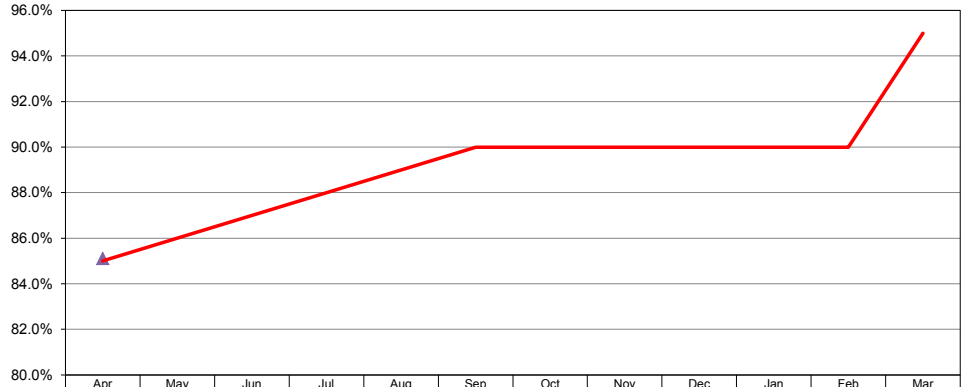
18 Weeks Referral To Treatment	Target/ Threshold 2018/19	Monthly Target/ Threshold	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Incomplete Pathways	92%	92%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%	83.8%
Waits over 52 weeks for incomplete pathways	0	0	1	0	1	1	0	1	0	0	0	1	2	1
Waits over 36 weeks for incomplete pathways	0	0	165	156	152	197	197	199	202	238	260	297	356	409
Total Admitted and Non Admitted waiters	< 26303	< 26303	25746	26202	26499	26148	25526	25174	24894	25006	25185	25334	26303	26967
Number of patients on Admitted Backlog (18+ weeks)	-	-	1376	1331	1418	1353	1457	1465	1448	1623	1818	1928	2223	2303
Number of patients on Non Admitted Backlog (18+ weeks)	-	-	1302	1520	1720	1976	1884	1699	1761	1816	1880	1921	2179	2070

Cancer (one month behind due to national reporting timetable)	Target/ Threshold 2018/19	Quarterly target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Cancer 2 week (all cancers)	93%	93%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%	1 month behind
Cancer 2 week (breast symptoms)	93%	93%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%	1 month behind
Cancer 31 day wait from diagnosis to first treatment	96%	96%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%	1 month behind
Cancer 31 day wait for second or subsequent treatment - surgery	94%	94%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%	1 month behind
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1 month behind
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%	1 month behind
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	90%	93.5%	96.4%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%	1 month behind

Sustainability and Transformation Fund Trajectory (STF) and Performance Recovery Trajectories

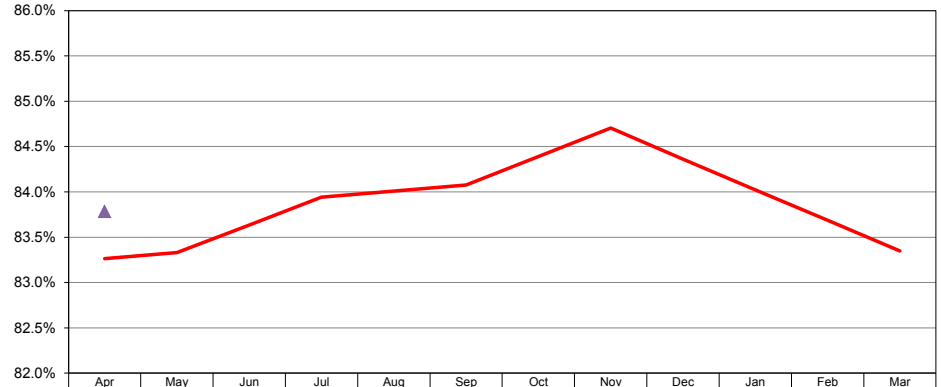
May 2018

Emergency Care Standard Improvement Trajectory



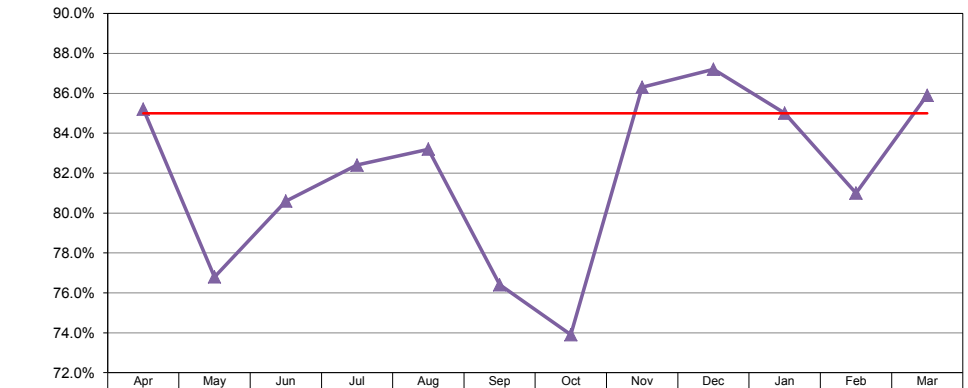
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance	85.1%											
STF Trajectory	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%

Referral To Treatment Incomplete Pathways



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Incomplete Pathways	83.8%											
Trajectory	83.3%	83.3%	83.6%	83.9%	84.0%	84.1%	84.4%	84.7%	84.4%	84.0%	83.7%	83.4%

Cancer 62 Day Waits For First Treatment (From Urgent GP Referral)



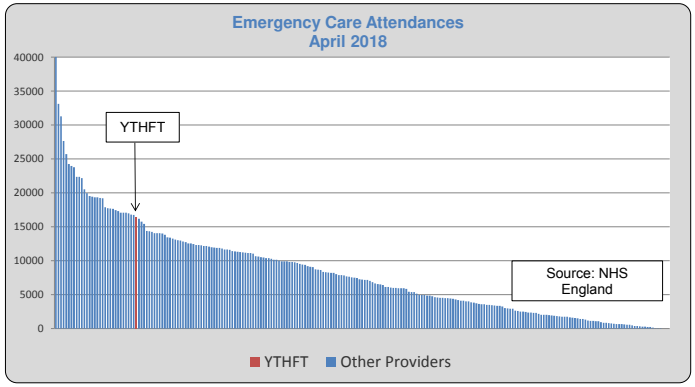
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer 62 Day Waits	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%
Trajectory	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

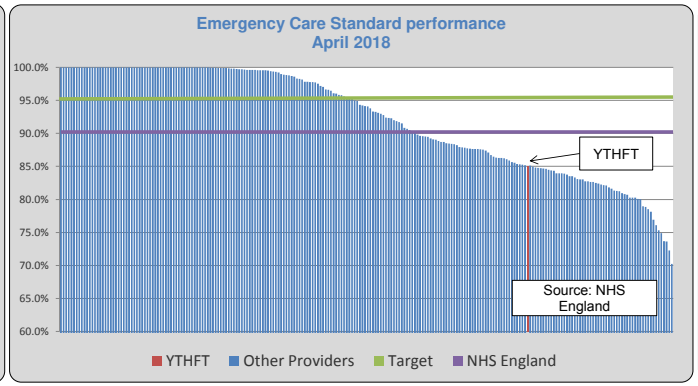
Please note: scales on graphs may be different.

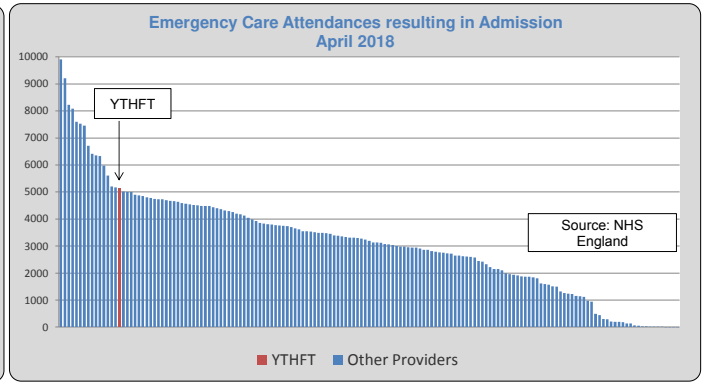
Performance Benchmarking

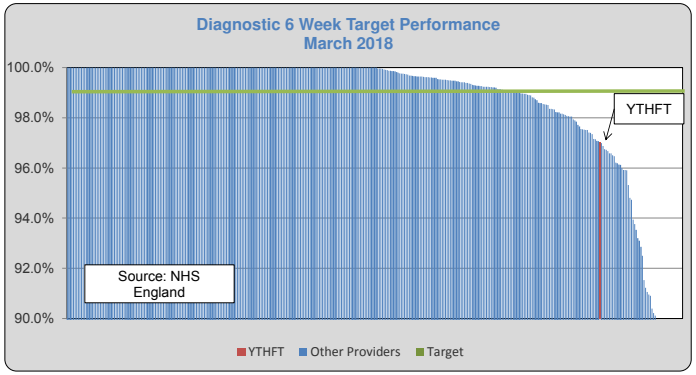
April 2018

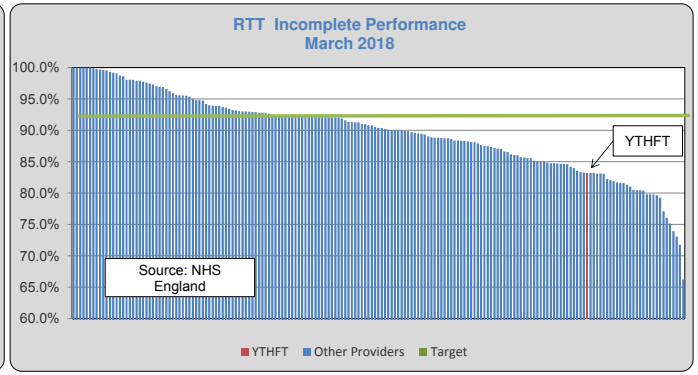
All graphs are benchmarked against latest available national data

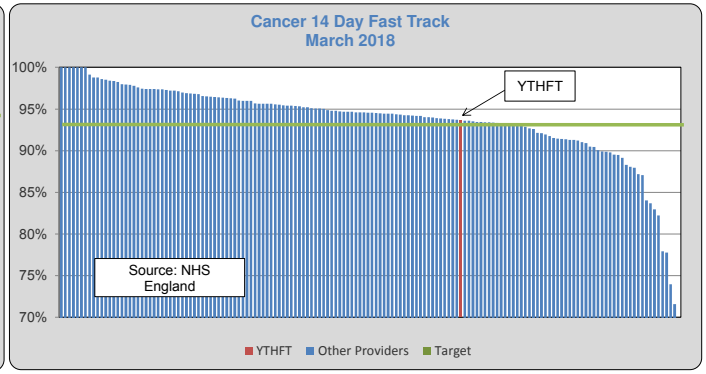


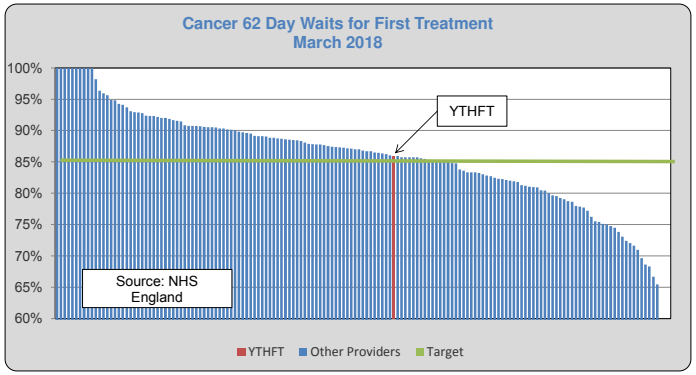








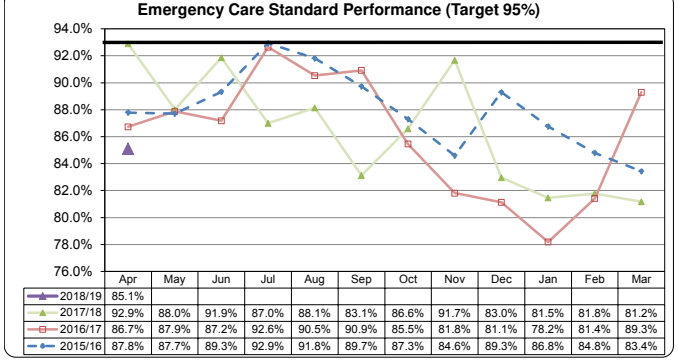




Trust Unplanned Care
Emergency Care Standard

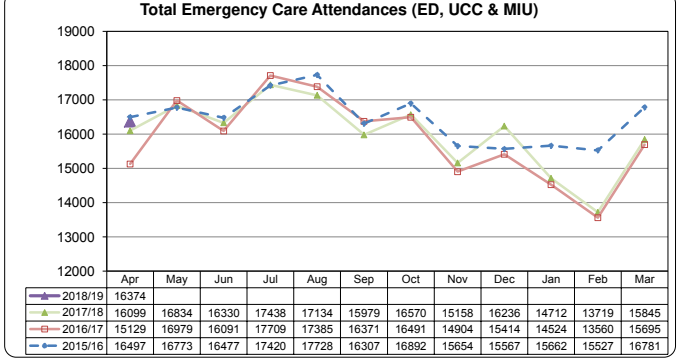
May 2018

Emergency Care Standard Performance (Target 95%)



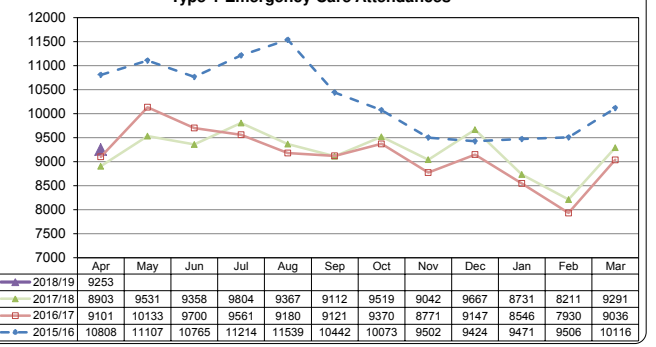
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	85.1%											
2017/18	92.9%	88.0%	91.9%	87.0%	88.1%	83.1%	86.6%	91.7%	83.0%	81.5%	81.8%	81.2%
2016/17	86.7%	87.9%	87.2%	92.6%	90.5%	90.9%	85.5%	81.8%	81.1%	78.2%	81.4%	89.3%
2015/16	87.8%	87.7%	89.3%	92.9%	91.8%	89.7%	87.3%	84.6%	89.3%	86.8%	84.8%	83.4%

Total Emergency Care Attendances (ED, UCC & MIU)



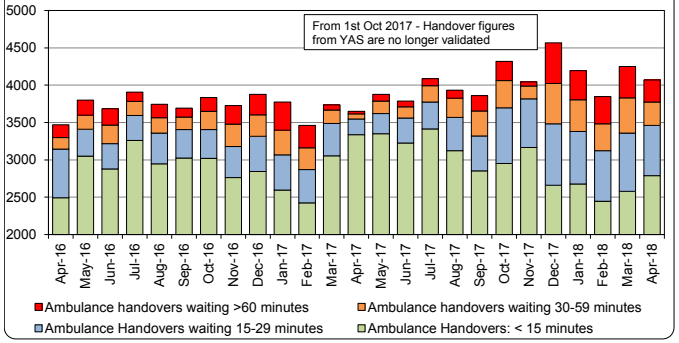
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	16374											
2017/18	16099	16834	16330	17438	17134	15979	16570	15158	16236	14712	13719	15845
2016/17	15129	16979	16091	17709	17385	16371	16491	14904	15414	14524	13560	15695
2015/16	16497	16773	16477	17420	17728	16307	16892	15654	15567	15662	15527	16781

Type 1 Emergency Care Attendances

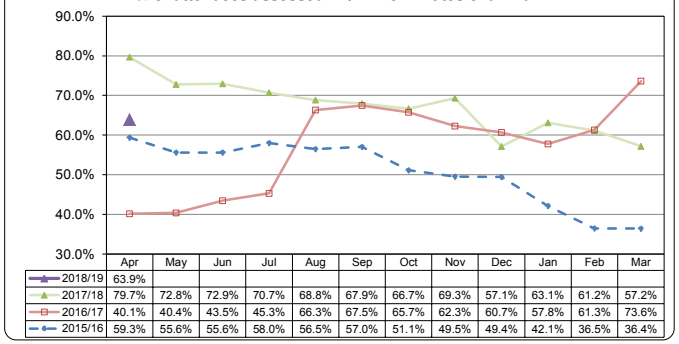


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9253											
2017/18	8903	9531	9358	9804	9367	9112	9519	9042	9667	8731	8211	9291
2016/17	9101	10133	9700	9561	9180	9121	9370	8771	9147	8546	7930	9036
2015/16	10808	11107	10765	11214	11539	10442	10073	9502	9424	9471	9506	10116

Ambulance Handovers

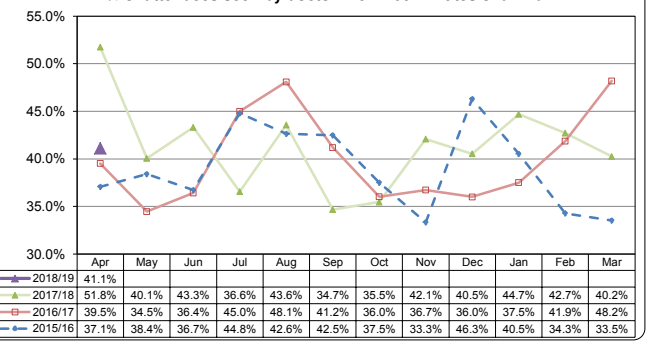


ED: % of attendees assessed within 15 minutes of arrival



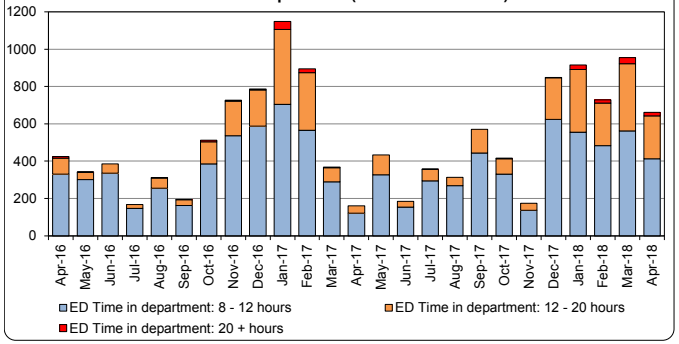
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	63.9%											
2017/18	79.7%	72.8%	72.9%	70.7%	68.8%	67.9%	66.7%	69.3%	57.1%	63.1%	61.2%	57.2%
2016/17	40.1%	40.4%	43.5%	45.3%	66.3%	67.5%	65.7%	62.3%	60.7%	57.8%	61.3%	73.6%
2015/16	59.3%	55.6%	55.6%	58.0%	56.5%	57.0%	51.1%	49.5%	49.4%	42.1%	36.5%	36.4%

ED: % of attendees seen by doctor within 60 minutes of arrival

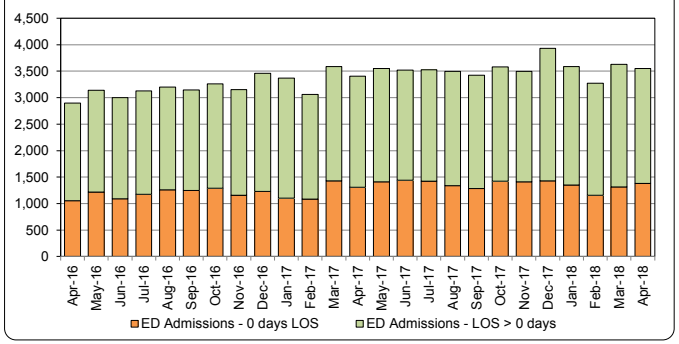


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	41.1%											
2017/18	51.8%	40.1%	43.3%	36.6%	43.6%	34.7%	35.5%	42.1%	40.5%	44.7%	42.7%	40.2%
2016/17	39.5%	34.5%	36.4%	45.0%	48.1%	41.2%	36.0%	36.7%	36.0%	37.5%	41.9%	48.2%
2015/16	37.1%	38.4%	36.7%	44.8%	42.6%	42.5%	37.5%	33.3%	46.3%	40.5%	34.3%	33.5%

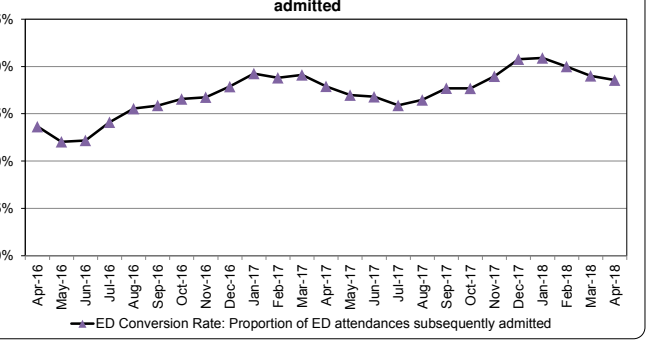
ED Time in Department (Number of Patients)



ED Admissions



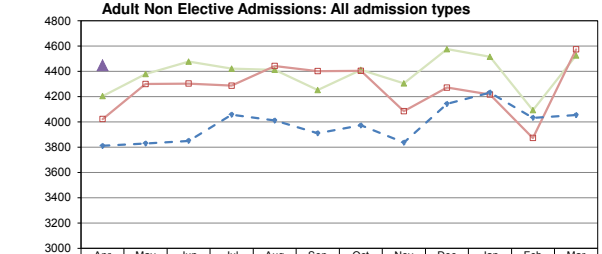
ED Conversion Rate; Proportion of ED attendances subsequently admitted



Trust Unplanned Care
Adult Admissions

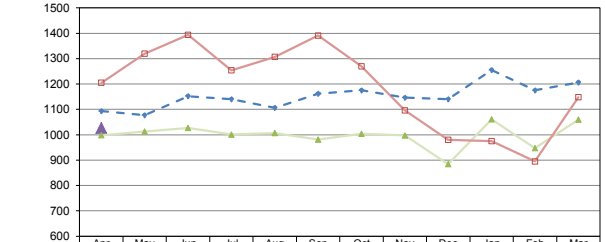
May 2018

Adult Non Elective Admissions: All admission types



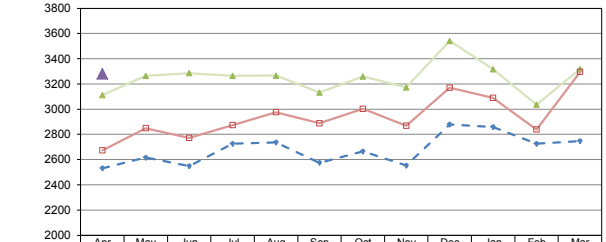
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	4447											
2017/18	4204	4378	4476	4421	4411	4251	4411	4304	4575	4515	4092	4525
2016/17	4022	4299	4303	4286	4442	4401	4403	4084	4271	4216	3872	4574
2015/16	3810	3829	3850	4057	4010	3910	3972	3836	4142	4232	4032	4054

Adult Non Elective Admissions: GP Admissions



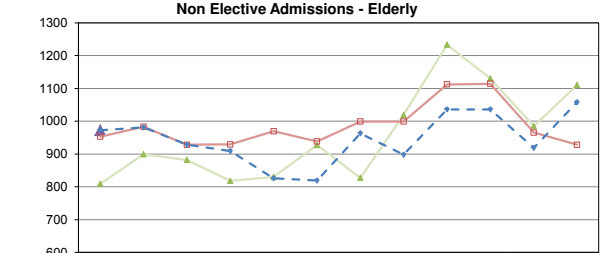
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1027											
2017/18	998	1013	1027	1001	1007	981	1004	997	884	1061	947	1060
2016/17	1205	1320	1394	1254	1307	1391	1270	1096	980	975	895	1148
2015/16	1093	1077	1152	1140	1106	1162	1175	1146	1140	1255	1175	1206

Adult Non Elective Admissions: ED Admissions



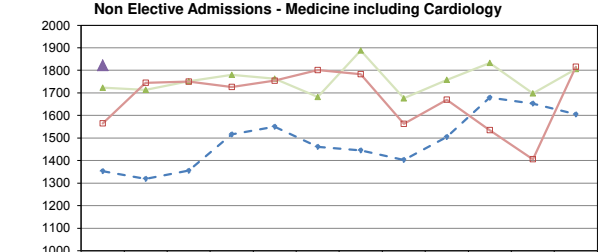
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	3281											
2017/18	3111	3264	3286	3264	3266	3132	3259	3172	3541	3317	3036	3318
2016/17	2674	2849	2772	2874	2976	2888	3003	2869	3170	3090	2839	3296
2015/16	2532	2616	2549	2726	2737	2575	2665	2553	2879	2859	2726	2747

Non Elective Admissions - Elderly



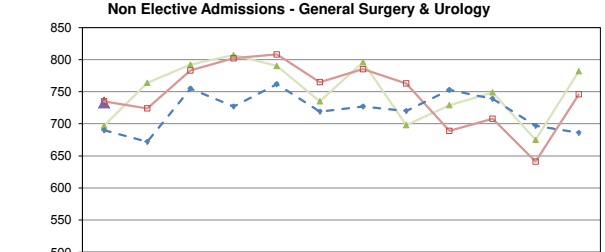
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	972											
2017/18	809	899	882	818	830	927	827	1019	1233	1130	985	1110
2016/17	953	983	928	929	969	938	999	999	1112	1114	965	928
2015/16	972	981	928	909	826	819	963	898	1036	1036	919	1058

Non Elective Admissions - Medicine including Cardiology



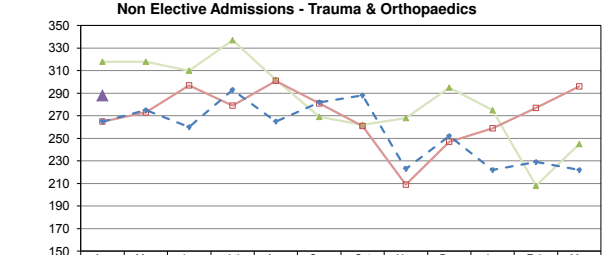
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1822											
2017/18	1723	1714	1751	1780	1763	1682	1888	1676	1758	1833	1698	1806
2016/17	1565	1745	1750	1726	1754	1801	1783	1563	1670	1535	1406	1816
2015/16	1353	1319	1355	1516	1550	1461	1445	1403	1505	1679	1653	1605

Non Elective Admissions - General Surgery & Urology



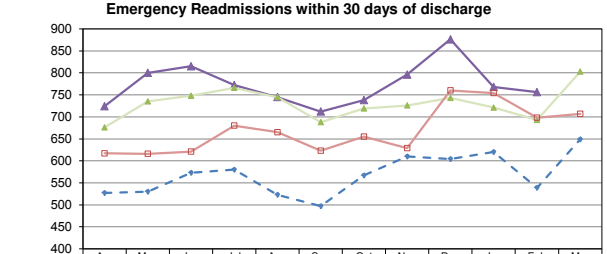
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	733											
2017/18	697	764	792	807	790	735	796	698	729	749	675	782
2016/17	735	724	783	802	808	765	785	763	689	708	641	746
2015/16	690	672	755	727	762	719	727	720	753	739	697	686

Non Elective Admissions - Trauma & Orthopaedics



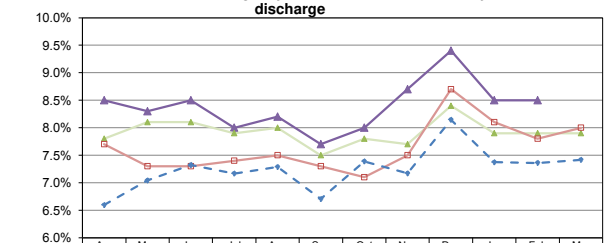
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	288											
2017/18	318	318	310	337	302	269	262	268	295	275	208	245
2016/17	265	273	297	279	301	281	261	209	247	259	277	296
2015/16	265	275	260	293	265	282	288	223	252	222	229	222

Emergency Readmissions within 30 days of discharge



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	724	800	815	772	745	712	738	796	876	768	756	
2016/17	676	735	748	766	745	688	719	726	743	721	693	803
2015/16	617	616	621	680	665	623	655	629	760	754	698	707
2014/15	527	530	573	580	523	497	567	610	604	620	539	649

Readmission Rate: Emergency Readmissions within 30 days of discharge

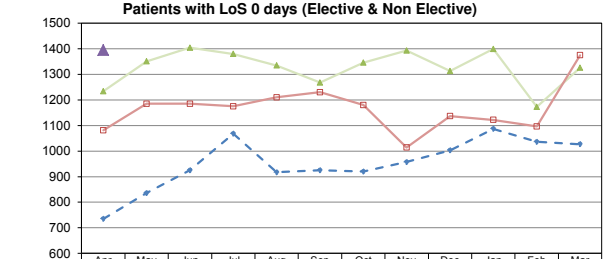


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	8.5%	8.3%	8.5%	8.0%	8.2%	7.7%	8.0%	8.7%	9.4%	8.5%	8.5%	
2016/17	7.8%	8.1%	8.1%	7.9%	8.0%	7.5%	7.8%	7.7%	8.4%	7.9%	7.9%	7.9%
2015/16	7.7%	7.3%	7.3%	7.4%	7.5%	7.3%	7.1%	7.5%	8.7%	8.1%	7.8%	8.0%
2014/15	6.6%	7.0%	7.3%	7.2%	7.3%	6.7%	7.4%	7.2%	8.1%	7.4%	7.4%	7.4%

Trust Length of Stay & Delayed Transfers of Care (DTOC)

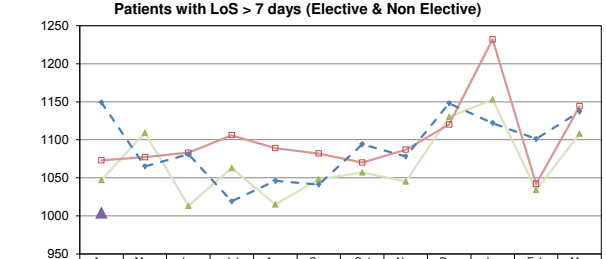
May 2018

Patients with LoS 0 days (Elective & Non Elective)



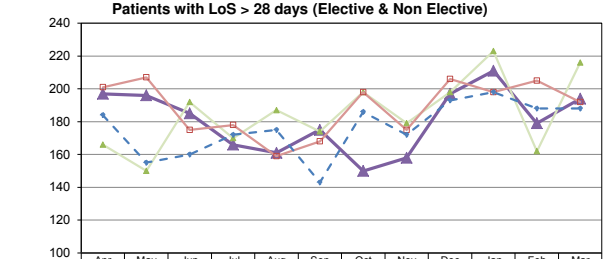
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1395											
2017/18	1234	1351	1404	1380	1335	1268	1346	1393	1313	1399	1173	1326
2016/17	1081	1185	1185	1175	1210	1230	1180	1014	1137	1122	1096	1375
2015/16	735	836	925	1068	917	925	920	957	1003	1087	1036	1027

Patients with LoS > 7 days (Elective & Non Elective)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1004											
2017/18	1047	1109	1013	1063	1015	1048	1057	1045	1130	1153	1034	1108
2016/17	1073	1077	1083	1106	1089	1082	1070	1087	1120	1232	1042	1144
2015/16	1149	1065	1081	1019	1046	1041	1094	1078	1148	1122	1101	1137

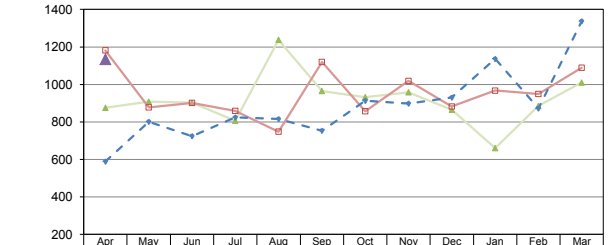
Patients with LoS > 28 days (Elective & Non Elective)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	197	196	185	166	161	175	150	158	197	211	179	194
2016/17	166	150	192	170	187	174	198	179	198	223	162	216
2015/16	201	207	175	178	159	168	198	175	206	198	205	192
2014/15	184	155	160	172	175	143	186	172	193	198	188	188

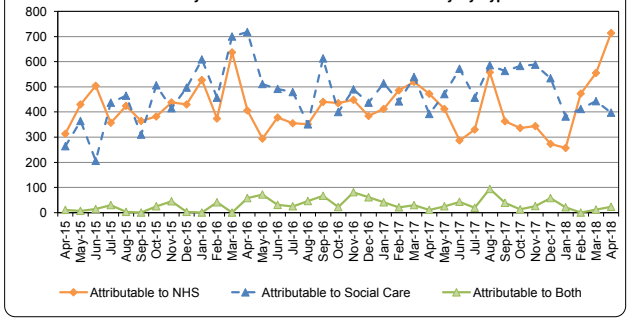
Updated one month in arrears

Acute Delayed Transfers of Care - Lost Bed Days

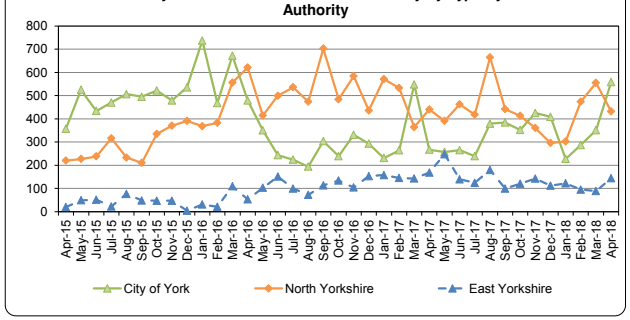


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1134											
2017/18	875	908	902	806	1238	965	932	958	865	660	885	1010
2016/17	1182	877	901	859	748	1120	857	1019	882	967	949	1089
2015/16	588	801	724	824	815	753	913	898	930	1136	872	1337

Acute Delayed Transfers of Care - Lost Bed Day by Type



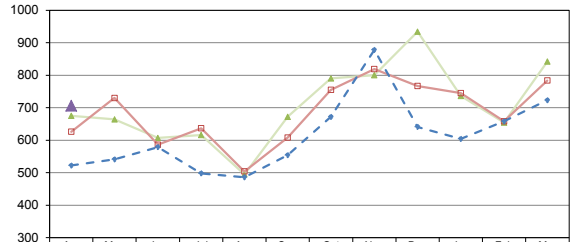
Acute Delayed Transfers of Care - Lost Bed Day by Type by Local Authority



Paediatric Admissions

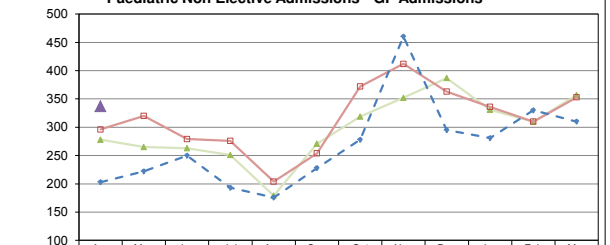
May 2018

Paediatric Non Elective Admissions



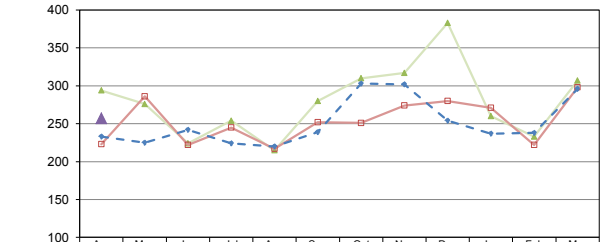
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	706											
2017/18	675	664	607	616	495	672	790	800	934	736	654	842
2016/17	626	730	586	637	504	608	755	819	767	745	658	784
2015/16	522	541	579	498	486	554	672	878	641	604	658	723

Paediatric Non Elective Admissions - GP Admissions



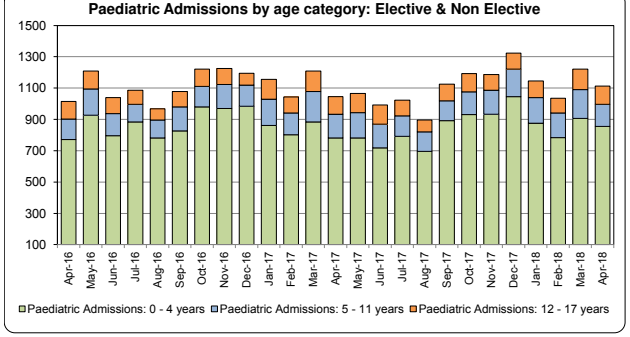
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	337											
2017/18	278	265	263	251	179	271	319	352	387	331	310	357
2016/17	296	320	279	276	204	254	372	412	363	336	310	353
2015/16	203	222	250	193	176	228	278	460	295	281	330	310

Paediatric Non Elective Admissions - ED Admissions

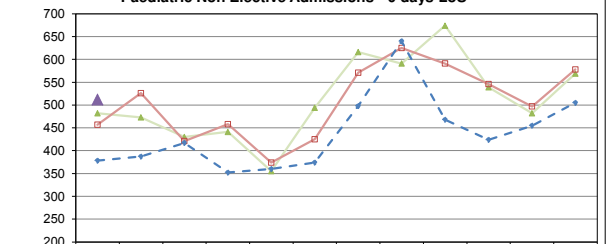


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	257											
2017/18	294	276	224	254	215	280	310	317	383	260	233	307
2016/17	223	286	222	245	217	252	251	274	280	271	222	298
2015/16	233	225	242	224	220	239	303	302	254	237	238	296

Paediatric Admissions by age category: Elective & Non Elective

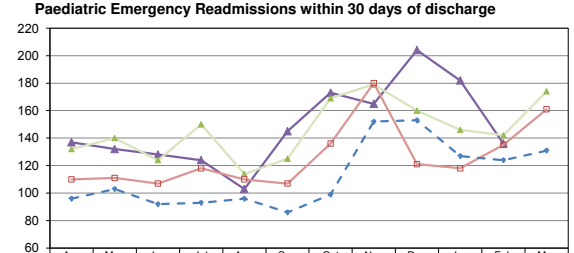


Paediatric Non Elective Admissions - 0 days LoS



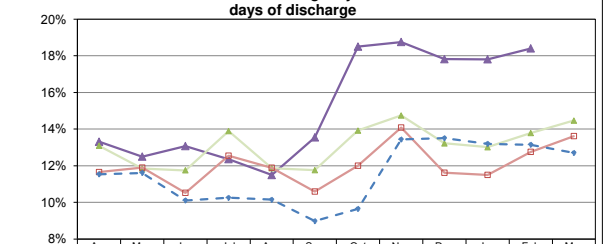
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	512											
2017/18	482	473	430	441	355	494	616	591	674	539	482	569
2016/17	457	526	421	458	374	425	571	625	591	546	497	578
2015/16	378	387	417	352	360	374	498	640	468	424	455	505

Paediatric Emergency Readmissions within 30 days of discharge



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	137	132	128	124	103	145	173	165	204	182	136	
2016/17	132	140	124	150	114	125	169	179	160	146	142	174
2015/16	110	111	107	118	110	107	136	180	121	118	135	161
2014/15	96	103	92	93	96	86	99	152	153	127	124	131

Paediatric Readmission Rate: Emergency Readmissions within 30 days of discharge

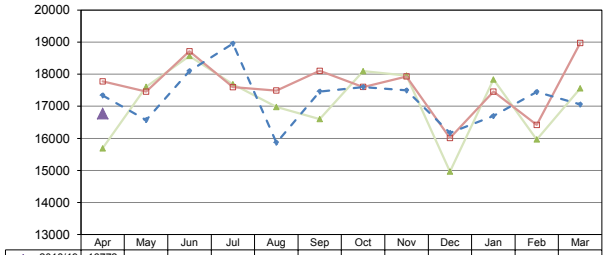


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	13.3%	12.5%	13.1%	12.4%	11.5%	13.6%	18.5%	18.8%	17.8%	17.8%	18.4%	
2016/17	13.1%	11.9%	11.8%	13.9%	11.9%	11.8%	13.9%	14.7%	13.2%	13.0%	13.8%	14.5%
2015/16	11.7%	11.9%	10.5%	12.6%	11.9%	10.6%	12.0%	14.1%	11.6%	11.5%	12.8%	13.6%
2014/15	11.5%	11.6%	10.1%	10.3%	10.1%	9.0%	9.6%	13.4%	13.5%	13.2%	13.1%	12.7%

Trust Planned Care
Outpatients

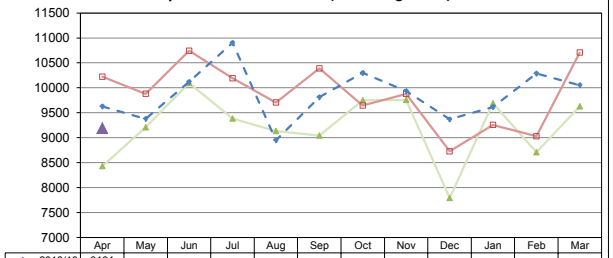
May 2018

Outpatients: All Referral Types (excluding AHPs)



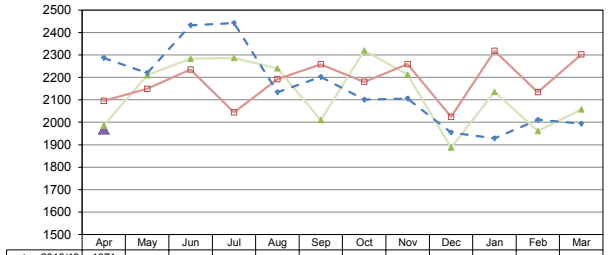
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	16772											
2017/18	15688	17604	18568	17686	16977	16601	18091	17957	14965	17832	15964	17559
2016/17	17774	17455	18711	17594	17489	18102	17600	17930	16011	17455	16415	18972
2015/16	17337	16572	18098	18950	15864	17459	17599	17492	16169	16696	17445	17056

Outpatients: GP Referrals (excluding AHPs)



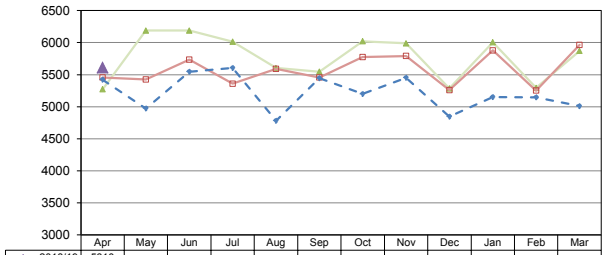
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	9191											
2017/18	8431	9208	10097	9386	9134	9044	9751	9757	7793	9692	8710	9630
2016/17	10223	9881	10742	10192	9706	10388	9645	9879	8728	9259	9029	10707
2015/16	9628	9379	10119	10903	8949	9812	10299	9934	9369	9616	10287	10052

Outpatients: Cons to Cons Referrals (excluding AHPs)



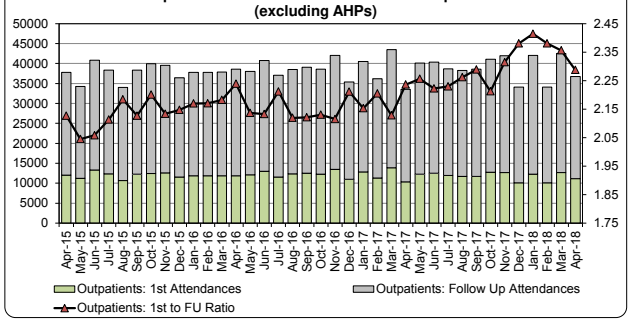
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1971											
2017/18	1985	2209	2283	2286	2240	2010	2319	2212	1888	2135	1961	2057
2016/17	2095	2149	2235	2044	2192	2258	2180	2259	2024	2318	2134	2302
2015/16	2287	2220	2432	2442	2134	2202	2101	2106	1955	1929	2011	1994

Outpatients: Other Referrals (excluding AHPs)

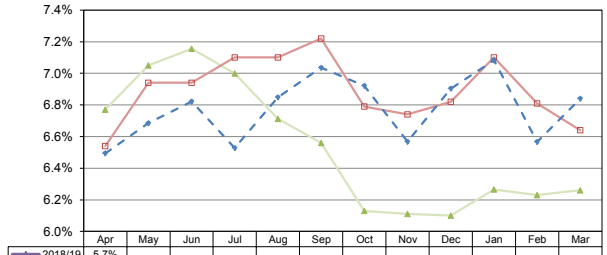


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5610											
2017/18	5272	6187	6188	6014	5603	5547	6021	5988	5284	6005	5293	5872
2016/17	5456	5425	5734	5358	5591	5456	5775	5792	5259	5878	5252	5963
2015/16	5422	4973	5547	5605	4781	5445	5199	5452	4845	5151	5147	5010

Outpatients: Attendances & 1st to Follow Up Ratio (excluding AHPs)

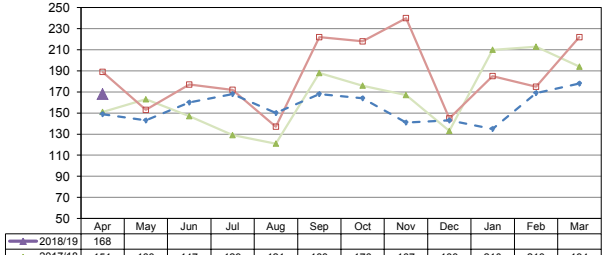


Outpatients: DNA rates



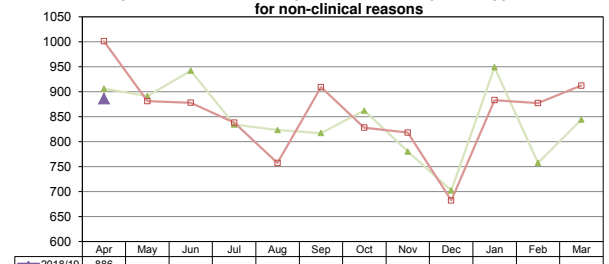
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5.7%											
2017/18	6.8%	7.1%	7.2%	7.0%	6.7%	6.6%	6.1%	6.1%	6.1%	6.3%	6.2%	6.3%
2016/17	6.5%	6.9%	6.9%	7.1%	7.1%	7.2%	6.8%	6.7%	6.8%	7.1%	6.8%	6.6%
2015/16	6.5%	6.7%	6.8%	6.5%	6.8%	7.0%	6.9%	6.6%	6.9%	7.1%	6.6%	6.8%

Outpatients: Cancelled Clinics with less than 14 days notice



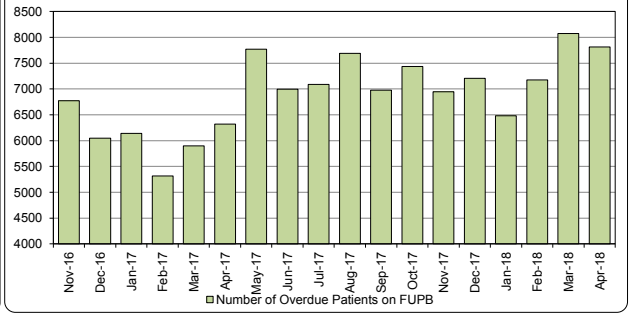
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	168											
2017/18	151	163	147	129	121	188	176	167	133	210	213	194
2016/17	189	153	177	172	137	222	218	240	145	185	175	222
2015/16	149	143	160	168	150	168	164	141	143	135	169	178

Outpatients: Number of Hospital Cancelled Outpatient Appointments for non-clinical reasons



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	886											
2017/18	906	891	942	834	823	817	862	780	702	949	757	844
2016/17	1001	881	878	838	757	909	828	818	682	883	877	912

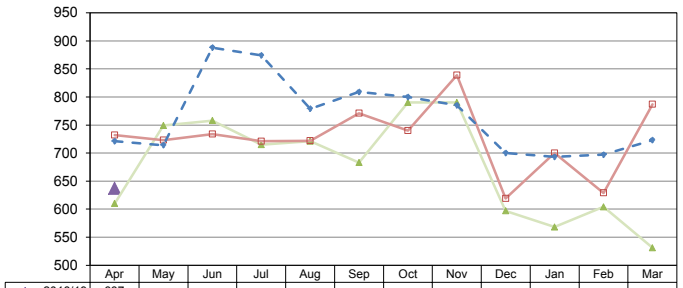
Number of Overdue Patients on FUPB



Trust Planned Care
Elective Activity & Theatre Utilisation

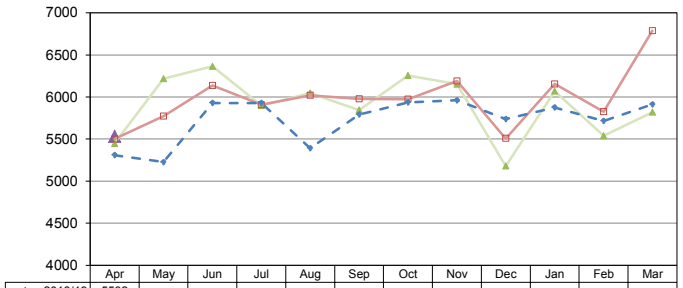
May 2018

Ordinary Elective Admissions



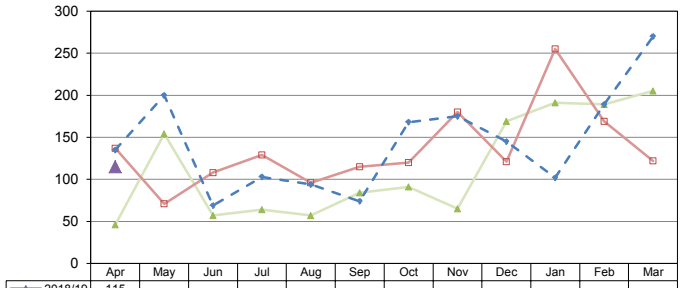
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	637											
2017/18	610	749	758	715	721	683	790	790	597	568	604	531
2016/17	732	723	734	721	722	771	740	839	619	700	629	787
2015/16	721	714	888	874	779	809	800	785	700	693	697	723

Ordinary Day Case Admissions



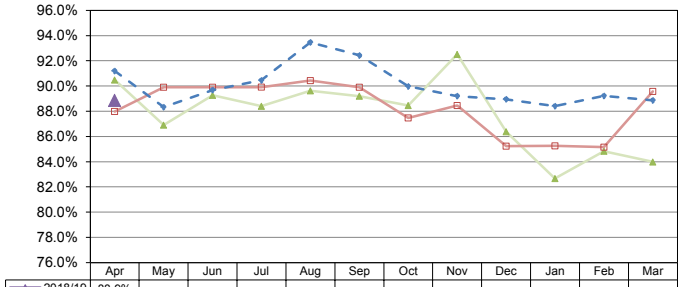
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	5532											
2017/18	5447	6216	6364	5896	6047	5845	6254	6151	5179	6069	5538	5819
2016/17	5500	5771	6137	5907	6019	5977	5973	6189	5507	6154	5824	6786
2015/16	5309	5226	5929	5929	5392	5792	5936	5960	5737	5876	5715	5912

Elective operations cancelled within 48 hours - Non clinical reasons



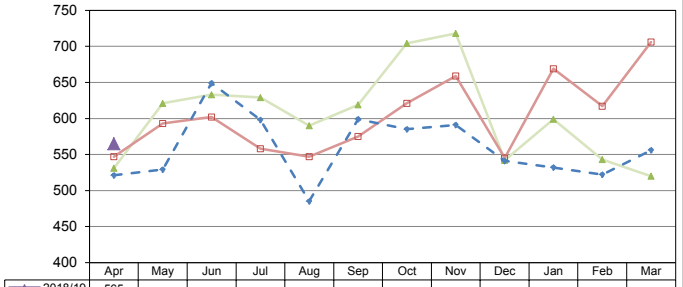
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	115											
2017/18	46	154	57	64	57	84	91	65	169	191	189	205
2016/17	137	71	108	129	96	115	120	180	121	255	169	122
2015/16	135	200	69	103	94	74	168	175	145	102	189	270

Theatres: Utilisation of planned sessions



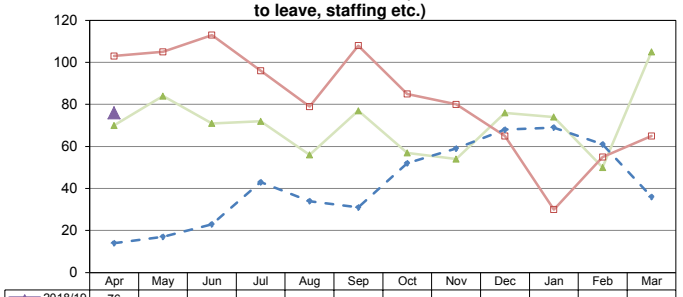
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	88.9%											
2017/18	90.5%	86.9%	89.3%	88.4%	89.6%	89.2%	88.4%	92.5%	86.4%	82.7%	84.8%	84.0%
2016/17	88.0%	89.9%	89.9%	89.9%	90.4%	89.9%	87.5%	88.4%	85.2%	85.3%	85.2%	89.6%
2015/16	91.2%	88.3%	89.7%	90.5%	93.5%	92.4%	90.0%	89.2%	89.0%	88.4%	89.2%	88.9%

Theatres: Number of sessions held



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	565											
2017/18	531	621	633	629	590	619	704	718	542	599	543	520
2016/17	547	593	602	558	547	575	621	659	545	669	617	706
2015/16	521	529	649	598	485	599	585	591	541	532	522	556

Theatres: Lost sessions < 6 weeks notice (list available but lost due to leave, staffing etc.)



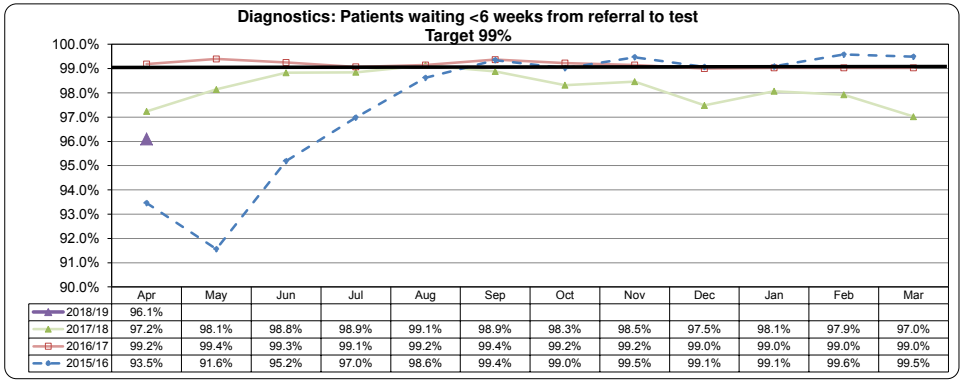
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	76											
2017/18	70	84	71	72	56	77	57	54	76	74	50	105
2016/17	103	105	113	96	79	108	85	80	65	30	55	65
2015/16	14	17	23	43	34	31	52	59	68	69	61	36

All cancellations are within 6 weeks of the planned procedure date. Cancellations exclude lists added in error and those that have been rescheduled.

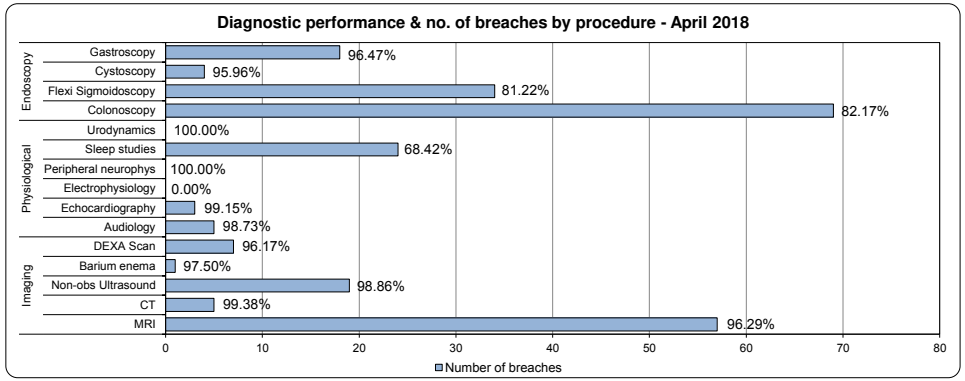
Diagnostics & Referral To Treatment

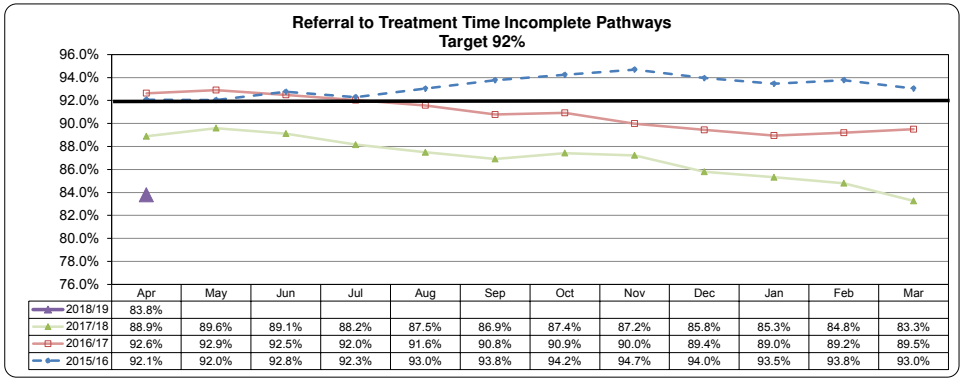
May 2018

The Trust is monitored at aggregate level against the Diagnostic & Referral to Treatment Incomplete Targets.

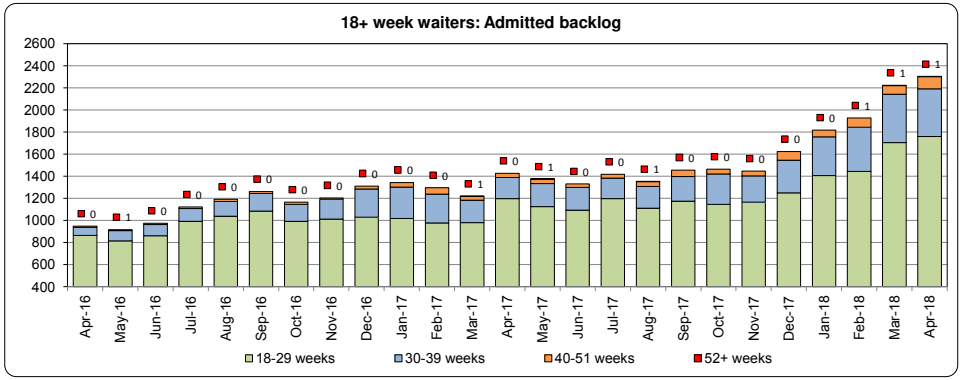


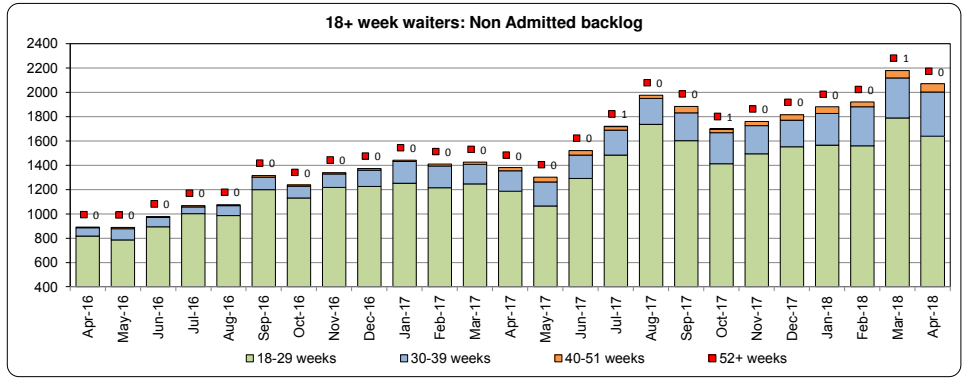
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	96.1%											
2017/18	97.2%	98.1%	98.8%	98.9%	99.1%	98.9%	98.3%	98.5%	97.5%	98.1%	97.9%	97.0%
2016/17	99.2%	99.4%	99.3%	99.1%	99.2%	99.4%	99.2%	99.2%	99.0%	99.0%	99.0%	99.0%
2015/16	93.5%	91.6%	95.2%	97.0%	98.6%	99.4%	99.0%	99.5%	99.1%	99.1%	99.6%	99.5%





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	83.8%											
2017/18	88.9%	89.6%	89.1%	88.2%	87.5%	86.9%	87.4%	87.2%	85.8%	85.3%	84.8%	83.3%
2016/17	92.6%	92.9%	92.5%	92.0%	91.6%	90.8%	90.9%	90.0%	89.4%	89.0%	89.2%	89.5%
2015/16	92.1%	92.0%	92.8%	92.3%	93.0%	93.8%	94.2%	94.7%	94.0%	93.5%	93.8%	93.0%

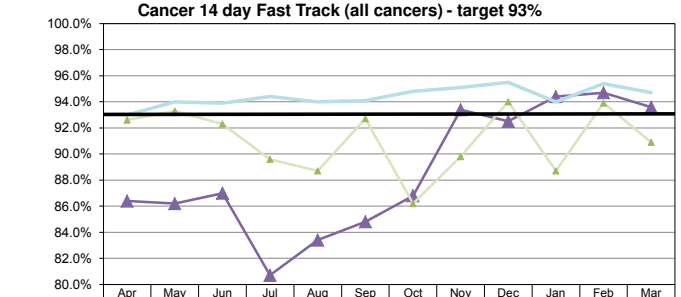




Trust Cancer

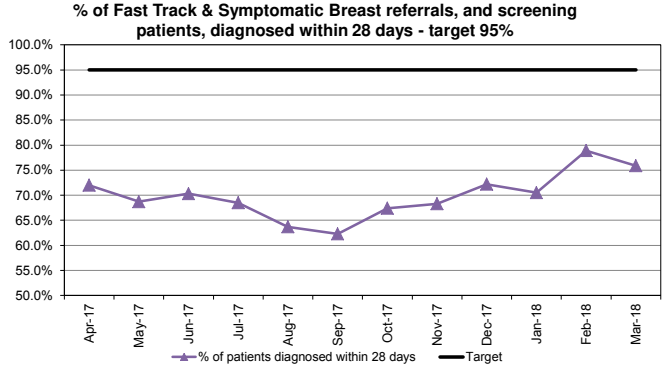
May 2018

Cancer 14 day Fast Track (all cancers) - target 93%

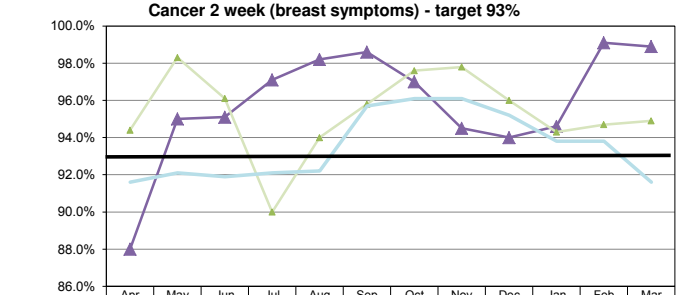


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	86.4%	86.2%	87.0%	80.7%	83.4%	84.8%	86.8%	93.4%	92.5%	94.4%	94.7%	93.6%
2016/17	92.6%	93.3%	92.3%	89.6%	88.7%	92.7%	86.2%	89.8%	94.0%	88.7%	93.9%	90.9%
NHSE 16/17	93.0%	94.0%	93.9%	94.4%	94.0%	94.1%	94.8%	95.1%	95.5%	94.0%	95.4%	94.7%

% of Fast Track & Symptomatic Breast referrals, and screening patients, diagnosed within 28 days - target 95%

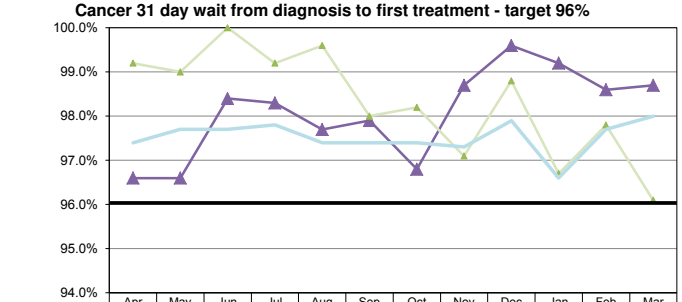


Cancer 2 week (breast symptoms) - target 93%



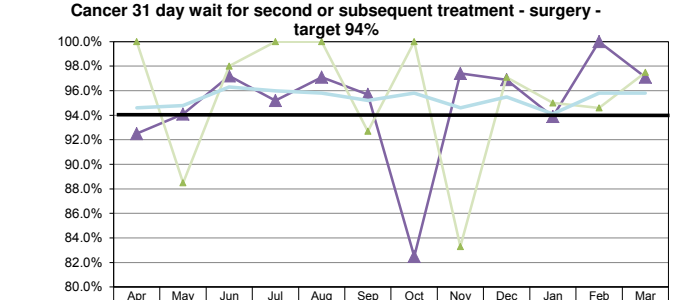
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	88.0%	95.0%	95.1%	97.1%	98.2%	98.6%	97.0%	94.5%	94.0%	94.6%	99.1%	98.9%
2016/17	94.4%	98.3%	96.1%	90.0%	94.0%	95.8%	97.6%	97.8%	96.0%	94.3%	94.7%	94.9%
NHSE 16/17	91.6%	92.1%	91.9%	92.1%	92.2%	95.7%	96.1%	96.1%	95.2%	93.8%	93.8%	91.6%

Cancer 31 day wait from diagnosis to first treatment - target 96%



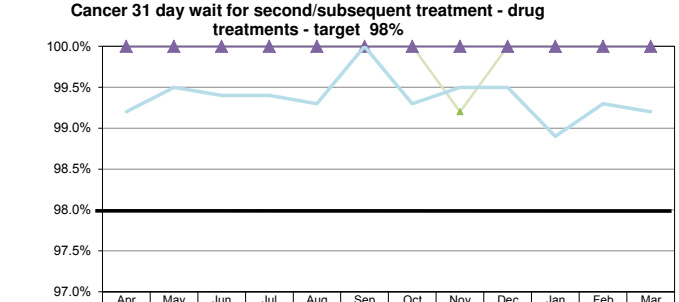
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	96.6%	96.6%	98.4%	98.3%	97.7%	97.9%	96.8%	98.7%	99.6%	99.2%	98.6%	98.7%
2016/17	99.2%	99.0%	100.0%	99.2%	99.6%	98.0%	98.2%	97.1%	98.8%	96.7%	97.8%	96.1%
NHSE 16/17	97.4%	97.7%	97.7%	97.8%	97.4%	97.4%	97.4%	97.3%	97.9%	96.6%	97.7%	98.0%

Cancer 31 day wait for second or subsequent treatment - surgery - target 94%



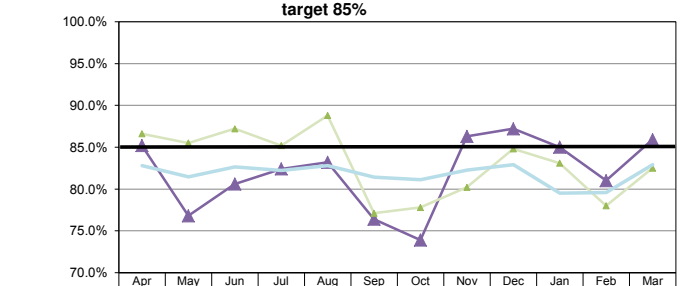
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	92.5%	94.1%	97.2%	95.2%	97.1%	95.7%	82.5%	97.4%	96.9%	93.9%	100.0%	97.1%
2016/17	100.0%	88.5%	98.0%	100.0%	100.0%	92.7%	100.0%	83.3%	97.1%	95.0%	94.6%	97.5%
NHSE 16/17	94.6%	94.8%	96.3%	96.0%	95.8%	95.2%	95.8%	94.6%	95.5%	94.1%	95.8%	95.8%

Cancer 31 day wait for second/subsequent treatment - drug treatments - target 98%



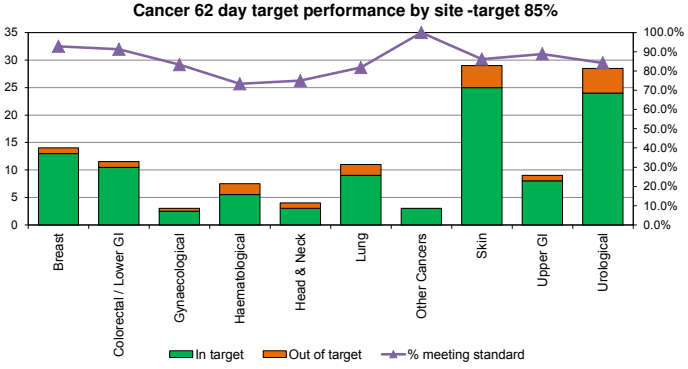
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	100.0%	100.0%
2017/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NHSE 16/17	99.2%	99.5%	99.4%	99.4%	99.3%	100.0%	99.3%	99.5%	99.5%	98.9%	99.3%	99.2%

Cancer 62 Day Waits for first treatment (from urgent GP referral) - target 85%

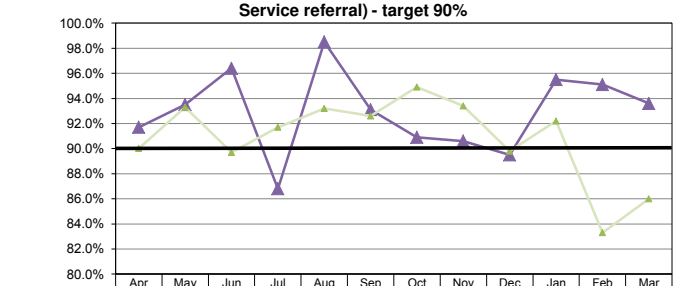


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	85.2%	76.8%	80.6%	82.4%	83.2%	76.4%	73.9%	86.3%	87.2%	85.0%	81.0%	85.9%
2016/17	86.6%	85.5%	87.2%	85.2%	88.8%	77.1%	77.8%	80.2%	84.8%	83.1%	78.0%	82.5%
NHSE 16/17	82.8%	81.4%	82.7%	82.2%	82.8%	81.4%	81.1%	82.3%	82.9%	79.5%	79.6%	82.9%

Cancer 62 day target performance by site -target 85%



Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - target 90%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	91.7%	93.5%	96.4%	86.8%	98.5%	93.1%	90.9%	90.6%	89.5%	95.5%	95.1%	93.6%
2016/17	90.0%	93.3%	89.7%	91.7%	93.2%	92.6%	94.9%	93.4%	89.8%	92.2%	83.3%	86.0%

To Chief executives acute trusts
CCG Accountable officers
STP leads

Copy Health and wellbeing board chairs
Directors of adult social services
Regional directors NHSE & NHSI
Chief executives mental health and community trusts
Members of the National Emergency Pressures Panel

13th June 2018

Dear colleague

Reducing long stays in hospital - to reduce patient harm and bed occupancy

Thank you for your continued work to ensure that you have sufficient capacity to deliver elective and emergency care performance and prepare for winter. I am writing to announce a new national ambition to lower bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by 25% and to ask you to work with your system partners to deliver on this ambition. This needs to be delivered whilst holding and/or reducing the length of stay for all other patients, and reducing bed occupancy to manageable levels.

The opportunity to reduce the number of long-stay patients in hospital

Nearly 350,000 patients spend more than three weeks in an acute hospital each year. Long stay patients account for 8% of admissions requiring an overnight stay and have an average length of stay of 40 days. Around one-fifth of beds are occupied by patients who have already been in hospital for more than three weeks.

Many of these patients are older people with reduced functional ability (frailty) and/or cognitive impairment (delirium or dementia), who deteriorate because they are in hospital. This is due to unnecessary waiting, sleep deprivation, increased risk of falls, increased likelihood of catching healthcare-associated infections and avoidable loss of muscle strength, leading to greater physical dependency (sometimes described as deconditioning). Hospital-related functional decline in older patients and the subsequent harm have poor consequences for many patients. A stay in hospital over 10 days leads to 10 years' muscle ageing for people most at risk. Repeat audits show that up to 50% of patients in hospital do not need to be in an acute bed and many could have avoided hospital admission altogether. Many of these are the people whose stay becomes longer, due to deconditioning and additional hospital acquired illness, infection and falls.

Congested hospitals struggle to deliver best care. By reducing the number of long stay patients in hospital we will collectively reduce bed occupancy to increase safe flow through the system, greatly improving the working and care environment, reducing A&E crowding and enabling patients to be treated consistently in the right bed by clinical teams with the right skills.

Tackling long stays in hospital will reduce risk of patient harm, unwarranted cost, and improve our ability to deliver high quality services. This is why we believe that the ambition to significantly reduce the number of long-stay patients in acute hospitals should be a top priority.

Our ambition is to reduce the number of beds occupied by long stay patients by 25%, freeing up at least 4,000 beds compared to 2017/18. This capacity is required by December 2018.

This initiative is important as providers and commissioners recently submitted plans for 2018/19 showing the NHS is expecting to increase activity and improve performance up to and during winter. These plans lack sufficient improvements in capacity, productivity or length of stay to give us confidence that they will be achieved. We recognise that most hospitals do not have the physical space or access to the nurse staffing to grow their bed base while maintaining a safe and productive care environment, so the NHS must have an unrelenting approach to reducing length of stay. Ian Dalton has recently written to acute trust chairs regarding the plans.

In supporting local systems to work together to deliver the ambition I enclose baselines for each acute trust, CCG and local authority on the number of beds occupied by long stay patients in 2017/18 and the corresponding ambitions to deliver a 25% reduction nationally (annex 1). The level of improvement expected from each system is based on the proportion of beds occupied by long stay patients, with the most challenged systems expected to make the greatest levels of improvement.

Achieving this will require concerted effort across the whole health and care leadership system: at least half the opportunity rests within the direct control of hospitals, and the remainder in joint working with GPs, local authorities, community health and social care providers and others.

We have not identified the specific local share of the contribution to come from acute, community and local authority sectors, this needs to be agreed locally. It is however imperative that all stakeholder recognise the need to reduce occupancy levels within acute trusts. Regions and STPs will play a critical role in supporting and monitoring delivery, and for local authorities that will be with the regional local government representatives.

The focus on reducing long stays in hospital will also need to be supported by a continued focus on reducing delayed transfers of care (DTOC). While progress was made in 2017/18 in reducing delays there is still further work to do to achieve the national ambition of no more than 4000 daily DTOC delays.

In support of this ambition we are:

- sharing a summary of actions to be taken to deliver the ambition (annex 2)
- publishing an improvement guide to support delivery
- shortly publishing the evidence base that shows A&E performance is significantly impacted by bed occupancy and the number of long stay patients in hospital
- inviting local system leadership teams to participate in a two-day change leaders programme focussed on how they can design and deliver the programme of interventions to deliver this ambition
- expanding and refocussing the ECIST programme team to work in regions supporting you in delivering this ambition
- finalising technical guidance on the measurement of the ambition and dashboards to enable progress to be monitored
- following up with a further letter in a few weeks about other actions that should be taken to improve delivery for this winter

You will remember the work generated last year by our difficulty in establishing how many beds were open and occupied. In too many hospitals bed managers are not using technology to manage beds and rely instead on telephone calls or walking around wards to find empty beds, meaning that patients wait for extended periods in emergency departments. In order to reduce the burden of reporting and, more importantly to support good bed management, we need every hospital to keep their PAS up to date in real time – admissions, discharges and internal patient transfers. This will enable the PAS or a connected system to provide a 'live' bed status.

In developing this length of stay ambition, we have modelled our approach on the successful work to significantly reduce healthcare-associated infections in the 2000s. It is strongly supported by the National Emergency Pressures Panel and is being co-developed with social care partners so that we ensure a timely return to the patient's own home for the vast majority of people.

Yours

Pauline Philip
National director of urgent and emergency care

Annex 2 – actions to be taken to deliver the ambition

How do you expect systems to deliver this?

1. Delivering this ambition will require the same level of focus, grip and leadership as when the significant reductions in healthcare acquired infections were delivered a decade ago.

2. What will work in each local system will differ based on local circumstances but the key activities which are required to deliver this improvement will include;

    - whole system leadership and partnership working with a shared aim grounded in patient safety and avoiding harm;
    - long-stay patient reviews and multi agency discharge events to ensure whole system partnership working in delivering the overall ambition;
    - putting in place executive lead escalation arrangements working with senior leadership across health and social care systems to tackle blockages that can't be addressed locally or internally;
    - delivering the existing delayed transfer of care reduction ambitions;
    - 7 day working to reduce the variation between weekday and weekend non-elective discharge volumes from acute hospitals.

3. For acute trusts a focus on:

    - treating lengths of stay above best practice guidelines as a safety issue which need urgently addressing ;
    - getting and using accurate daily information on all long stay patients in hospital, supported by real time use of Patient Administration Systems used for bed management and to give automatic capacity and occupancy information;
    - work at the front door (and ideally before it), including ambulatory emergency care, therapy services and appropriate care pathways to avoid admissions for patients who do not require acute care in hospital and are at risk of deconditioning if they do. This will reduce the number of complex discharges;
    - routinely screening within 2 hours of presentation all older people (aged 75 and over) for their prior degree of frailty using a validated tool, their prior level of functional need and their present cognitive status. This data and clinical judgment should be used to identify within 72 hours of admission and pro-actively plan for discharge home of:

- those patients who are most vulnerable to hospital-associated de-conditioning and who are judged fit enough to be provided rehabilitation and recovery care in a community setting
- those patients who require end of life care and for whom this can be provided in a community setting

- trusts implementing processes so that patients who require admission for more than 72 hours are not moved from their admitting ward until discharge from hospital except where this is deemed necessary on clinical grounds by a senior clinician (equivalent ST3 level doctor or above);
- ensuring that simple and timely discharges are optimised, including through criteria led discharge ;
- work in the hospital to address bottlenecks and expedite discharges, including by implementing Red2Green and SAFER patient flow bundle systematically across ALL wards;
- supporting hospital therapy, medical and nursing teams to identify and address inappropriate risk adversity which may be delaying assessment for , or leading to the requesting of excessive packages of community care;
- work closely, supportively and continuously with community health and social care partners to expedite discharges from acute and community beds in order to ensure whole system flow;
- ensuring effective Board accountability, including publishing monthly board reports on number of stranded (7 days or more) and long stay (21 days or more) patients delayed in hospital and the coded reasons for these delays.

4. For system partners in community and local government a focus on:
    - delivering 100% access to extended GP services;
    - preventing unnecessary hospital admissions - the default should be that all care home residents with ‘urgent’ and ‘less urgent’ needs at risk of admission to hospital, first have a clinical assessment, through a GP, paramedic or other health professional based ‘Hear & Treat’/‘See & Treat’ model;
    - ensuring that home and bed based intermediate care, crisis response and reablement should be available in all areas for step up care as an alternative to hospital admission as well as on discharge. These should be available to self funders as well as people needing council or NHS funded support;

- ensuring staff in hospitals have timely access to social care assessment staff and social care practitioners seven days a week, and that multi-disciplinary teams work together to make referrals and support discharge seven days a week;
- ensuring that all inpatients and their relatives, and in particular those who arrange and fund their own support, have access to information and advice in hospitals so that they can begin to make plans for discharge as soon as possible;
- offering a co-designed and mutually supported (by care providers) trusted assessment service for care homes, so that care home managers do not have to come into hospitals themselves and can rely on a trusted assessment in order to decide about potential admissions;
- home and bed based intermediate care, crisis response and reablement (for step up and step down care) should commence within 2 days of receiving the appropriate referrals. [NICE guidance (NG74) for bed based services extended to home based services to avoid a perverse incentive to refer patients to bed based services];
- care homes accept admissions (discharges from hospital) 7 days a week; for new residents until 5pm and returning residents up until 8pm;
- ensuring discharge to assess services are available in all areas, so that there is default expectation of home first, with increasing proportion of patients supported to return to their own home rather than going into long term care.

- An improvement guide on reducing long stays in hospital will be available at https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays

How will progress be measured?

5. Technical guidance will be published in due course.
6. The ambition will be for each local system to deliver. Every acute trust will be required to report progress through their Board papers. A proposed dashboard for operational use and for Board reporting is being developed.
7. We encourage trusts to collect data frequently and regularly on their current inpatients, including their current length of stay, expected date of discharge, the number of patients 'who no longer require hospital care and are well enough for cared in a [named] community setting' and the reasons for patients still being in hospital. There are a number of tools and approaches to support this including use of Red2Green and number of stranded patients at 7, 14 and 21 days. Where trusts have significant performance challenges or are off track with their agreed improvement trajectory we may require additional reporting.

Humber Coast and Vale Cancer Alliance

Provider Cancer Waiting Times Dashboard

Period: May 2017 - April 2018

Version 1.1

Humber Coast and Vale Cancer Alliance
Provider Cancer Waiting Times (CWT) Dashboard

Period: May 2017 - April 2018

Background

Cancer Waiting Times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. These were first introduced through the NHS Cancer Plan (September 2000) and extended in the Cancer Reform Strategy (2007). A review of the standards in 2010 led to confirmation in Improving Outcomes: A Strategy for Cancer (2011) that they would be retained.

All cancer waiting times standards are monitored through the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) which is an information standard applicable to all cancer services providers funded by the NHS in England. Data is sent to the CWT collection service. NHS England are given a monthly extract of pseudonymised data, which is used to produce official quarterly reports and monthly management reports.

The official quarterly reports can be found at the NHS statistics page:

http://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Operational standards

The current measures and the operational standards are:

Two weeks from urgent GP referral for suspected cancer to first appointment (**93%**)

Two weeks from referral for breast symptoms (whether cancer is suspected or not) to first appointment (**93%**)

62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia) (**85%**)

62 days from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment (**90%**)

62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set)

31 days from diagnosis (decision to treat) to first treatment for all cancers (**96%**)

31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery) (**94%**)

31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (radiotherapy) (**94%**)

31 days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti cancer drug therapy, eg chemotherapy)**(98%)**

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In 2015, the Cancer Taskforce recommended the introduction of a new 28 day Faster Diagnosis Standard. Changes to the CWT system and dataset that are being introduced from April 2018 mark the start of the implementation of this new standard, which will be fully implemented by 2020.

Guidance

Guidance documents can be found at: https://digital.nhs.uk/cancer-waiting-times (NHS users only)

This includes:

How to record the data: **National Cancer Waiting Times Monitoring Data Set Guidance**
How to upload the data: **Cancer Waiting Times User Manual**
How to view what has been uploaded: **Cancer Waiting Times Reports User Manual**

Further questions and queries about how to record different cases, what to do about mistakes in the data records or data requests can be sent to the Cancer Waiting Times mailbox: cancer-waits@dh.gsi.gov.uk

For queries regarding the data uploads process contact the Open Exeter Helpdesk on 01392 251289

Source of the above informtion: http://www.ncin.org.uk/collecting_and_using_data/data_collection/gfocw

HCVCA Summary Cancer Standards Report by Provider: May 2017 - April 2018

Cancer Alliance (All NHS Providers)

Cancer Alliance (All Providers)	Standard	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Two Week Wait - All Cancer	93.00%	92.55%	92.43%	89.95%	91.21%	91.71%	92.48%	95.52%	94.49%	95.38%	96.14%	95.00%	94.93%
Two Week Wait - Breast Symptoms	93.00%	95.21%	94.46%	91.70%	95.26%	91.33%	89.33%	93.05%	92.67%	90.99%	93.20%	92.07%	88.91%
62 Day - All Cancer	85.00%	75.00%	75.61%	79.31%	78.49%	72.08%	76.49%	80.41%	82.23%	78.78%	78.21%	77.65%	73.67%
62 Day Screening - All Cancer	90.00%	83.50%	89.43%	83.61%	81.38%	90.35%	80.73%	83.97%	86.00%	85.90%	86.42%	88.89%	85.22%
62 Day Consultant Upgrade - All Cancer	No Standard	60.00%	100.00%	90.91%	81.38%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	81.82%	57.89%
31 Day First Treatment - All Cancer	96.00%	97.20%	97.92%	97.17%	97.34%	97.74%	98.11%	97.83%	99.68%	98.05%	97.49%	98.05%	98.72%
31 Day Sub Treatment - Surgery	94.00%	96.40%	93.28%	93.55%	95.18%	93.43%	90.48%	94.44%	95.28%	89.13%	93.39%	94.07%	95.50%
31 Day Sub Treatment - Drugs	98.00%	99.54%	100.00%	99.47%	100.00%	100.00%	100.00%	100.00%	100.00%	99.60%	100.00%	99.06%	99.56%
31 Day Sub Treatment - Radiotherapy	94.00%	98.04%	98.40%	98.25%	99.20%	98.65%	98.07%	98.98%	97.73%	95.70%	97.37%	96.48%	97.90%

HEY

HEY	Standard	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Two Week Wait - All Cancer	93.00%	96.04%	95.30%	94.11%	94.31%	94.51%	94.86%	96.30%	94.70%	96.86%	96.75%	95.40%	94.40%
Two Week Wait - Breast Symptoms	93.00%	95.42%	93.75%	88.05%	93.60%	89.72%	85.25%	91.46%	90.79%	90.55%	91.82%	88.36%	84.95%
62 Day - All Cancer	85.00%	71.43%	77.88%	74.71%	76.63%	73.70%	80.11%	78.85%	77.91%	78.55%	73.68%	73.05%	70.57%
62 Day Screening - All Cancer	90.00%	78.00%	82.69%	80.70%	63.38%	86.84%	68.89%	80.65%	83.33%	82.05%	77.14%	82.61%	77.36%
62 Day Consultant Upgrade - All Cancer	No Standard	50.00%	100.00%	100.00%	63.38%	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	60.00%	50.00%
31 Day First Treatment - All Cancer	96.00%	97.28%	97.08%	95.60%	96.20%	97.51%	98.66%	96.30%	99.65%	97.28%	96.32%	97.28%	98.81%
31 Day Sub Treatment - Surgery	94.00%	96.72%	89.71%	94.03%	93.15%	90.54%	91.86%	93.24%	93.65%	87.50%	89.04%	91.55%	95.16%
31 Day Sub Treatment - Drugs	98.00%	100.00%	100.00%	98.15%	100.00%	100.00%	100.00%	100.00%	100.00%	99.02%	100.00%	98.85%	98.97%
31 Day Sub Treatment - Radiotherapy	94.00%	98.04%	98.40%	98.23%	99.20%	98.64%	98.07%	98.98%	97.73%	95.68%	97.35%	96.48%	97.90%

NLaG

NLaG	Standard	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Two Week Wait - All Cancer	93.00%	97.24%	95.70%	95.51%	97.42%	96.11%	96.94%	97.48%	96.81%	94.61%	97.10%	96.37%	97.08%
Two Week Wait - Breast Symptoms	93.00%	94.87%	95.33%	94.87%	96.12%	88.14%	96.88%	95.96%	93.97%	86.21%	88.46%	94.29%	93.98%
62 Day - All Cancer	85.00%	77.54%	62.58%	84.51%	74.32%	61.39%	72.83%	74.57%	80.92%	70.05%	81.76%	73.82%	72.55%
62 Day Screening - All Cancer	90.00%	57.14%	86.67%	83.33%	100.00%	88.24%	77.78%	75.00%	71.43%	82.35%	80.00%	93.33%	100.00%
62 Day Consultant Upgrade - All Cancer	No Standard	62.50%	100.00%	100.00%	100.00%	NA	100.00%	100.00%	100.00%	100.00%	100.00%	84.62%	66.67%
31 Day First Treatment - All Cancer	96.00%	98.01%	99.23%	99.26%	100.00%	97.92%	99.29%	100.00%	100.00%	98.10%	98.50%	98.68%	99.29%
31 Day Sub Treatment - Surgery	94.00%	100.00%	100.00%	86.67%	100.00%	100.00%	100.00%	92.31%	100.00%	82.35%	100.00%	100.00%	95.00%
31 Day Sub Treatment - Drugs	98.00%	97.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.37%	100.00%
31 Day Sub Treatment - Radiotherapy	94.00%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

York

York	Standard	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Two Week Wait - All Cancer	93.00%	86.16%	86.98%	80.66%	83.40%	84.85%	86.77%	93.37%	92.49%	94.41%	94.70%	93.65%	93.93%
Two Week Wait - Breast Symptoms	93.00%	95.00%	95.10%	97.06%	98.20%	98.63%	97.01%	94.50%	93.97%	94.59%	99.12%	98.91%	96.19%
62 Day - All Cancer	85.00%	76.95%	81.01%	82.63%	83.15%	76.63%	74.06%	86.40%	87.21%	85.13%	81.12%	86.01%	78.03%
62 Day Screening - All Cancer	90.00%	93.48%	96.43%	86.79%	98.53%	93.22%	90.91%	90.57%	89.47%	95.45%	95.12%	93.62%	90.91%
62 Day Consultant Upgrade - All Cancer	No Standard	60.00%	100.00%	80.00%	98.53%	50.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	57.14%
31 Day First Treatment - All Cancer	96.00%	96.58%	98.39%	98.35%	97.72%	97.94%	96.80%	98.72%	99.57%	99.18%	98.62%	98.73%	98.25%
31 Day Sub Treatment - Surgery	94.00%	94.12%	97.22%	95.24%	97.14%	95.74%	82.50%	97.44%	96.88%	93.88%	100.00%	97.14%	96.55%
31 Day Sub Treatment - Drugs	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
31 Day Sub Treatment - Radiotherapy	94.00%	NA	NA	100.00%	NA	100.00%	NA	NA	NA	100.00%	100.00%	NA	NA

Virgin

Virgin - (Skin Cancer Service)	Standard	Qtr 1 Apr - Jun 17	Qtr 2 Jul - Sep 17	Qtr 3 Oct - Dec 17	Qtr 4 Jan - Mar 18	Apr-18
Two Week Wait - All Cancer	93.00%	98.96 (190/192)	98.59 (280/284)	96.15 (200/208)	95.38 (165/173)	100.00 (110/110)
62 Day - All Cancer	85.00%	100.00 (20/20)	79.31 (11.5/14.5)	95.00 (9.5/10)	67.86 (9.5/14)	0.0 (0/0)
31 Day First Treatment - All Cancer	96.00%	88.46 (20/23)	81.82 (9/11)	60.00 (3/5)	0.0 (0/0)	0.0 (0/0)

At or above Operational Standard

Below Operational Standard

Note:

This data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Urgent GP Referral - First Seen - within 14 Days - Provider Report : 1.1

Monthly Reports: **April 2018**

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage seen in target (number of 2WW patients seen within 14 days / number of 2WW patients first seen)

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Breast	96.69 (321/332)	97.95 (239/244)	99.18 (242/244)	97.80 (802/820)	88.46%
Lung	98.11 (52/53)	100.00 (49/49)	96.97 (32/33)	98.52 (133/135)	94.73%
Gynae	90.68 (107/118)	95.05 (96/101)	93.10 (81/87)	92.81 (284/306)	92.58%
Upper GI	95.17 (138/145)	95.00 (114/120)	92.11 (70/76)	94.43 (322/341)	89.24%
Lower GI	95.40 (228/239)	96.50 (248/257)	95.86 (324/338)	95.92 (800/834)	88.76%
Urological	85.89 (140/163)	99.20 (124/125)	95.52 (192/201)	93.25 (456/489)	90.59%
Testicular	100.00 (2/2)	100.00 (7/7)	100.00 (6/6)	100.00 (15/15)	94.42%
Haem	100.00 (7/7)	100.00 (18/18)	100.00 (7/7)	100.00 (32/32)	95.36%
Leukaemia	**0 (0/0)**	**0 (0/0)**	**0 (0/0)**	**0 (0/0)**	100.00%
Head & Neck	98.18 (108/110)	96.51 (83/86)	96.00 (144/150)	96.82 (335/346)	93.08%
Skin	94.27 (296/314)	95.24 (20/21)	83.85 (218/260)	89.75 (534/595)	92.91%
Sarcoma	100.00 (2/2)	**0 (0/0)**	**0 (0/0)**	100.00 (2/2)	90.04%
Brain/CNS	100.00 (11/11)	**0 (0/0)**	100.00 (1/1)	100.00 (12/12)	95.07%
Children's	100.00 (5/5)	**0 (0/0)**	100.00 (6/6)	100.00 (11/11)	93.28%
Other	**0 (0/0)**	**0 (0/0)**	100.00 (8/8)	100.00 (8/8)	86.90%
All Cancers	94.40 (1417/1501)	97.08 (998/1028)	93.93 (1331/1417)	94.93 (3746/3946)	90.84%

Key:

At or above Operational Standard (93.0%)

Below Operational Standard

0 (0/0) No relevant patients seen for tumour group

Urgent GP Referral - First Seen - within 14 Days - Provider Report : 1.2

Monthly Reports: April 2018

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage seen in target (number of 2WW patients seen within 14 days / number of 2WW patients first seen)

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Breast Symptoms	84.95 (254/299)	93.98 (78/83)	96.19 (101/105)	88.91 (433/487)	84.29%

Key:

At or above Operational Standard (93.0%)

Below Operational Standard

0 (0/0) No relevant patients seen for tumour group

First Definitive Treatment - 31 Day Standard - Provider

Monthly Reports: **April 2018**

Report :2.1

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage treated within 31 days of decision to treat (number of patients treated within 31 days of decision to treat/number of patients first treated)

* 'Other' is all ICD-10 codes that are not Breast, Lower GI, Lung, Skin or Urological

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Breast	97.96 (48/49)	100.00 (27/27)	100.00 (40/40)	99.14 (115/116)	98.39%
Lung	100.00 (46/46)	100.00 (19/19)	100.00 (25/25)	100.00 (90/90)	97.37%
Lower GI	100.00 (31/31)	100.00 (15/15)	100.00 (19/19)	100.00 (65/65)	97.54%
Urological	98.73 (78/79)	100.00 (33/33)	97.30 (36/37)	98.66 (147/149)	95.19%
Skin	95.56 (43/45)	100.00 (5/5)	100.00 (50/50)	98.00 (98/100)	98.04%
Other*	100.00 (85/85)	97.56 (40/41)	94.74 (54/57)	97.81 (179/183)	97.68%
All	98.81 (331/335)	99.29 (139/140)	98.25 (224/228)	98.72 (694/703)	97.29%

Key:

At or above Operational Standard (96.0%)

Below Operational Standard

0 (0/0) No patients treated for tumour group

First Treatment - 31 days - Rarer Tumours - Provider

Monthly Reports: April 2018

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage treated within 31 days of urgent referral (number of patients treated within 31 days of urgent referral / number of patients first treated following urgent referral)

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Testicular	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	87.61%
Acute Leukaemia	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	86.67%
Children's	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	50.00%
All	0 (0/0)	0 (0/0)	0 (0/0)	0 (0/0)	86.92%

Key:

At or above national %

Below national '%

0 (0/0) No patients treated for tumour group

Sub Treatment - 31 Day Standard - Provider Report 2.2

Monthly Reports: April 2018

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage treated within 31 days of decision to treat (number of patients treated within 31 days of decision to treat/number of patients first treated)

	Standard	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Drug Treatment	98%	98.97 (96/97)	100.00 (39/39)	100.00 (93/93)	99.56 (228/229)	99.30%
Radiotherapy Treatments	94%	97.90 (140/143)	**0 (0/0)**	**0 (0/0)**	97.90 (140/143)	97.03%
Surgery	94%	95.16 (59/62)	95.00 (19/20)	96.55 (28/29)	95.50 (106/111)	94.28%

Key:

At or above Operational Standard

Below Operational Standard

0 (0/0) No patients treated for tumour group

62 Day Target - Provider

Monthly Reports: **April 2018**

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage treated within 62 days of decision to treat (number of patients treated within 62 days of decision to treat/number of patients first treated)

* 'Other' is all ICD-10 codes that are not Breast, Lower GI, Lung, Skin or Urological

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
Breast	66.67 (14/21)	100.00 (20/20)	100.00 (15/15)	87.50 (49/56)	93.83%
Lung	58.70 (13.5/23)	42.11 (4/9.5)	68.75 (5.5/8)	56.79 (23/40.5)	71.80%
Lower GI	50.00 (5/10)	80.00 (4/5)	60.71 (8.5/14)	60.34 (17.5/29)	72.34%
Uro (exc testes)	75.73 (39/51.5)	60.00 (12/20)	75.00 (24/32)	72.46 (75/103.5)	79.52%
Skin	92.31 (18/19.5)	50.00 (1.5/3)	88.33 (26.5/30)	87.62 (46/52.5)	95.69%
Other*	66.67 (22/33)	73.68 (14/19)	71.21 (23.5/33)	70.00 (59.5/85)	74.01%
All	70.57 (111.5/158)	72.55 (55.5/76.5)	78.03 (103/132)	73.67 (270/366.50)	82.29%

At or above Operational Standard (85.0%)

Below Operational Standard

0 (0/0) No patients urgently referred with suspected cancer first treated for tumour group

More than 62 Days to First Treatment - Provider

Monthly Reports: April 2018

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: the number treated after 62 days of decision to treat

* 'Other' is all ICD-10 codes that are not Breast, Lower GI, Lung, Skin or Urological

Cancer	HEY				NLaG				York			
	63 to 76 Days	77 to 90 Days	91 to 104 Days	More than 104 days	63 to 76 Days	77 to 90 Days	91 to 104 Days	More than 104 days	63 to 76 Days	77 to 90 Days	91 to 104 Days	More than 104 days
Breast	4.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Lower GI	1.0	3.0	0.0	1.0	1.0	0.0	0.0	0.0	2.0	1.0	2.5	0.0
Lung	2.5	4.5	1.0	1.5	1.0	4.5	0.0	0.0	0.5	1.5	0.0	0.5
Other*	7.0	1.0	1.0	2.0	1.0	1.0	1.0	2.0	3.0	2.0	2.5	2.0
Skin	0.5	1.0	0.0	0.0	1.0	0.5	0.0	0.0	3.5	0.0	0.0	0.0
Uro (exc testes)	5.0	4.0	1.0	2.5	4.5	1.0	0.5	2.0	4.0	2.5	0.5	1.0
All	**20.0**	**15.5**	**3.0**	**8.0**	**8.5**	**7.0**	**1.5**	**4.0**	**13.0**	**7.0**	**5.5**	**3.5**
Total Exceeding 62 Days				**46.5**				**21.0**				**29.0**

62 Day Standard - Screening - Provider

Monthly Reports: April 2018

Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Numbers shown below reflect: percentage treated within 62 days of screening referral (number of patients treated with 62 days of screening referral / number of patients first treated following screening referral)

	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
All Cancers	77.36 (20.5/26.5)	100.00 (3.5/3.5)	90.91 (25/27.5)	85.22 (49/57.5)	88.24%

At or above Operational Standard (90.0%)

Below Operational Standard

0 (0/0) No patients urgently referred with suspected cancer first treated for tumour group

62 Day Standard - Upgrade - Provider

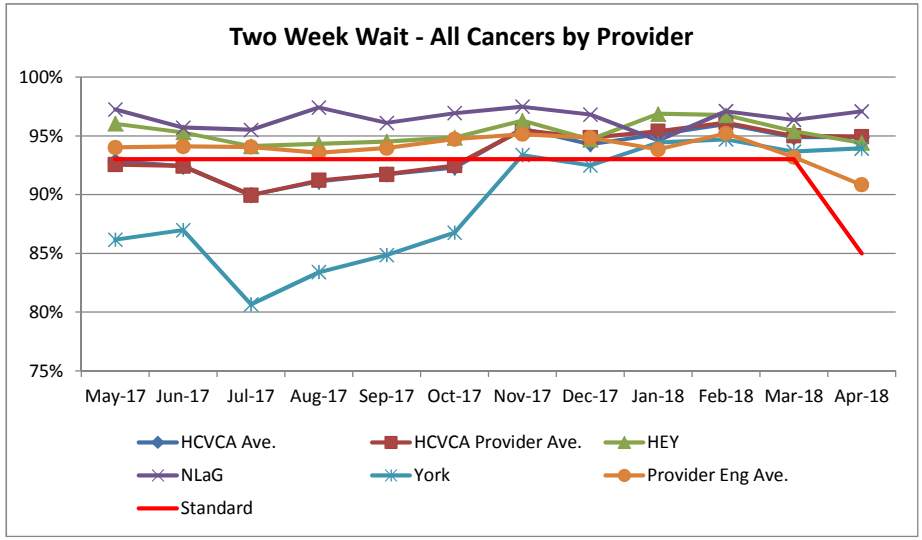
Monthly Reports: April 2018

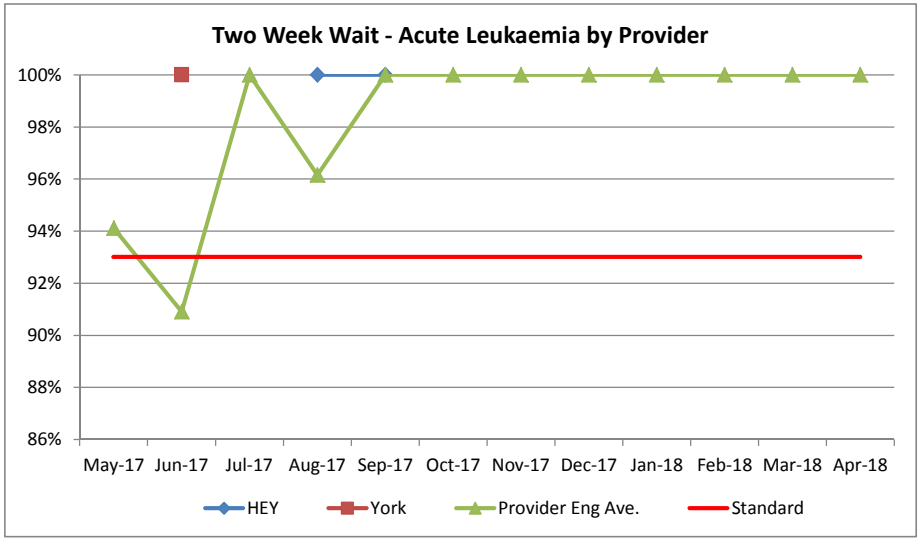
Please note that this data reflects what is available on https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/
Numbers shown below reflect: percentage treated within 62 days of upgrade by consultant or health professional (number of patients treated with 62 days of upgradel / number of patients first treated following upgrade)

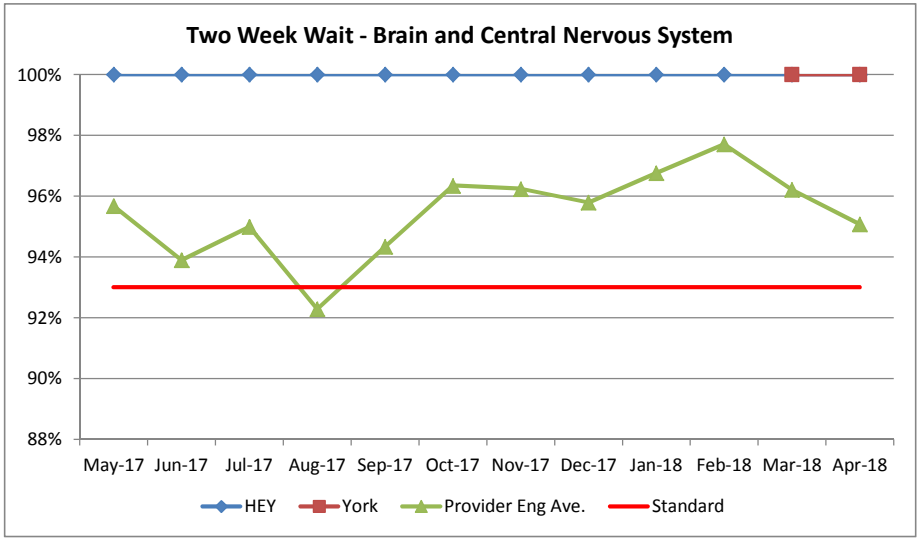
	HEY	NLaG	York	HCVCA Provider Ave.	Provider England Ave.
All	50.00 (1.5/3)	66.67 (2/3)	57.14 (2/3.5)	57.89 (5.5/9.5)	85.05%

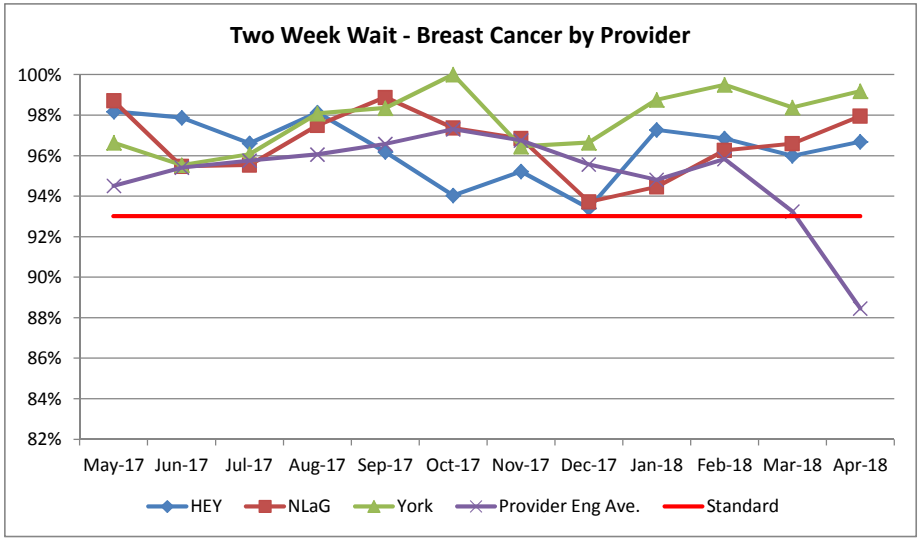
Note:
There is no operational standard set for 62 days of upgrade by consultant

Two weeks from urgent GP referral for suspected cancer to first appointment

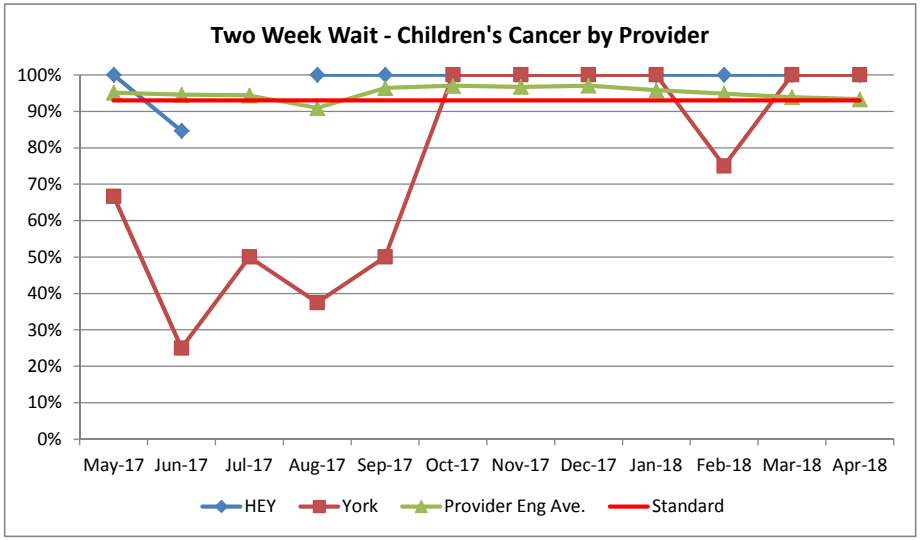


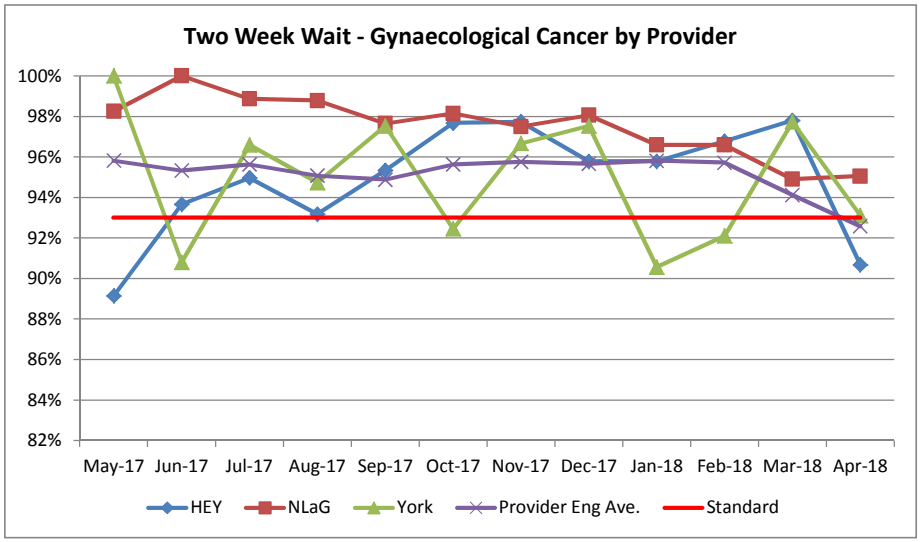


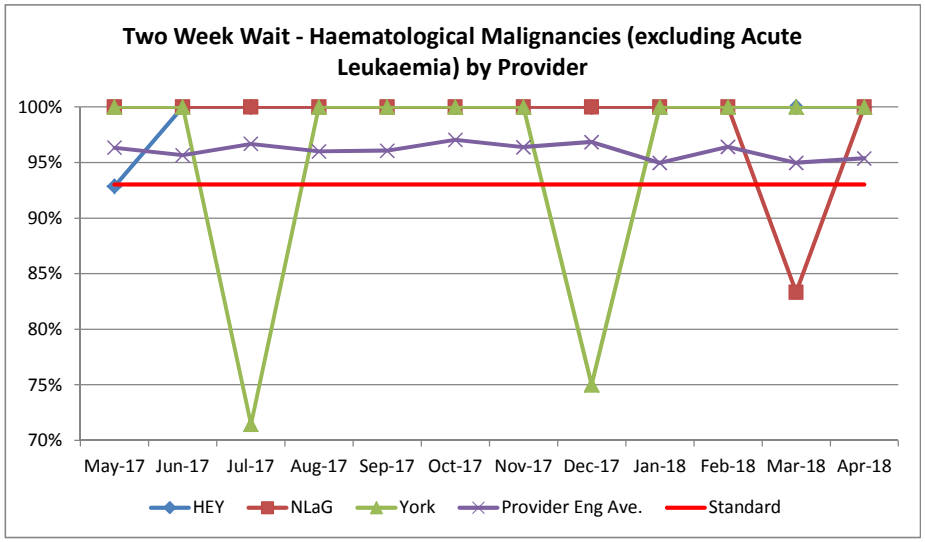


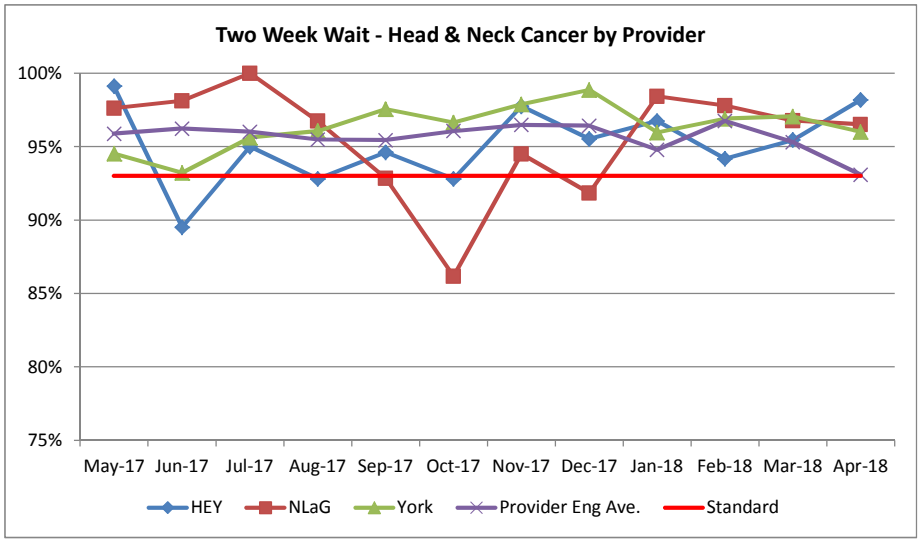


Two weeks from urgent GP referral for suspected cancer to first appointment

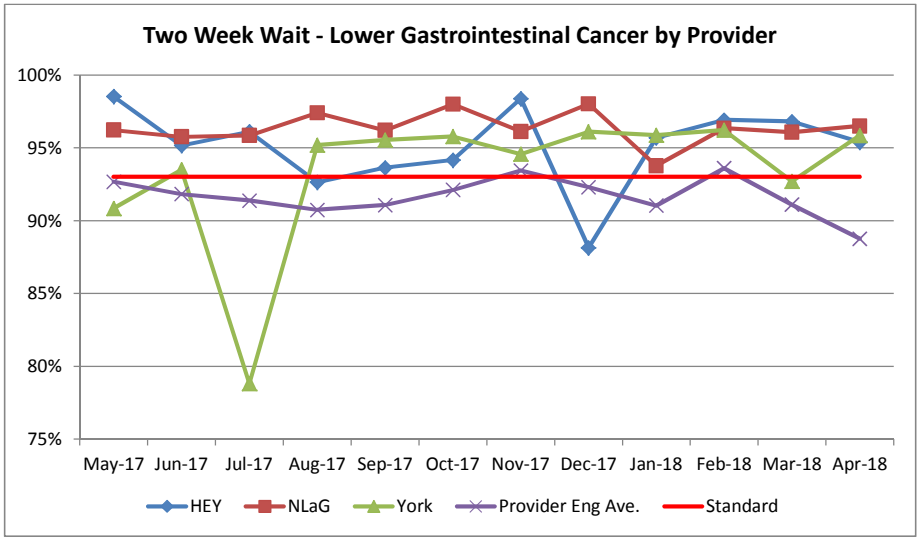


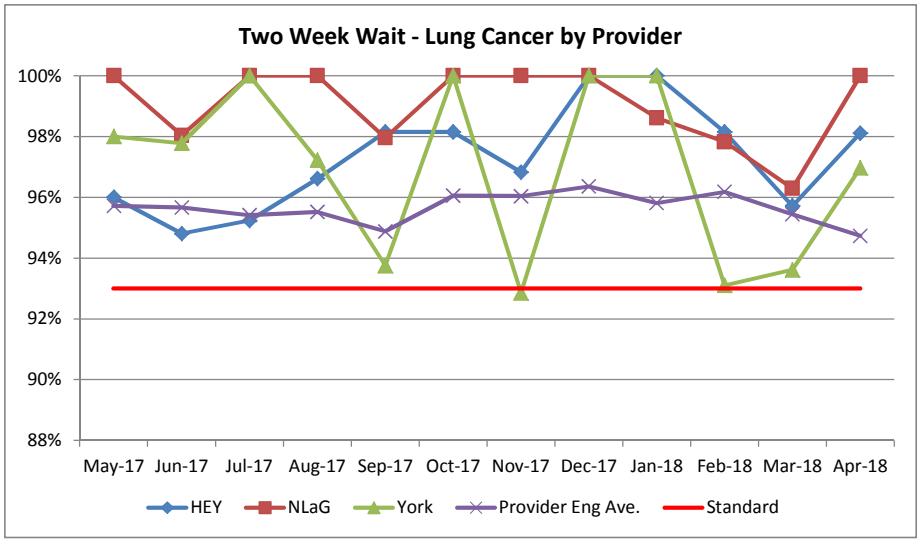


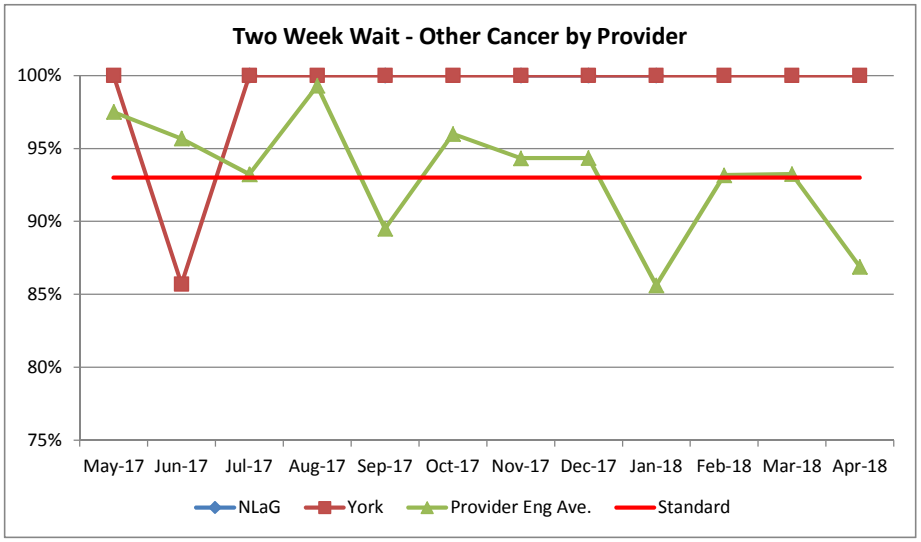


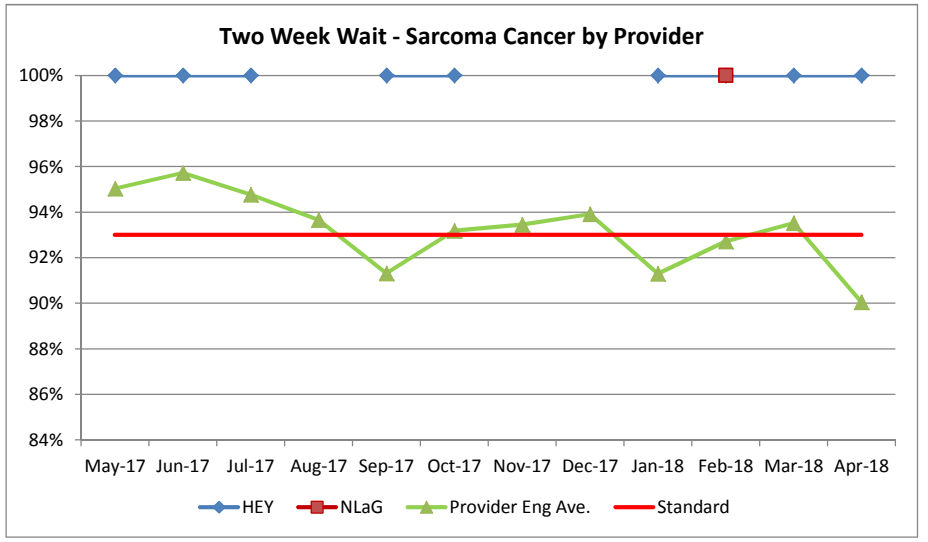


Two weeks from urgent GP referral for suspected cancer to first appointment

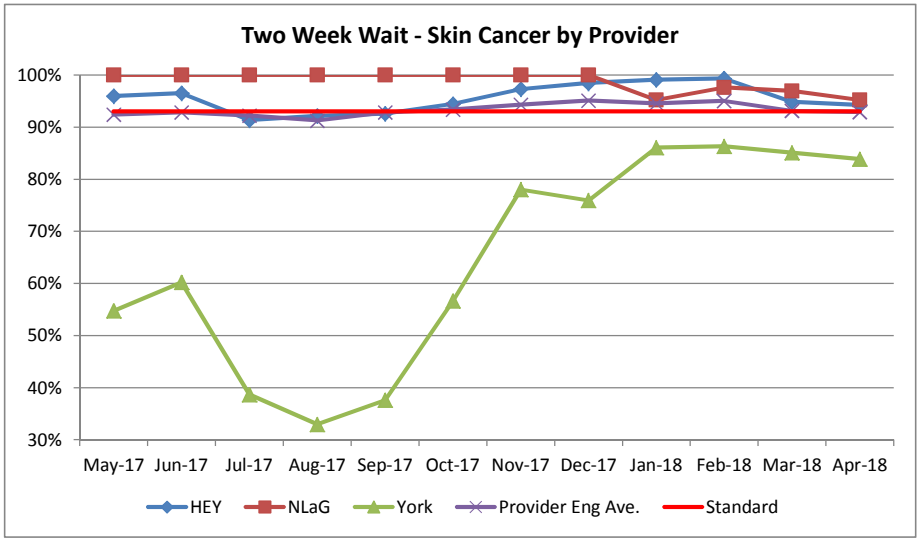


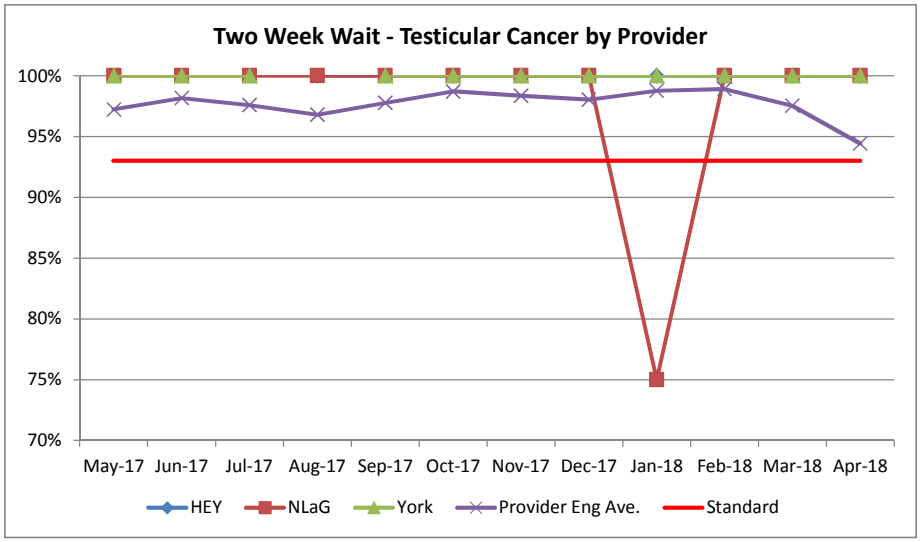


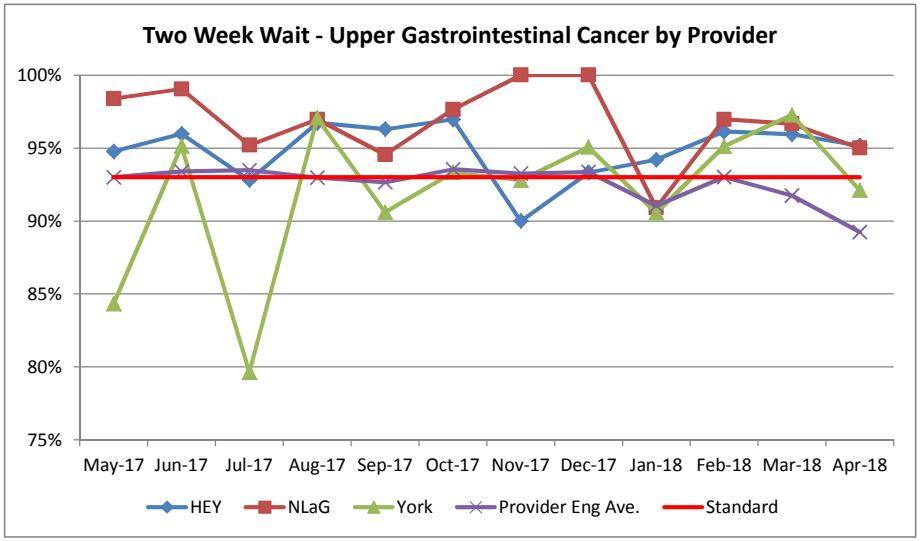


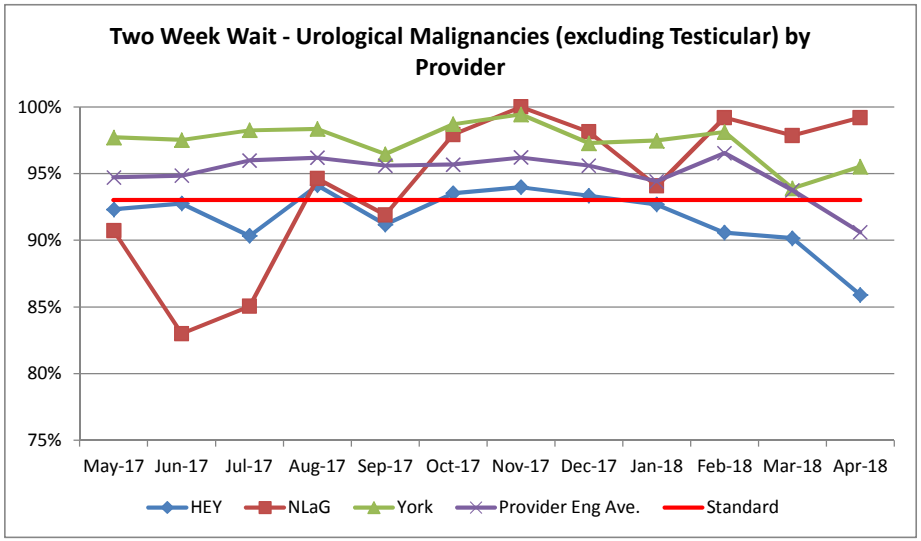


Two weeks from urgent GP referral for suspected cancer to first appointment

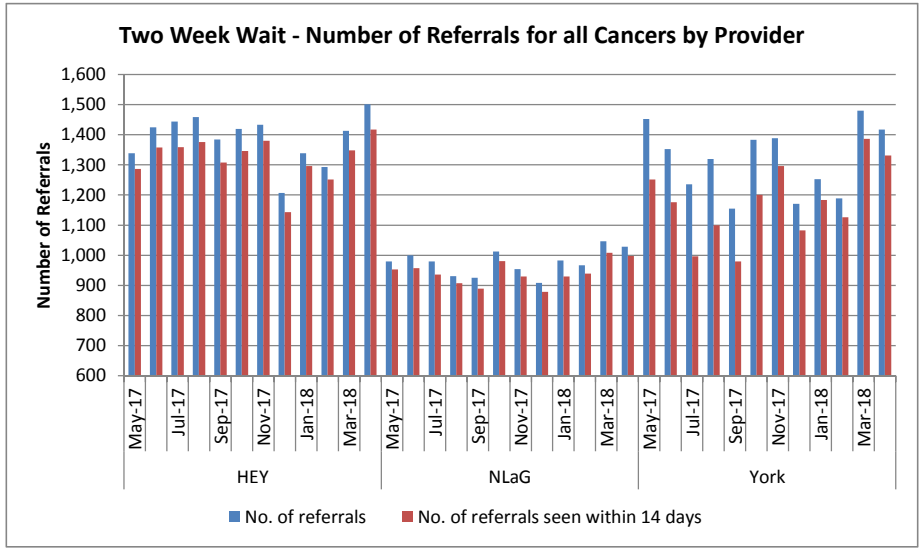


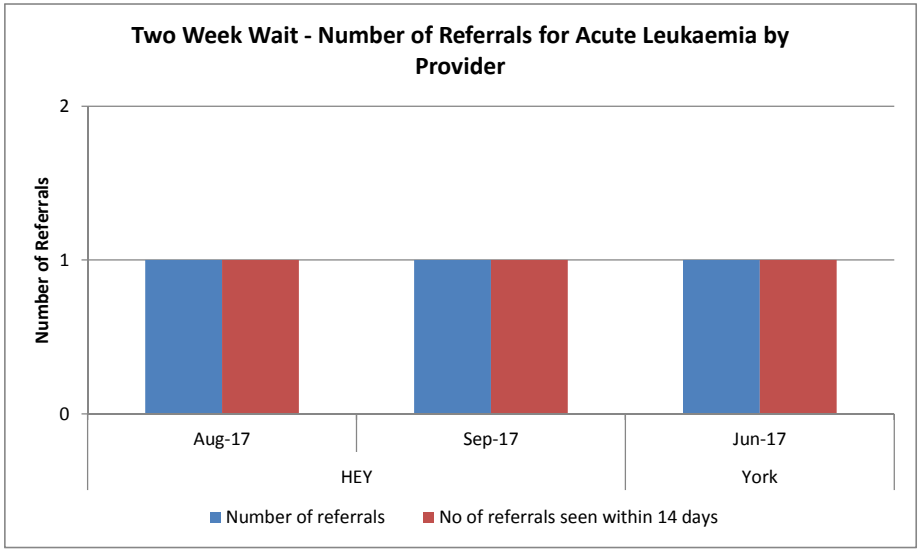


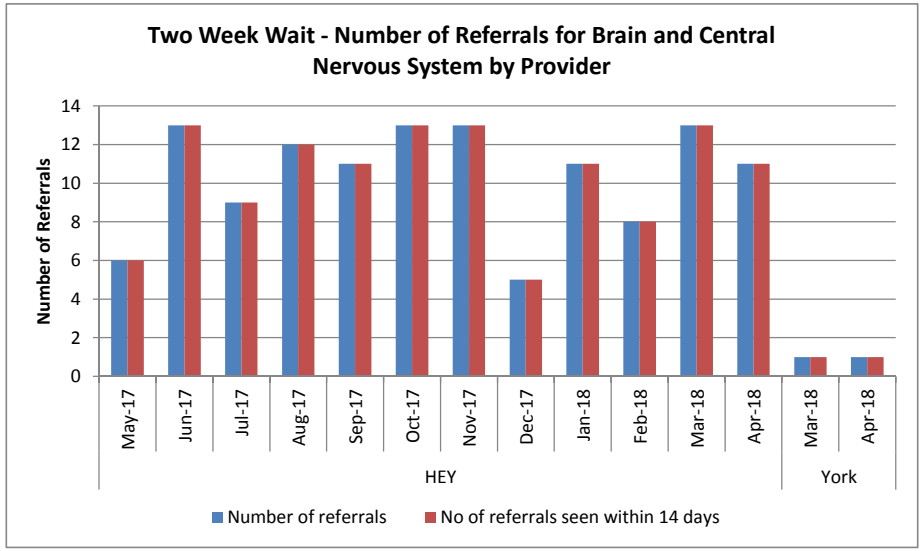


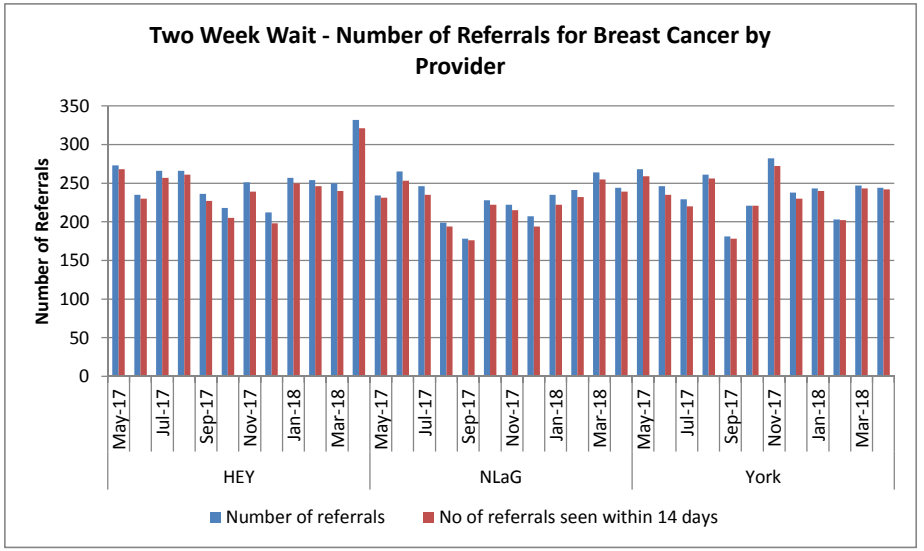


Two weeks from urgent GP referral for suspected cancer to first appointment

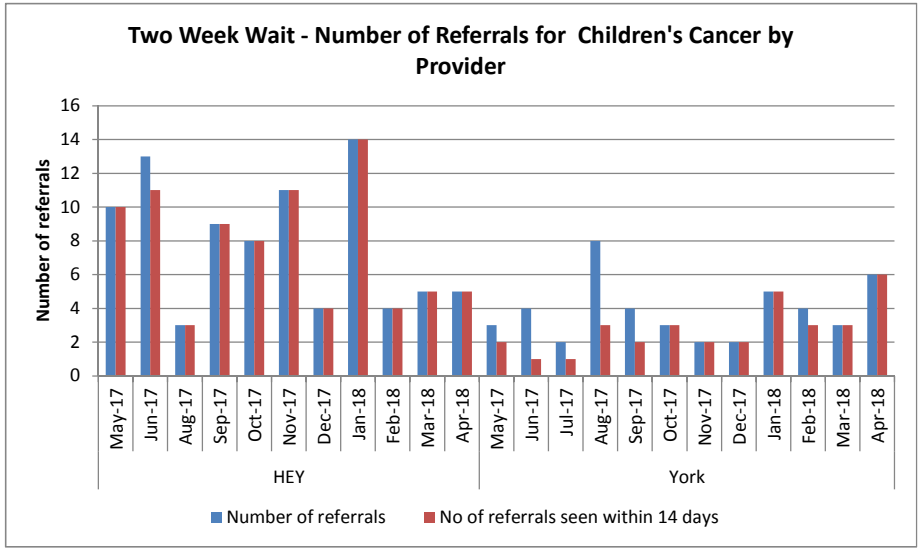


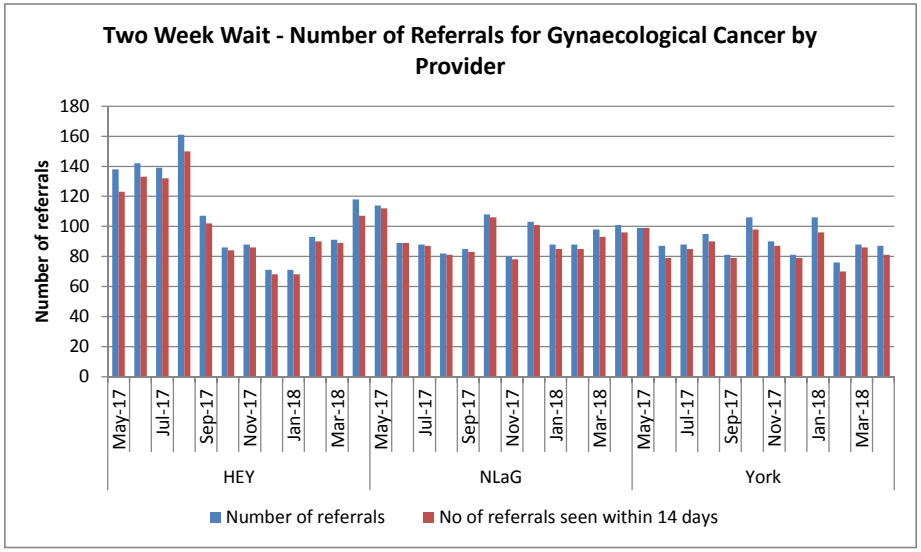


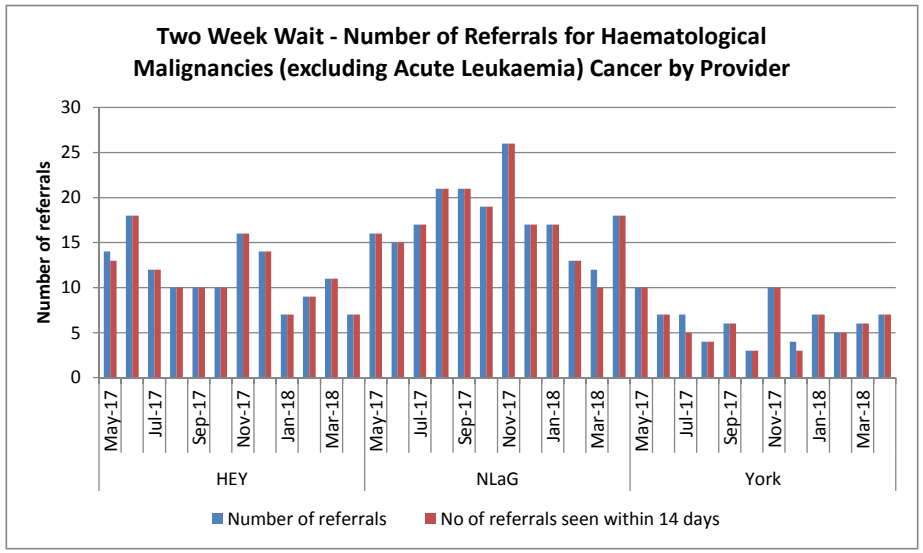


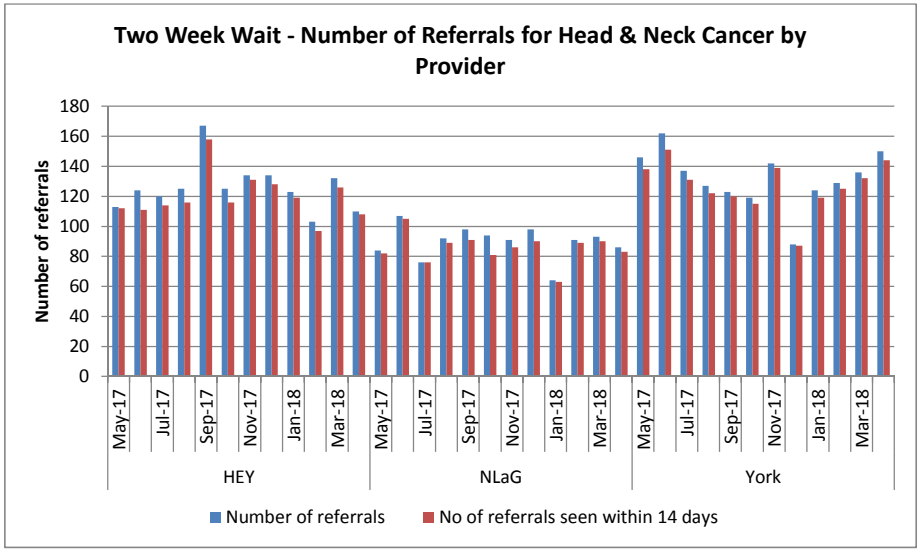


Two weeks from urgent GP referral for suspected cancer to first appointment

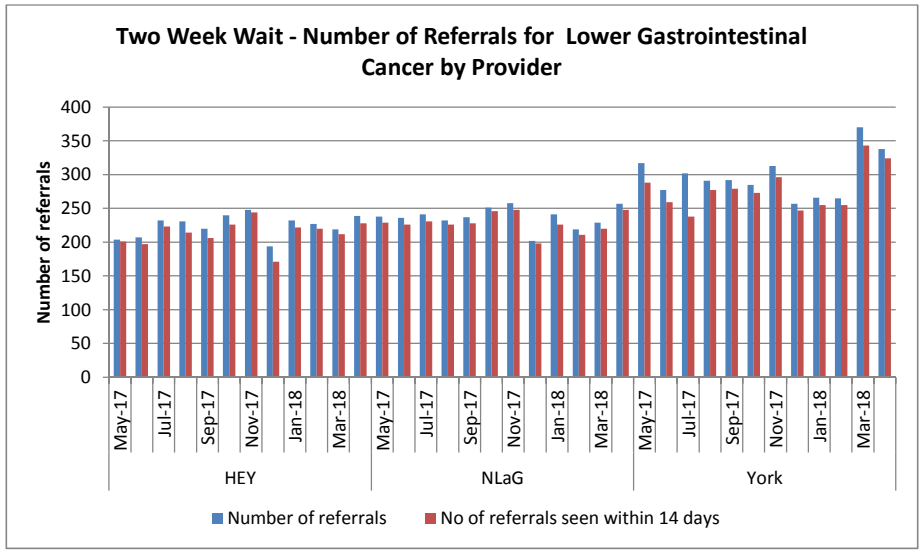


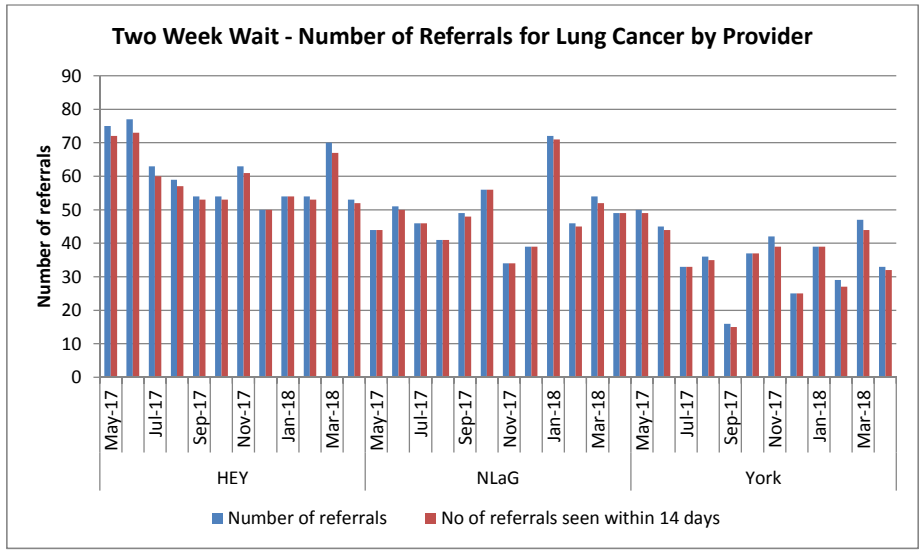


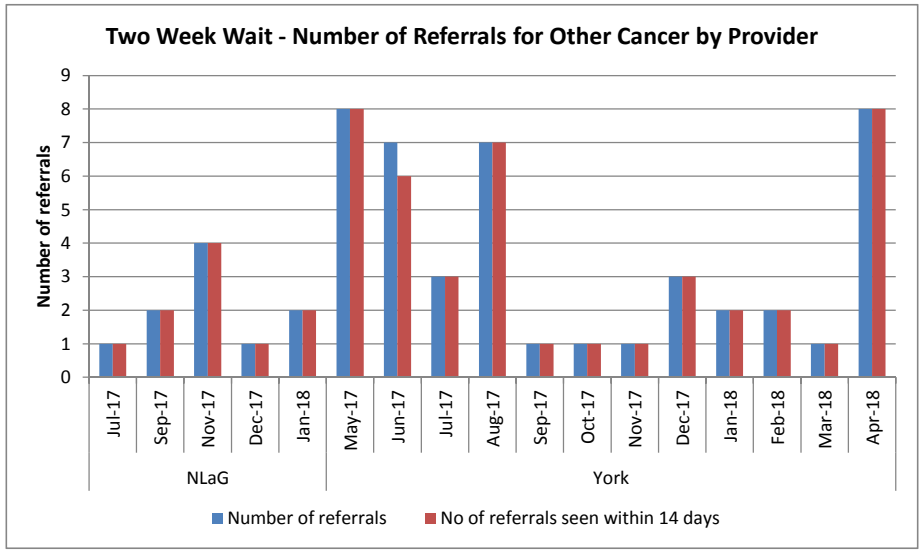


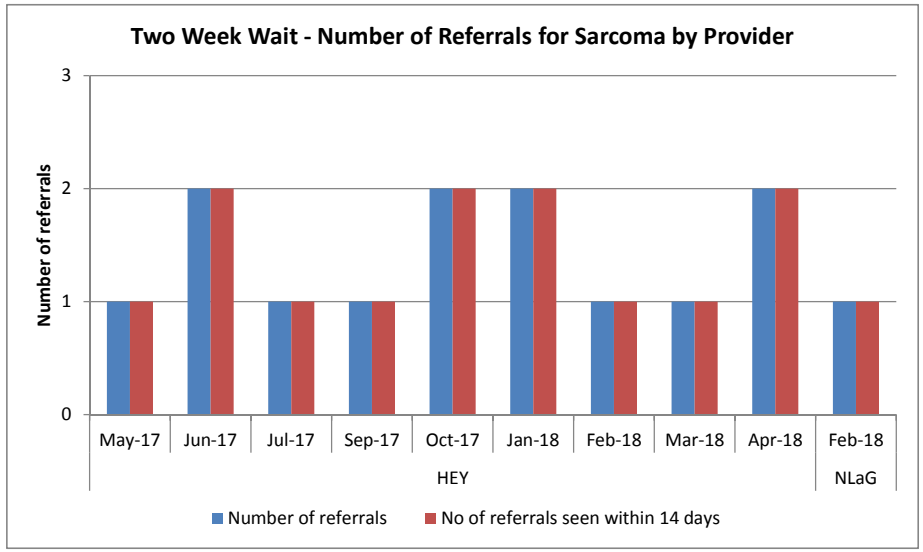


Two weeks from urgent GP referral for suspected cancer to first appointment

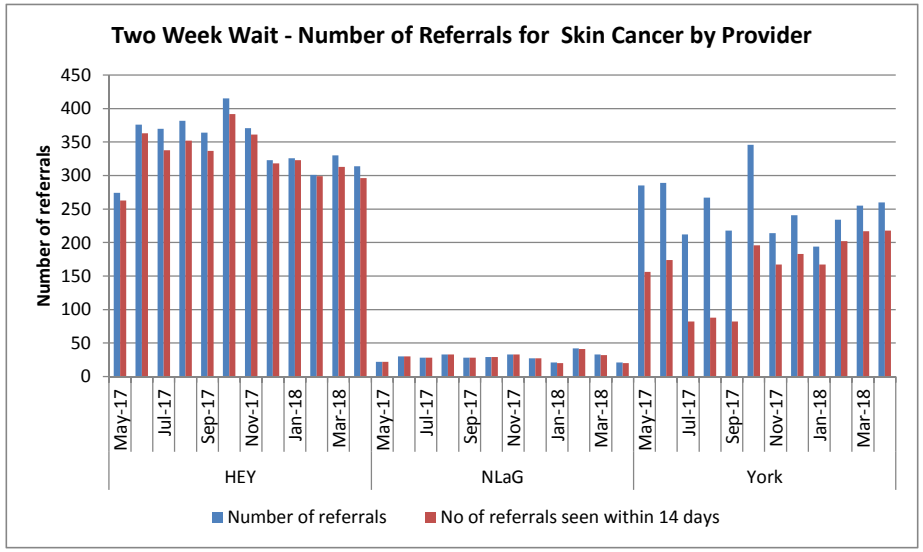


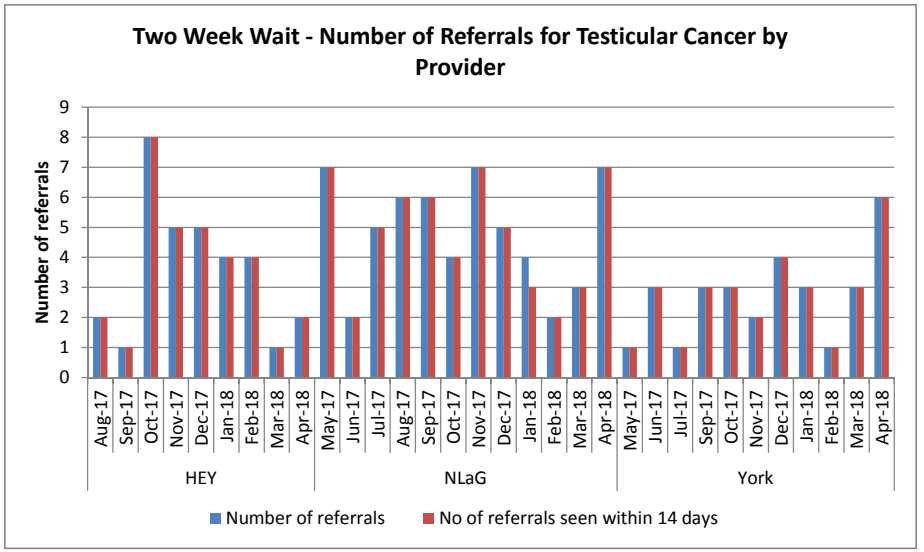


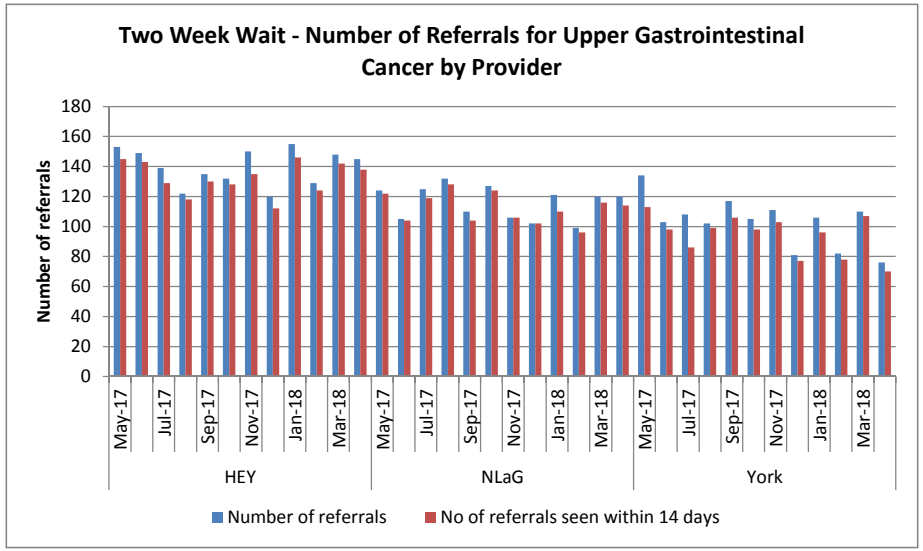


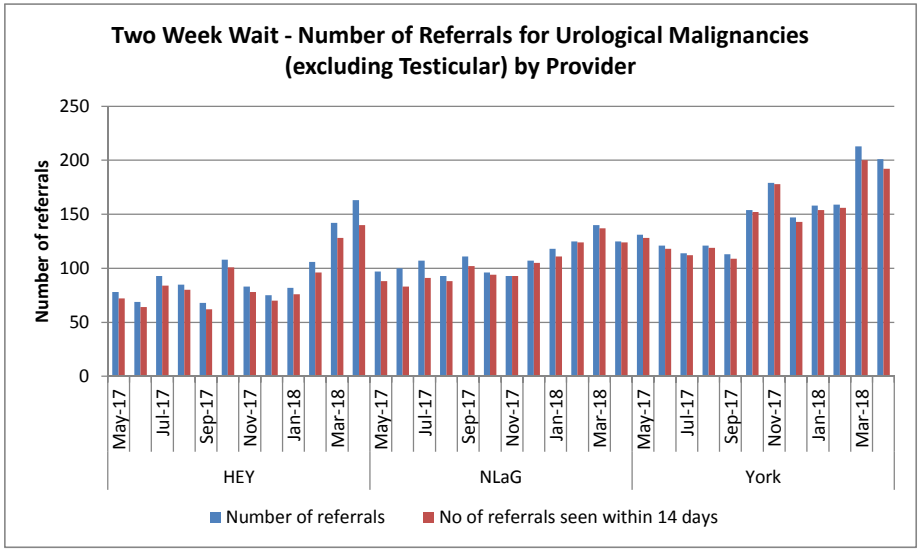


Two weeks from urgent GP referral for suspected cancer to first appointment

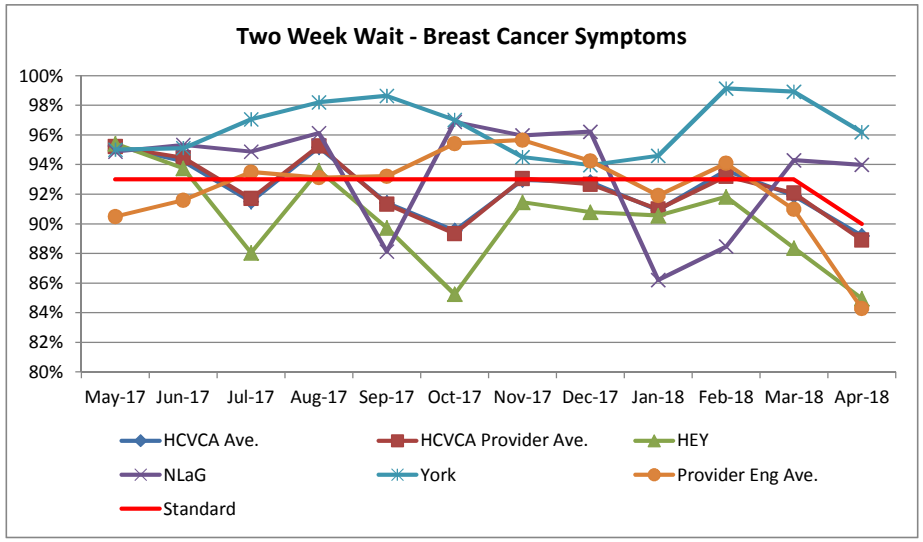


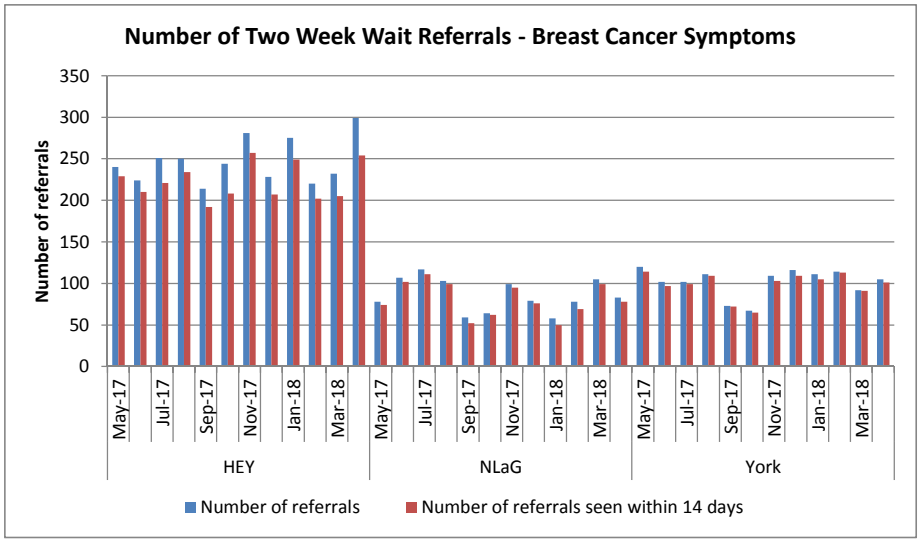




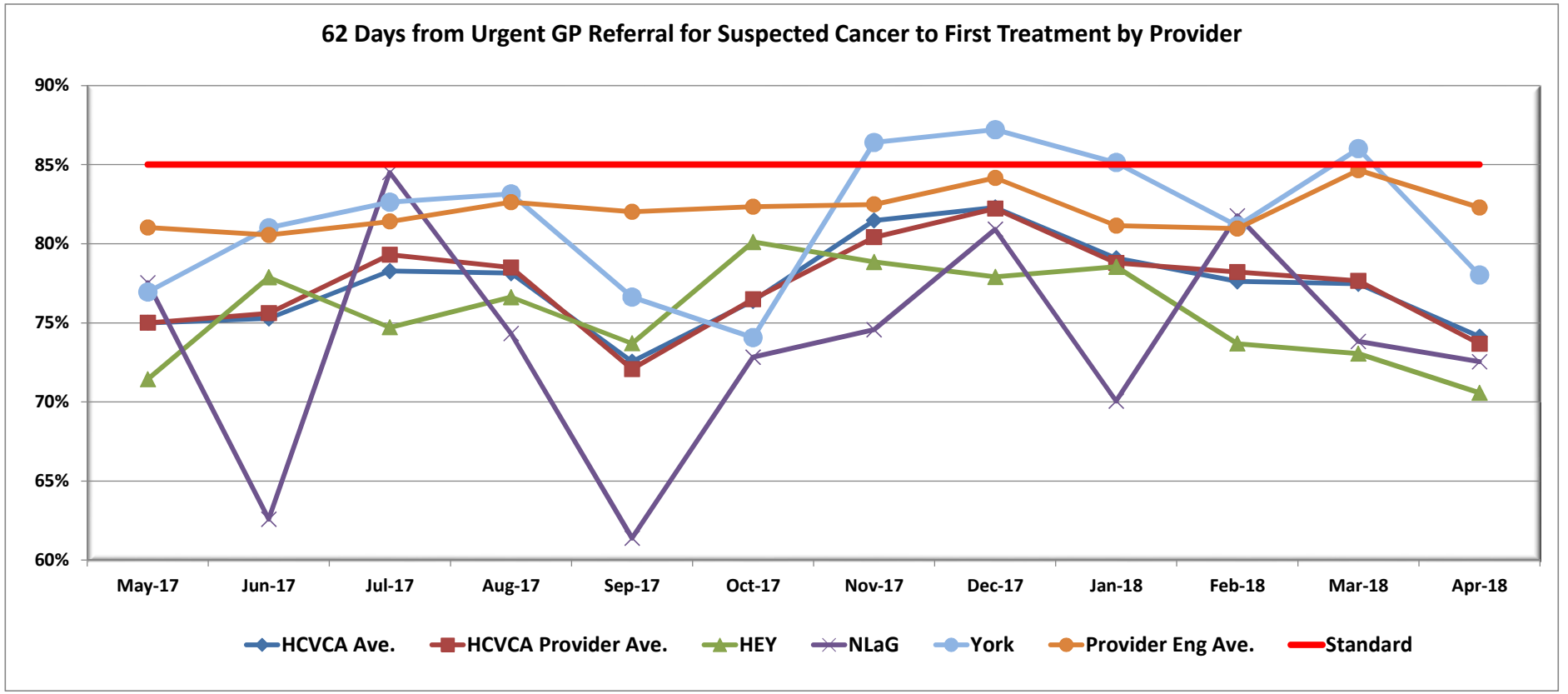


Two weeks from referral for Breast Symptoms (whether cancer is suspected or not) to first appointment



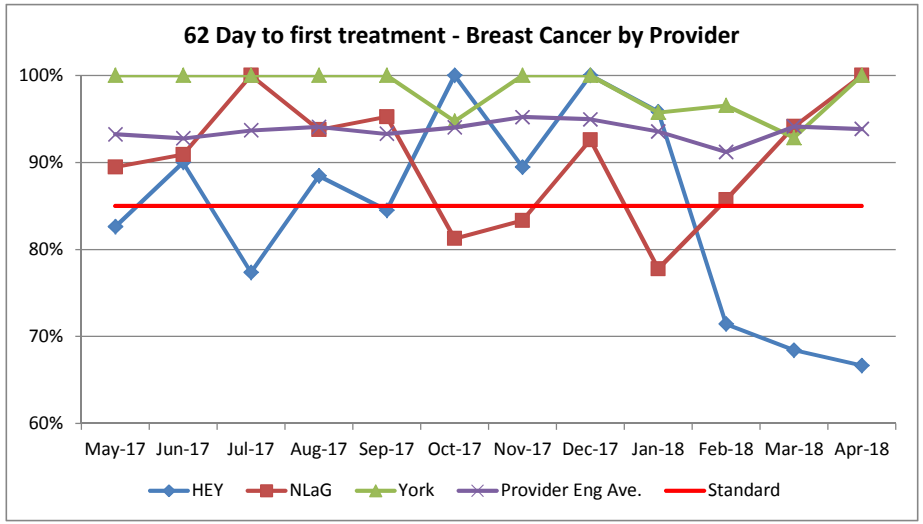


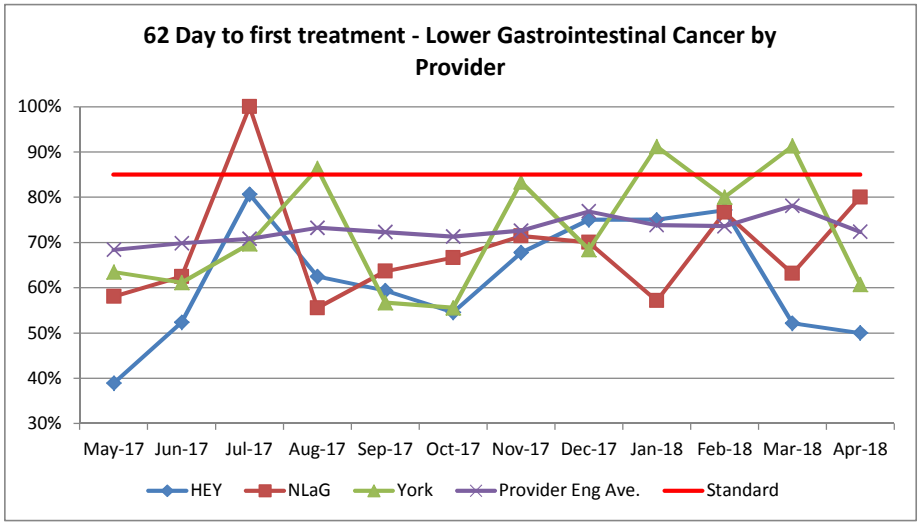
62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia)

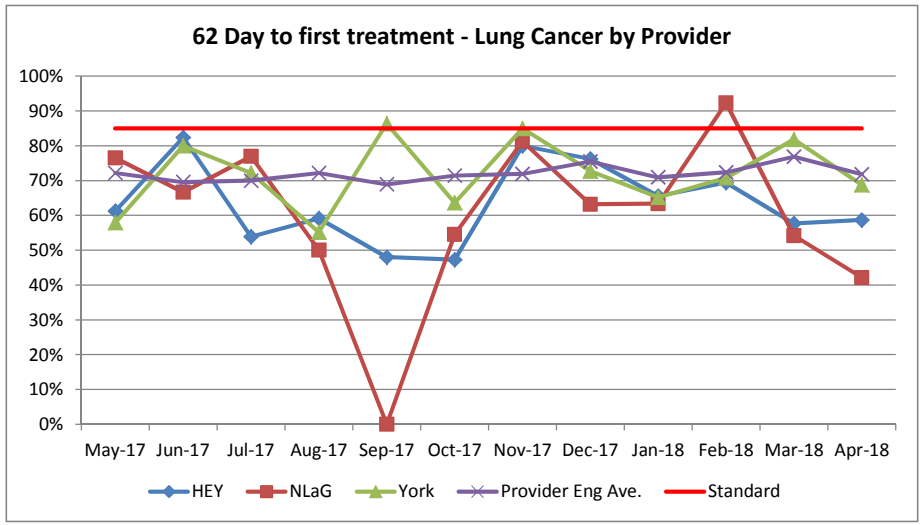


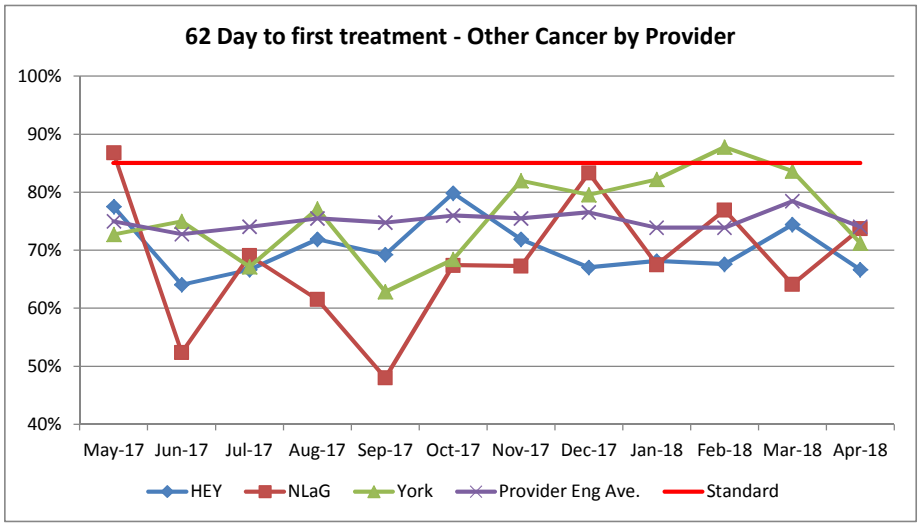
	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
HCVCA	75.00%	75.27%	78.27%	78.15%	72.55%	76.40%	81.47%	82.30%	79.08%	77.62%	77.46%	74.12%
HCVCA Provider Ave.	75.31%	73.82%	80.62%	78.04%	70.57%	75.67%	79.94%	82.23%	78.78%	78.21%	77.65%	73.67%
HEY	71.43%	77.88%	74.71%	76.63%	73.70%	80.11%	78.85%	77.91%	78.55%	73.68%	73.05%	70.57%
NLaG	77.54%	62.58%	84.51%	74.32%	61.39%	72.83%	74.57%	80.92%	70.05%	81.76%	73.82%	72.55%
York	76.95%	81.01%	82.63%	83.15%	76.63%	74.06%	86.40%	87.21%	85.13%	81.12%	86.01%	78.03%
Provider Eng Ave.	81.03%	80.55%	81.40%	82.63%	82.03%	82.34%	82.48%	84.16%	81.15%	80.96%	84.65%	82.29%
Standard	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia)

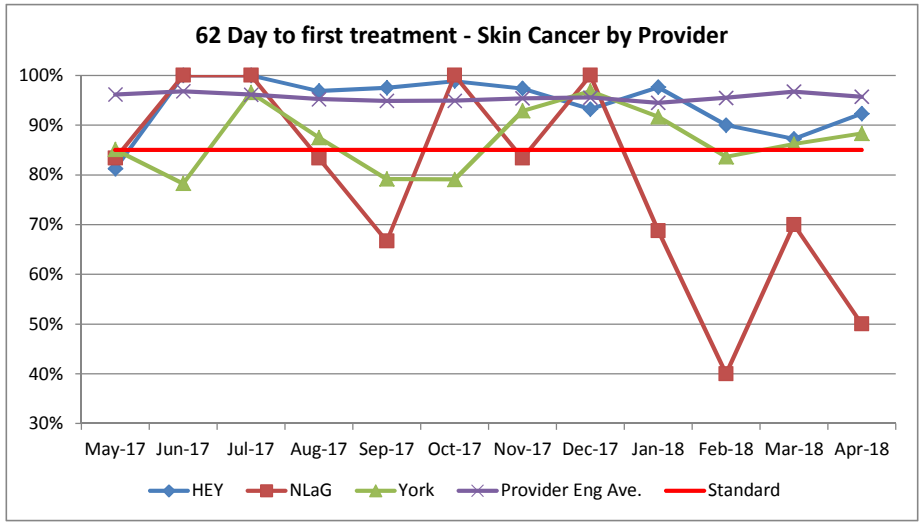


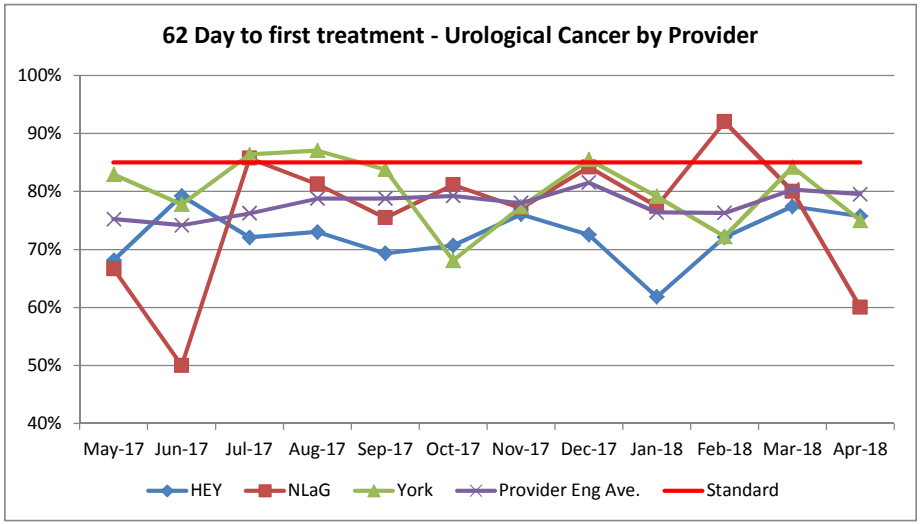




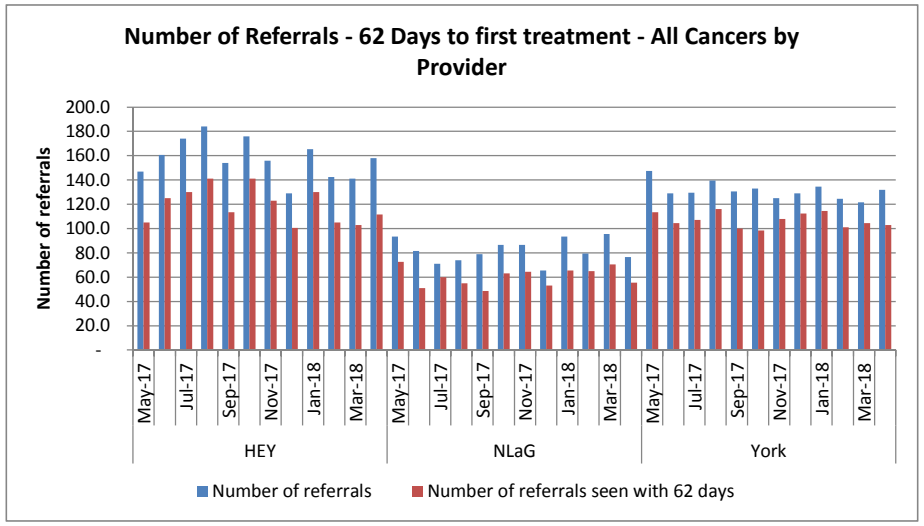


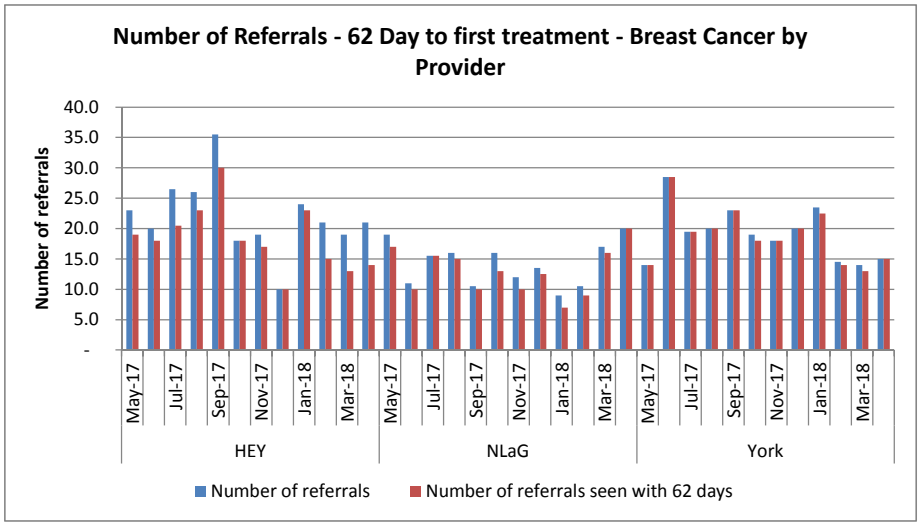
62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia)

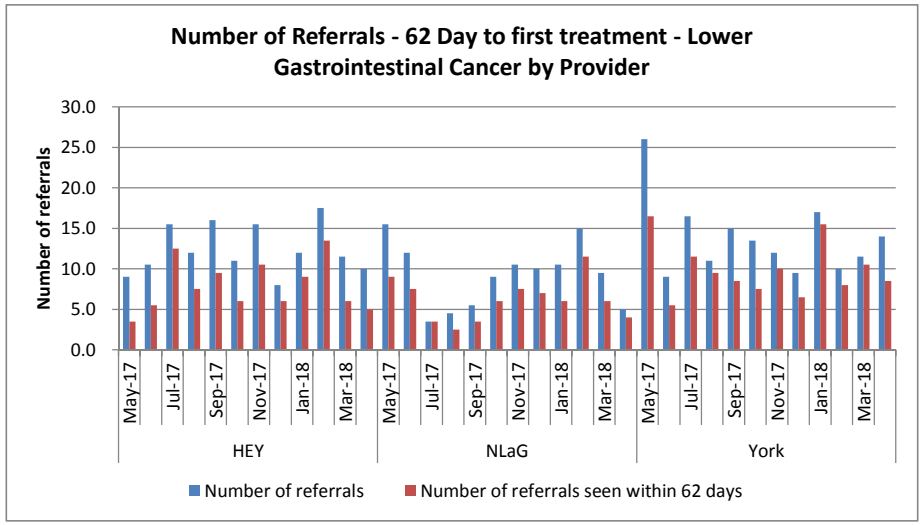


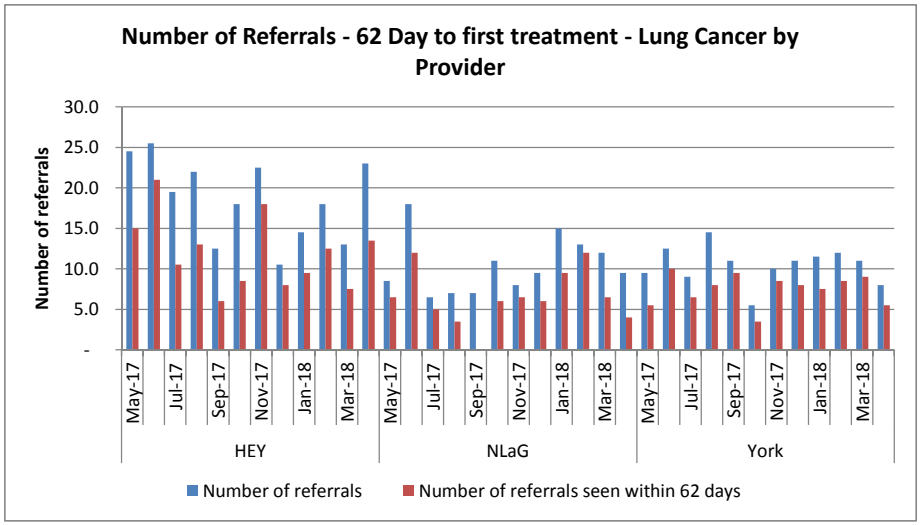


62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia)

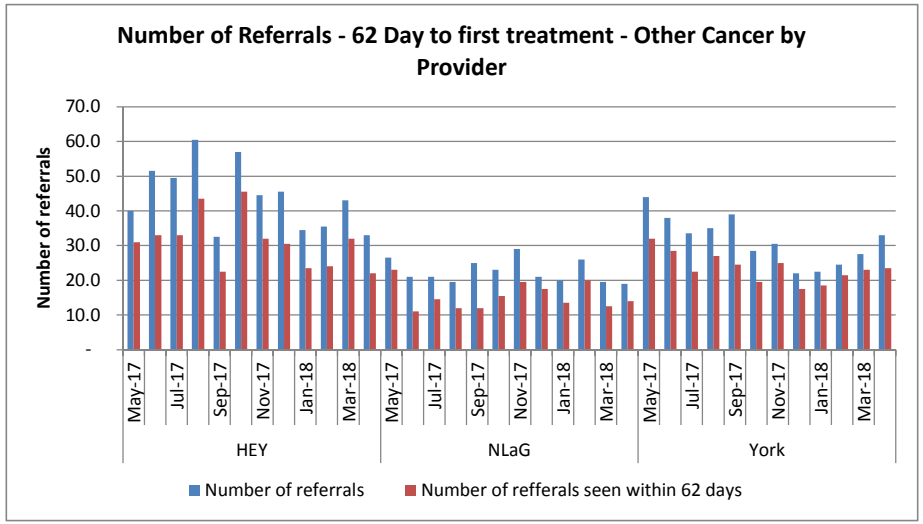


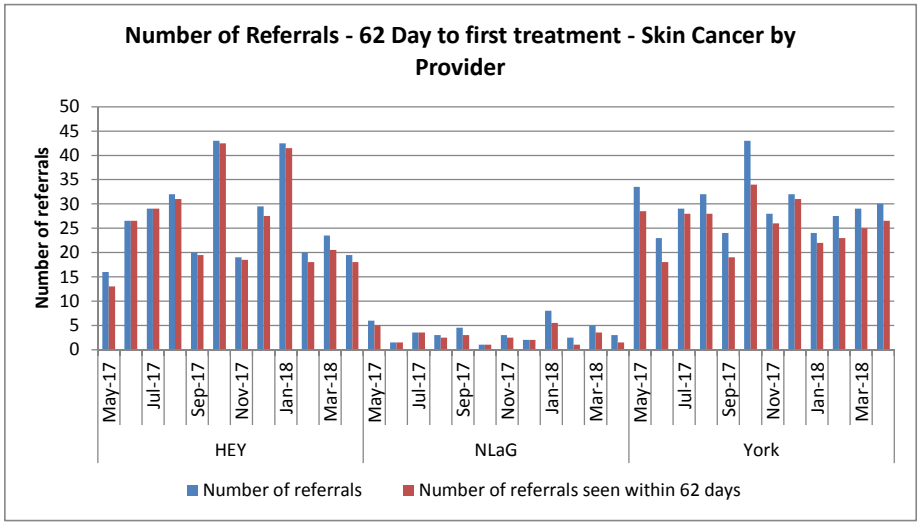


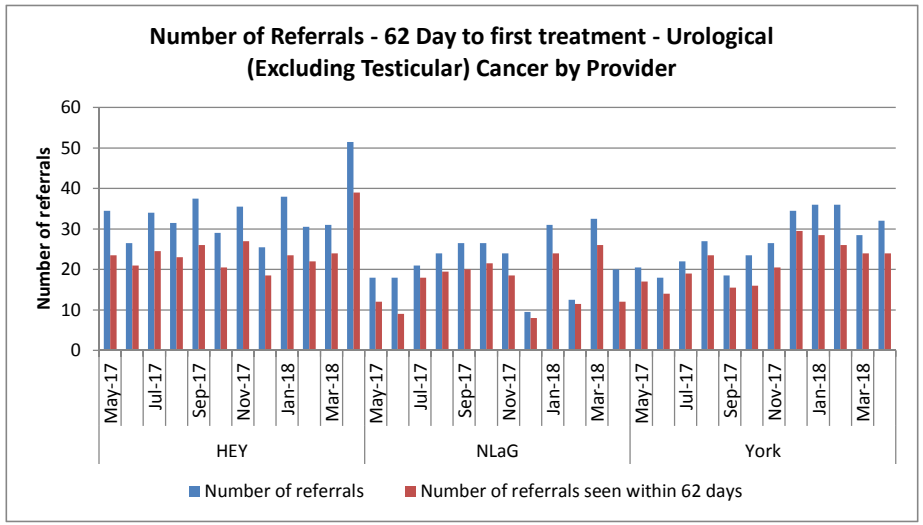




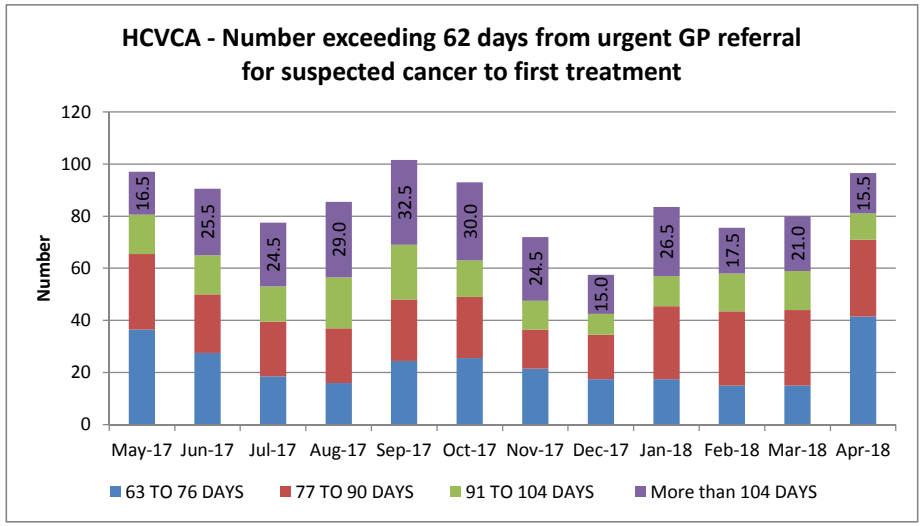
62 days from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia)

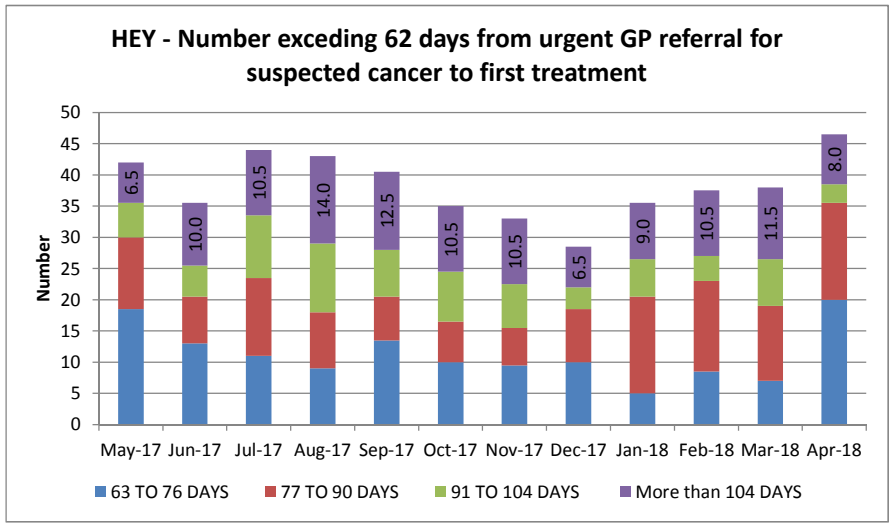


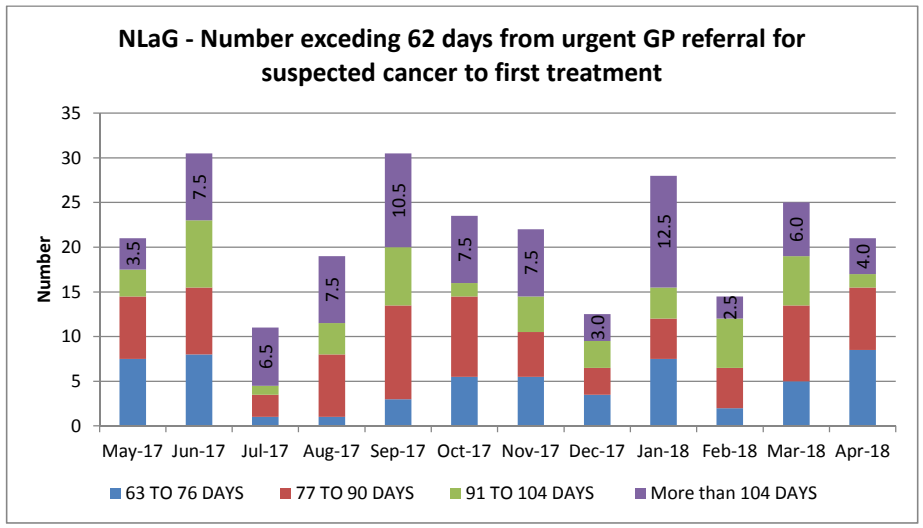


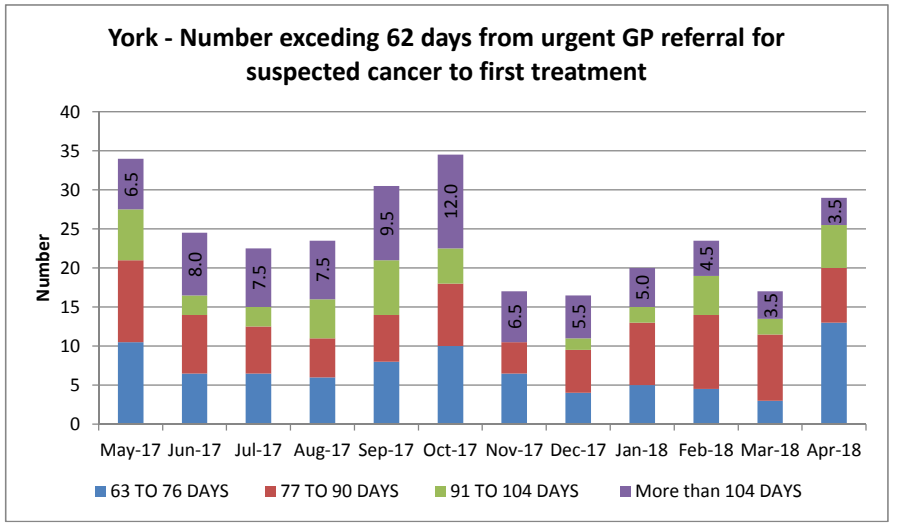


Number exceeding 62 days from urgent GP referral for suspected cancer to first treatment

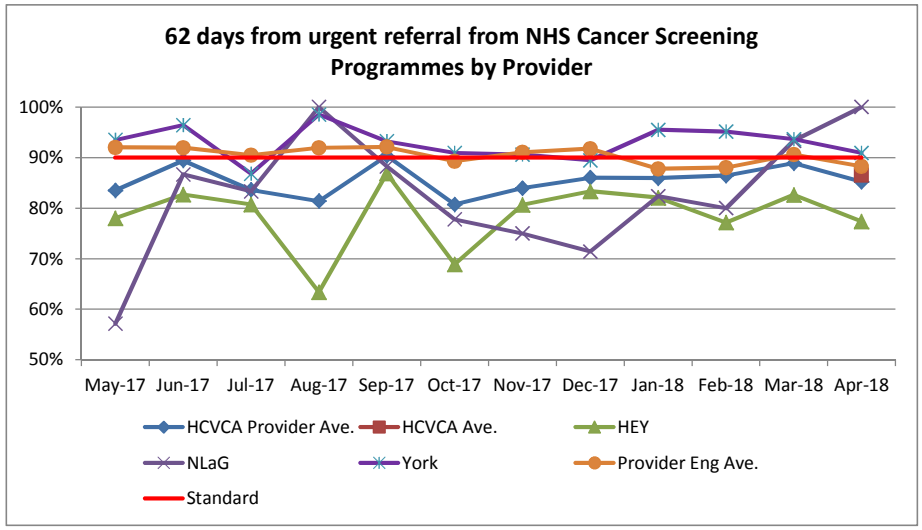


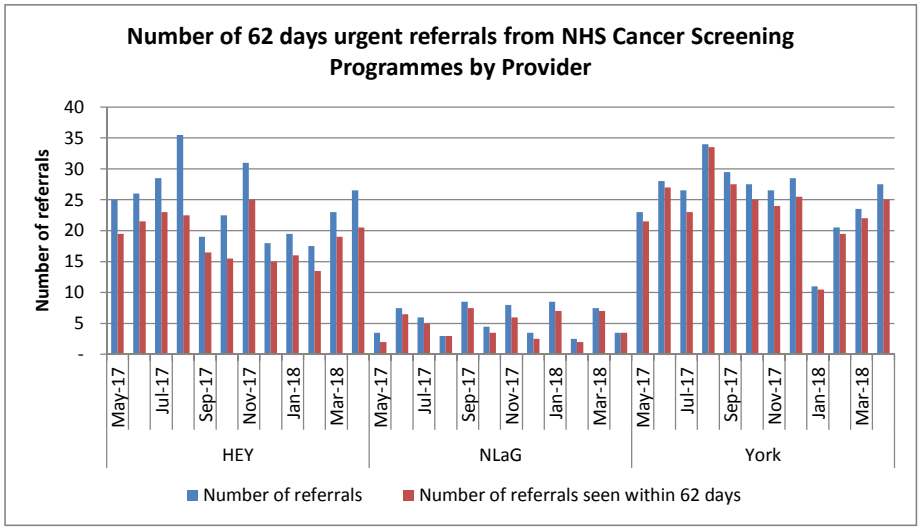




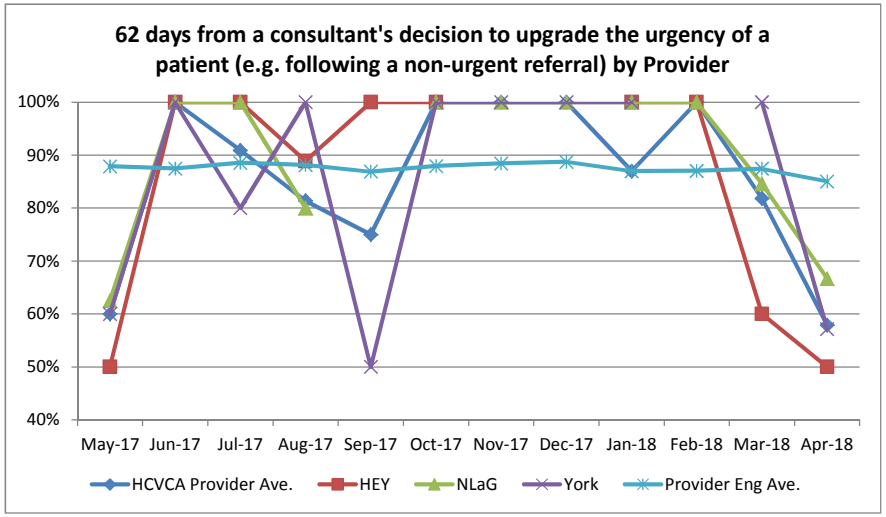


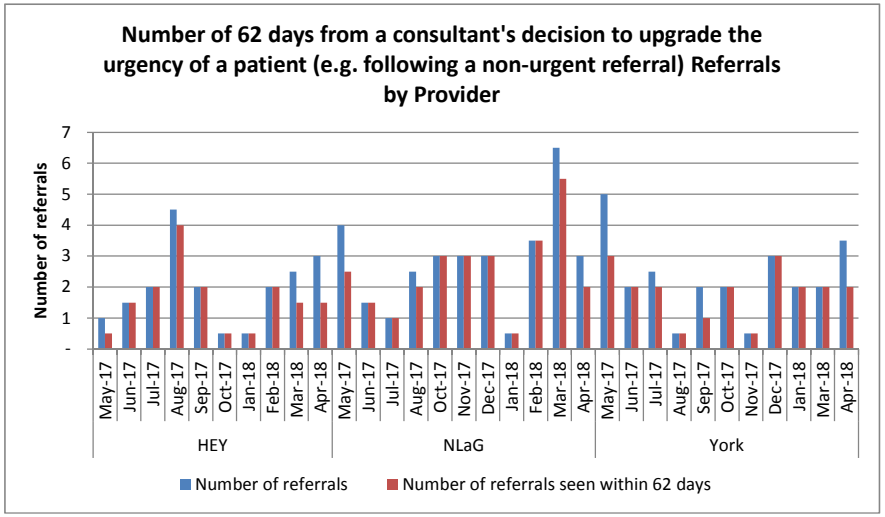
62 days from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment



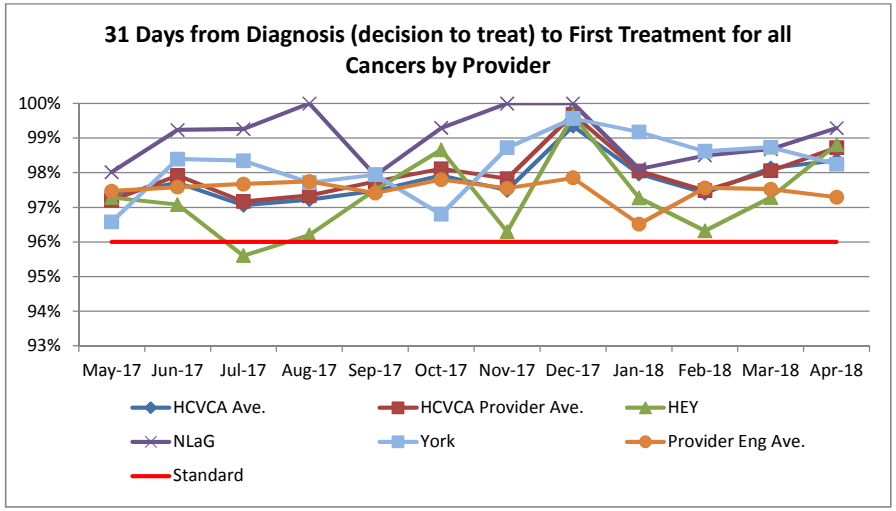


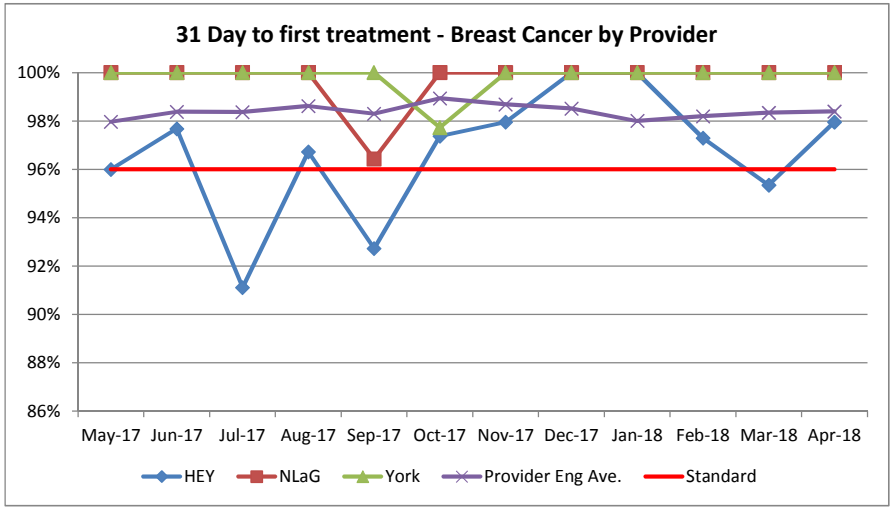
62 days from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set)

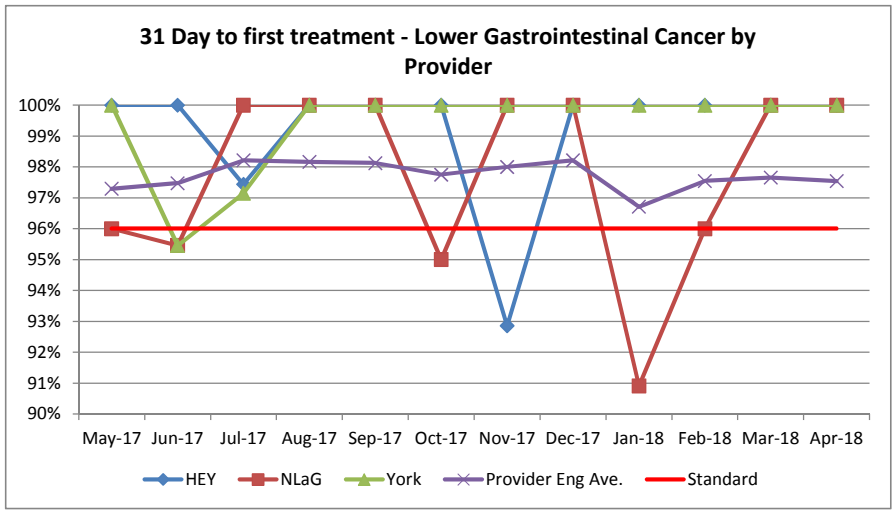


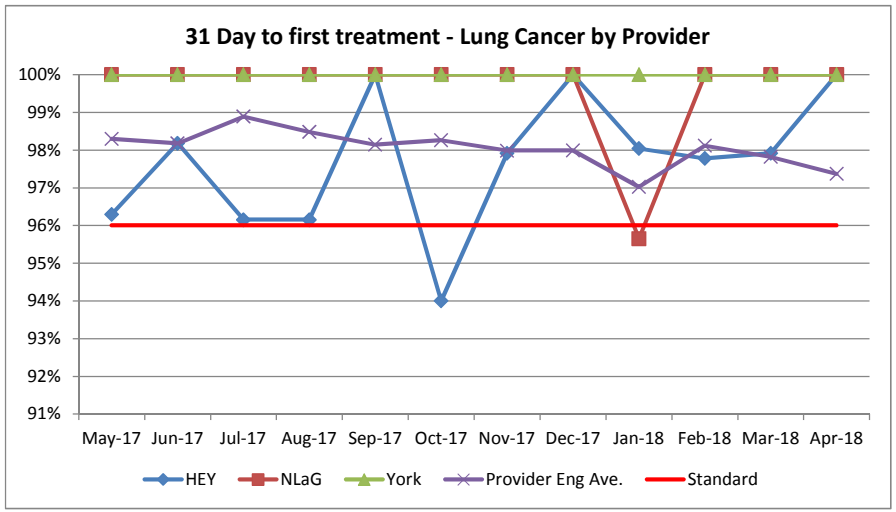


31 Days from Diagnosis (decision to treat) to First Treatment for all Cancers and tumour Site by Provider

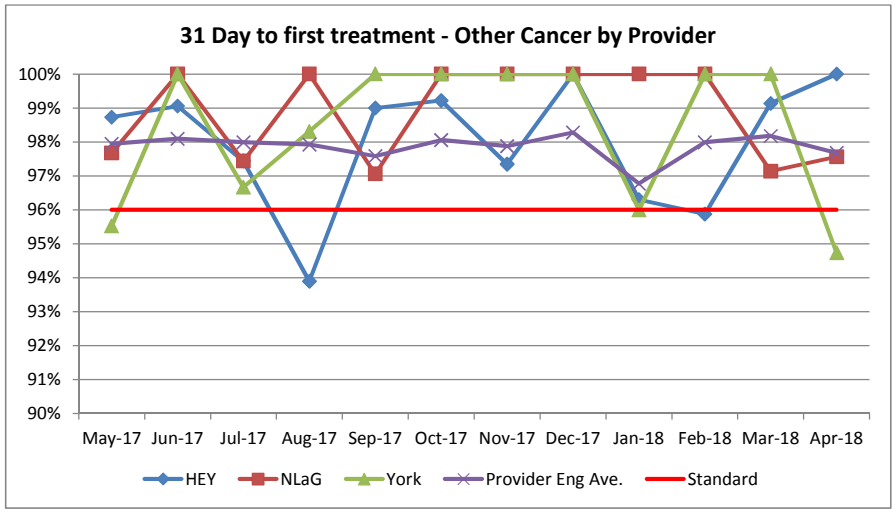


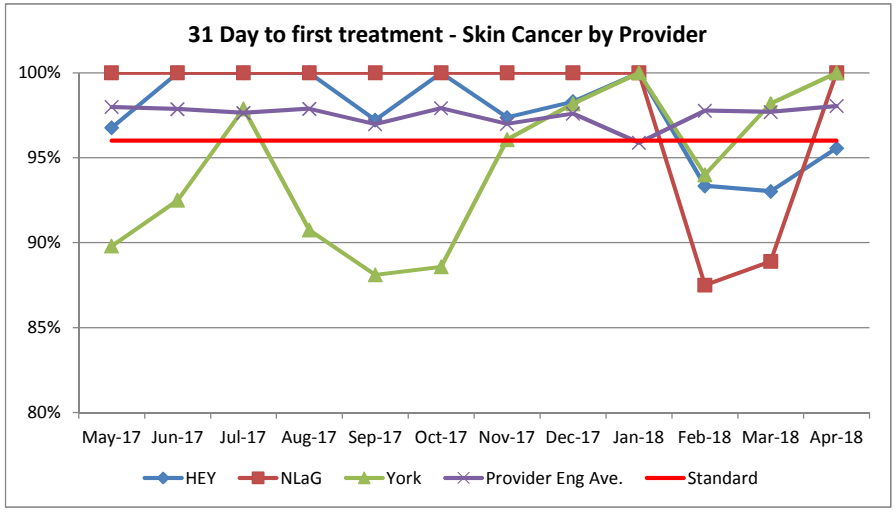


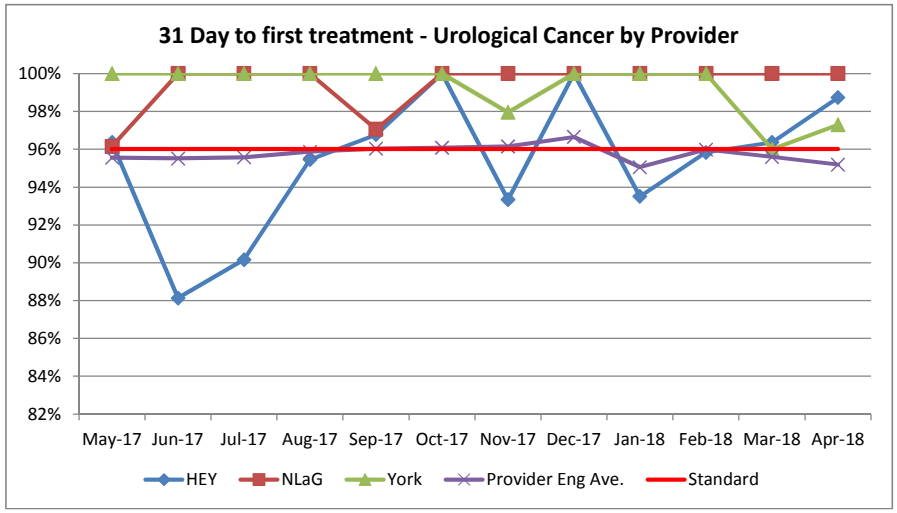




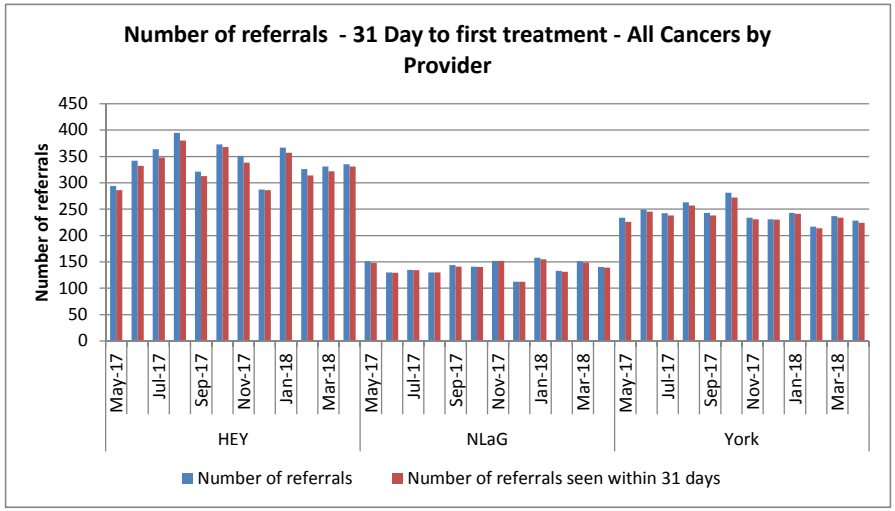
31 Days from Diagnosis (decision to treat) to First Treatment for all Cancers and tumour Site by Provider

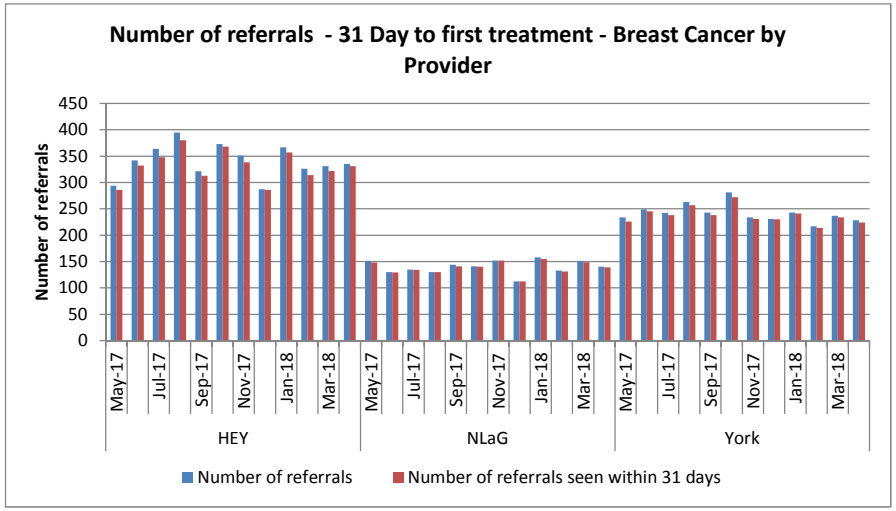


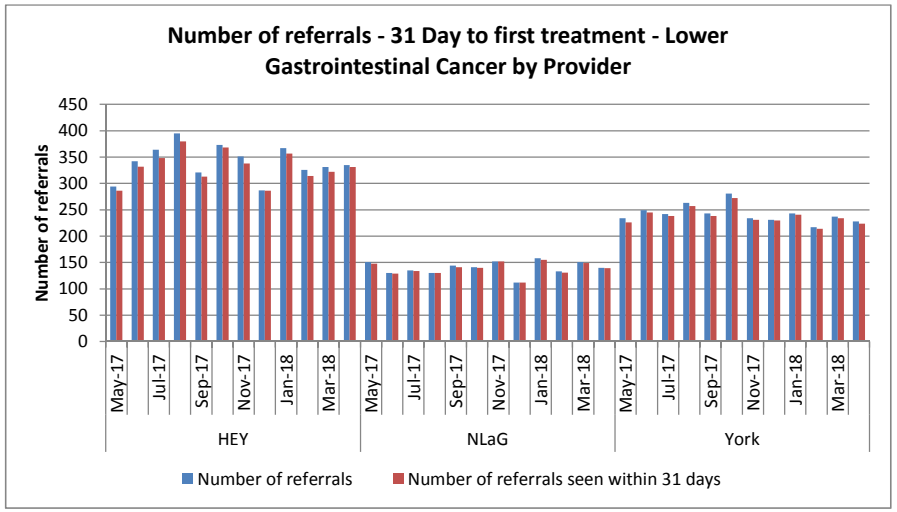


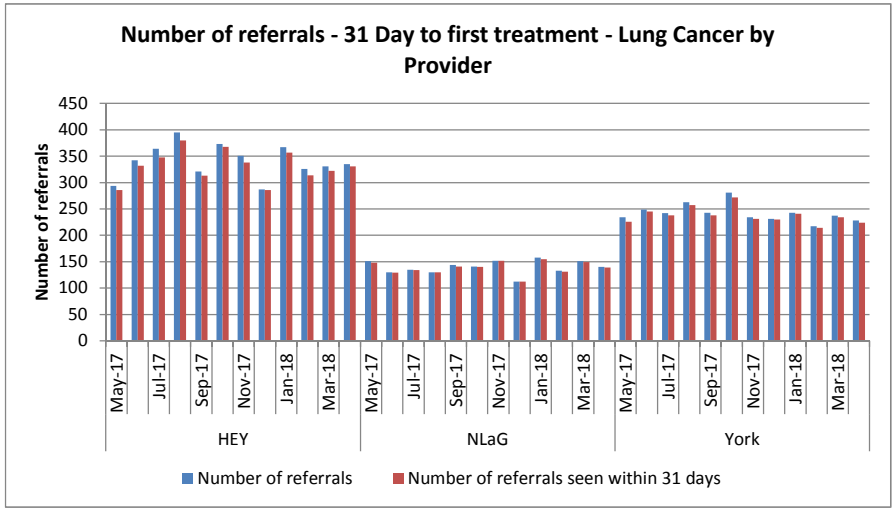


31 Days from Diagnosis (decision to treat) to First Treatment for all Cancers and tumour Site by Provider

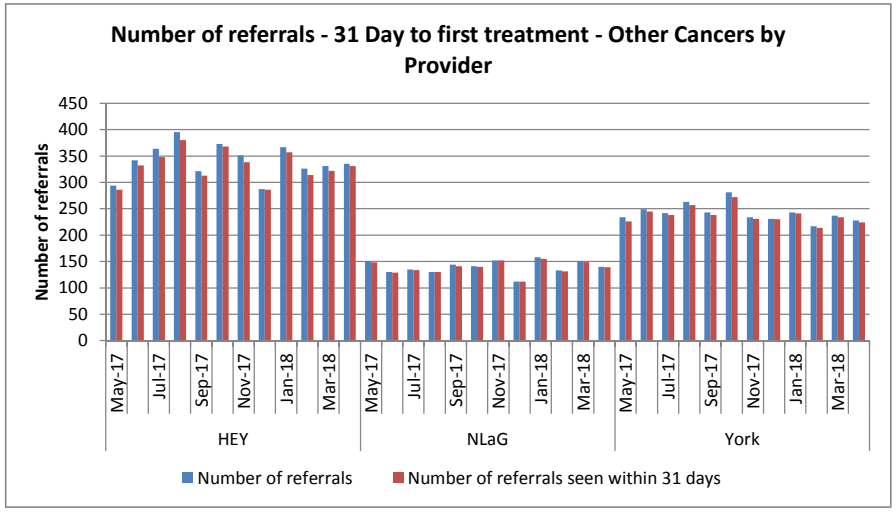


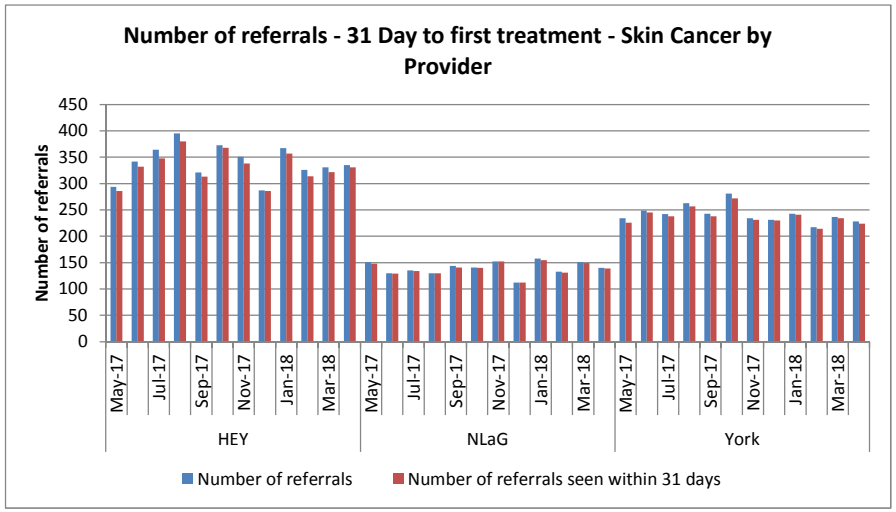


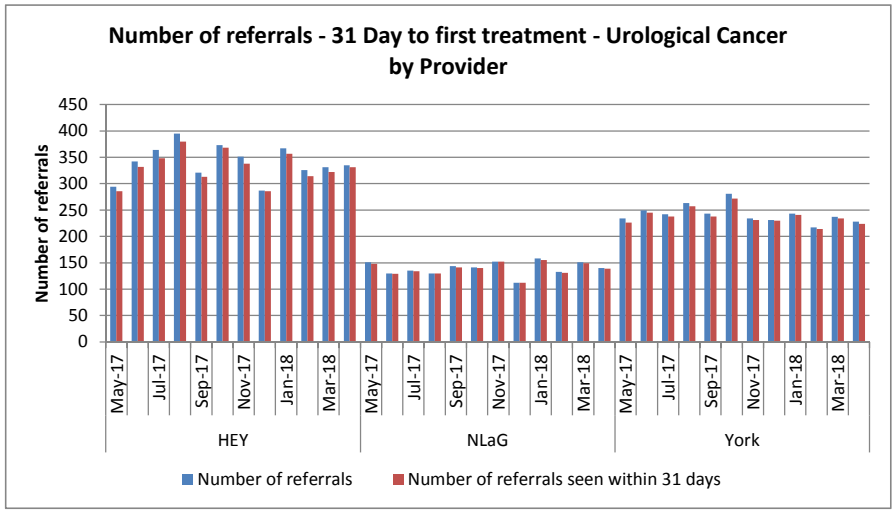




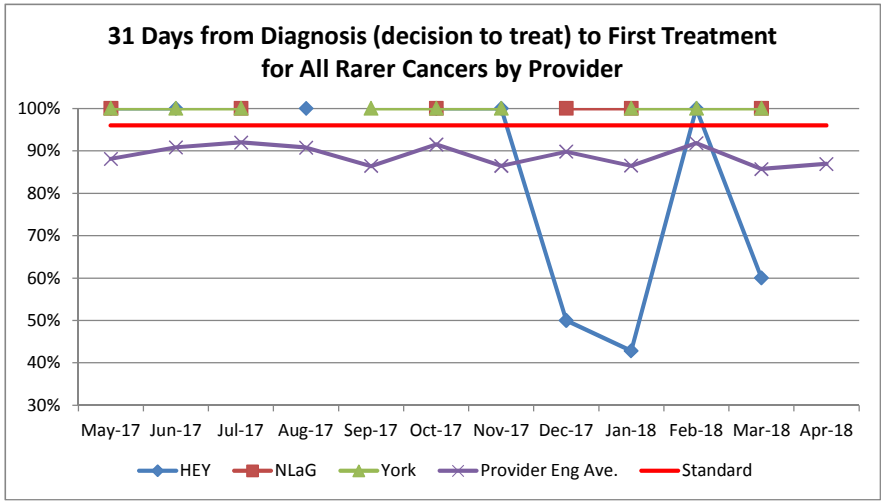
31 Days from Diagnosis (decision to treat) to First Treatment for all Cancers and tumour Site by Provider

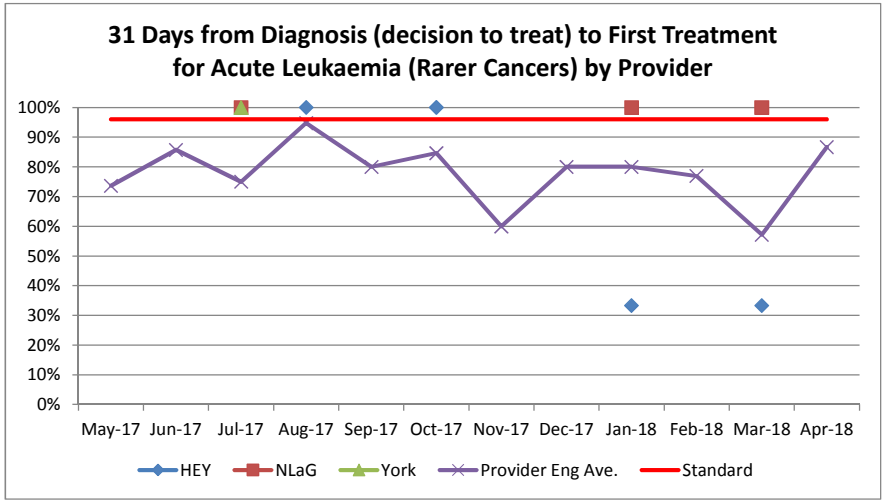


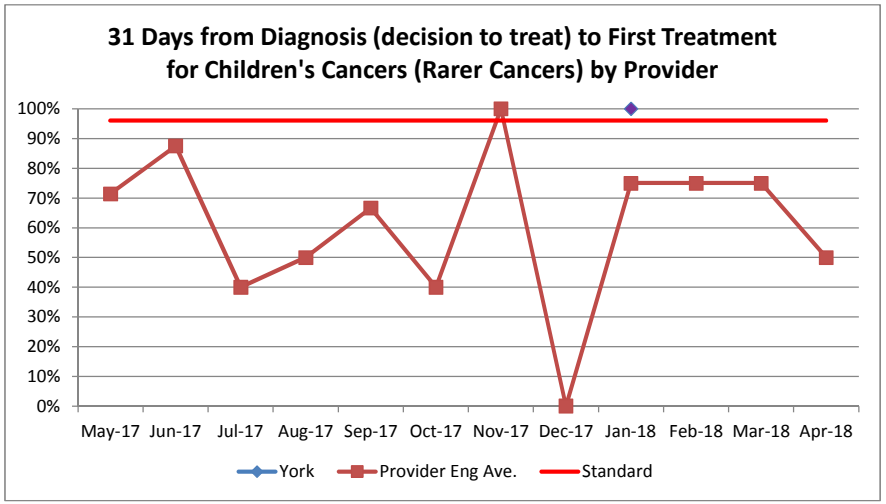


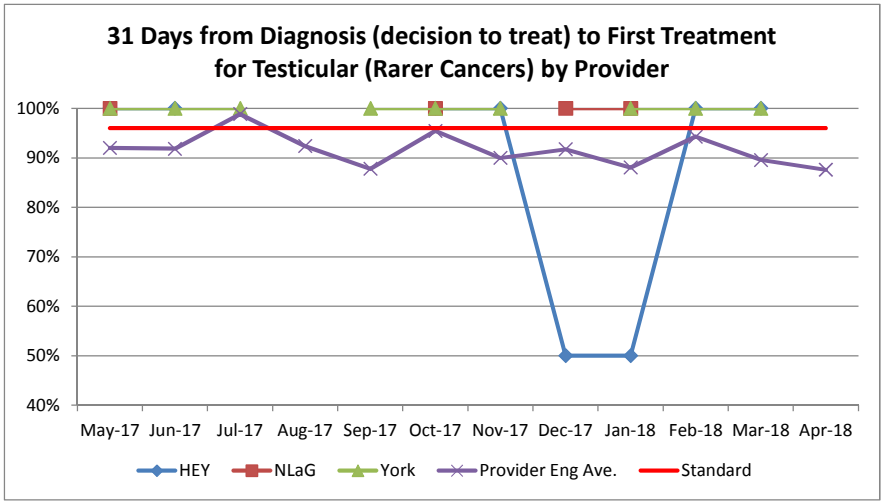


31 Days from Diagnosis (decision to treat) to First Treatment for all Rarer Cancers and tumour Site by Provider

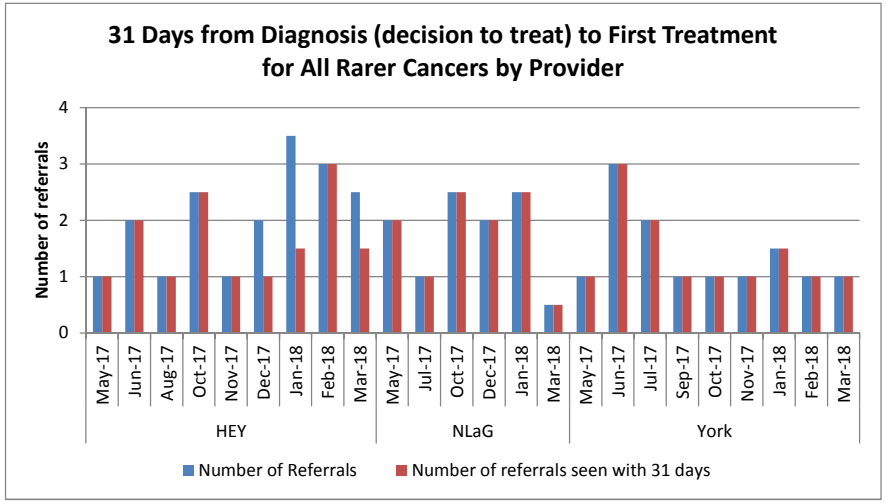


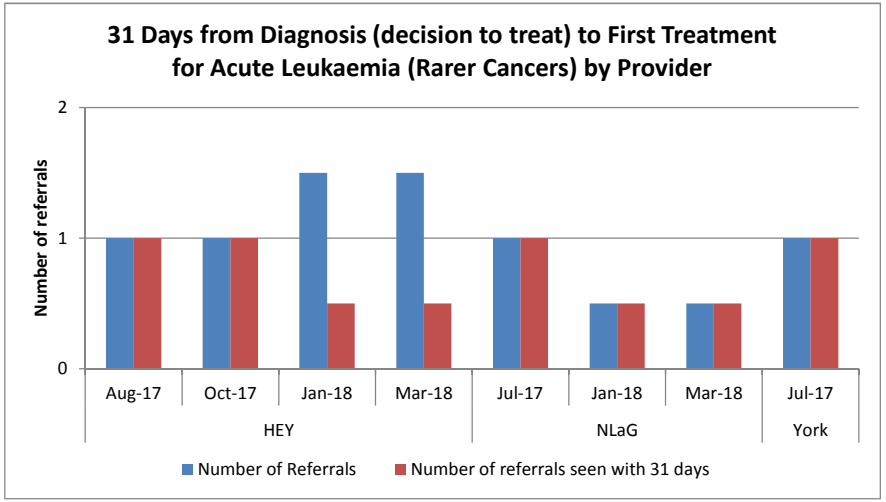


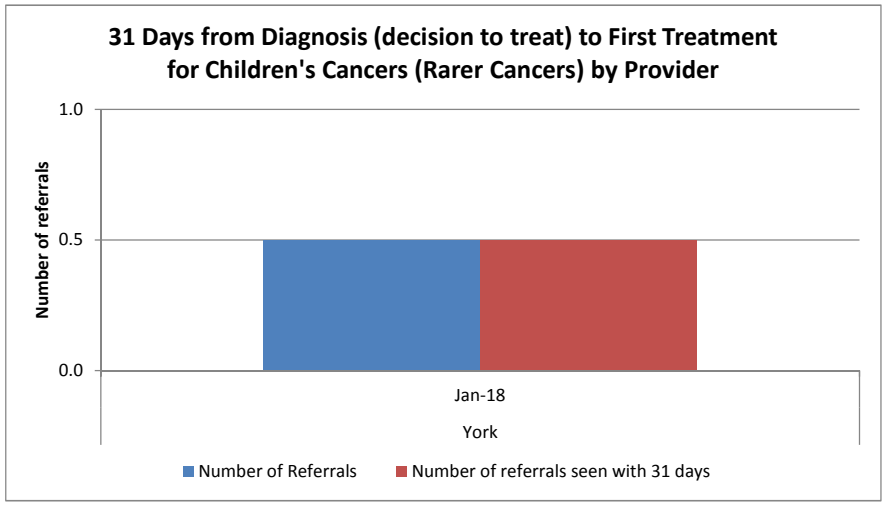


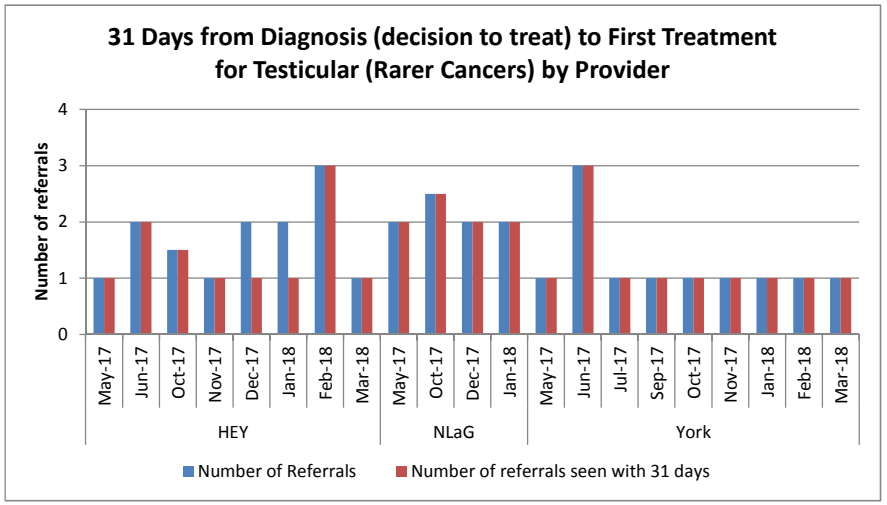


31 Days from Diagnosis (decision to treat) to First Treatment for all Rarer Cancers and tumour Site by Provider

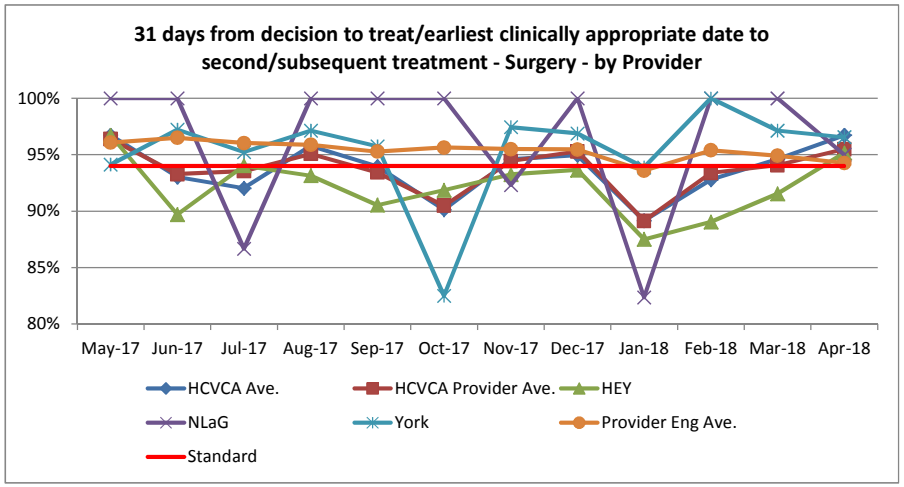


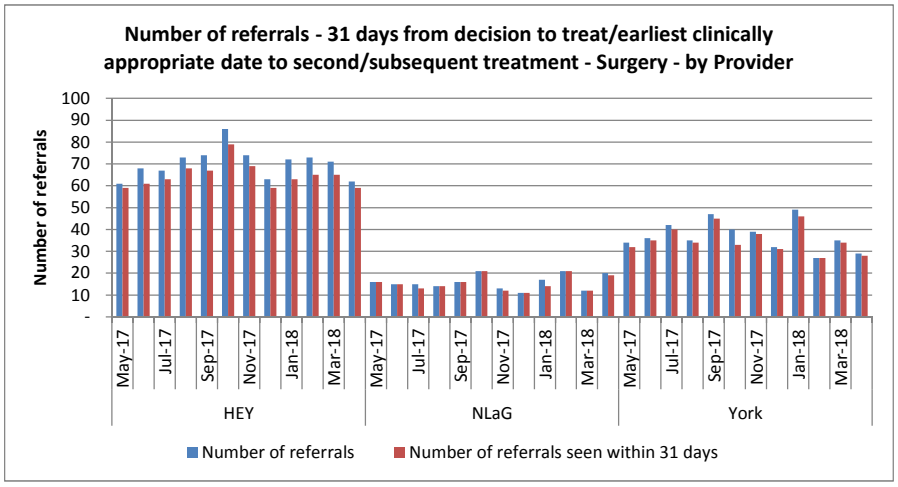




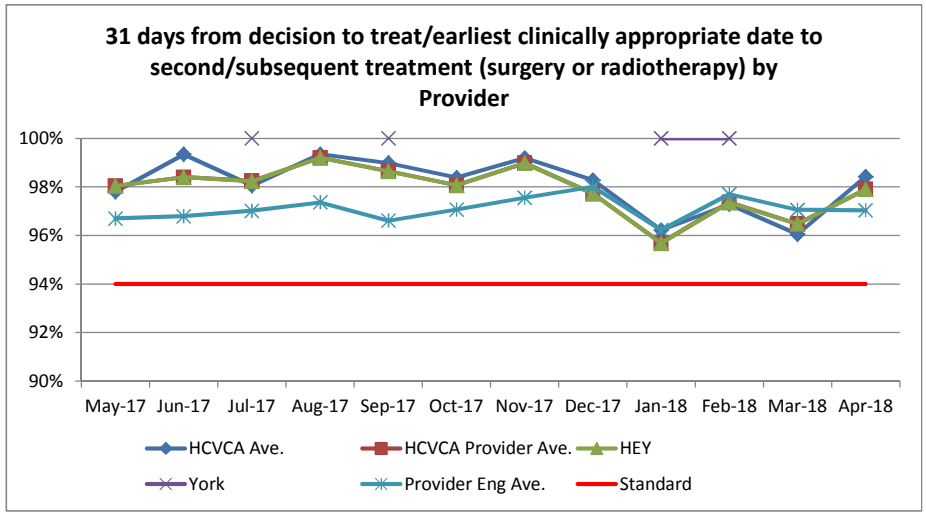


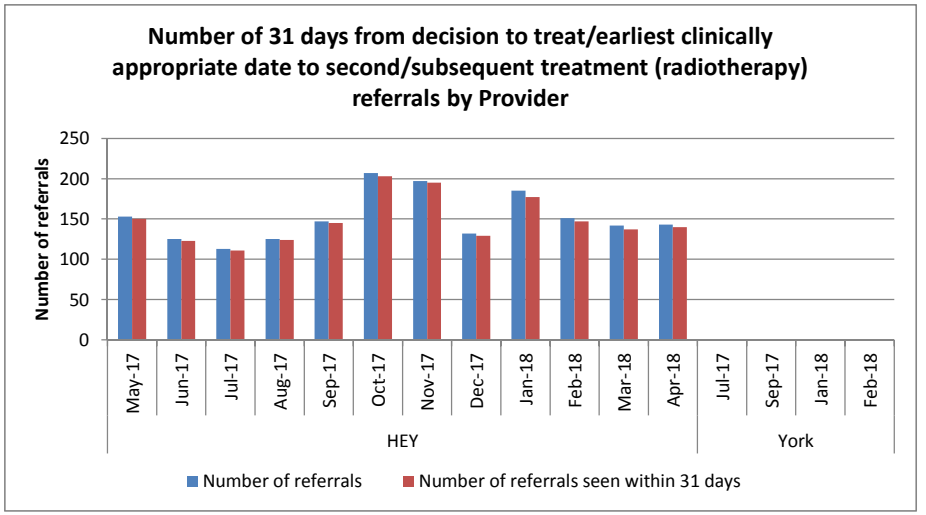
31 Days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery)



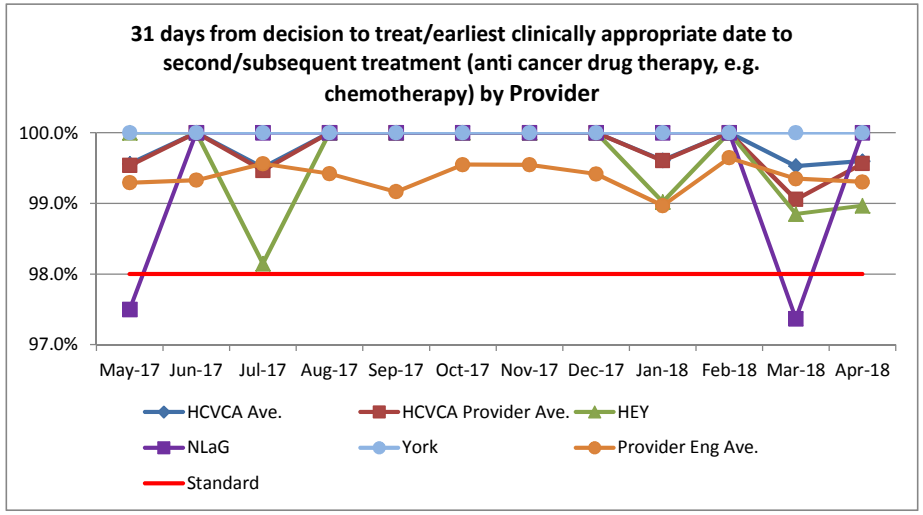


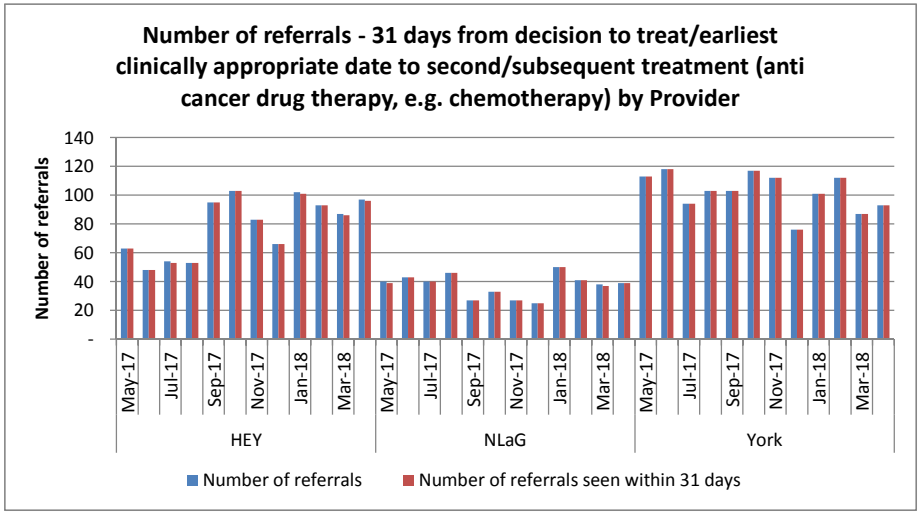
31 Days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (radiotherapy)





31 Days from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti cancer drug therapy, e.g. chemotherapy)





Item Number: 12

Name of Presenter: Abigail Combes

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Committees

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

Reason for Report
The restructure of the Governing Body, stability within the executive team and the move towards system working and out of directions requires the CCG to consider the function and delegation of each of the Committees of the Governing Body. There is also a need to consider whether there remains a need for some smaller committees (e.g. Clinical Executive).

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☒Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

Page 8 of the report onwards highlights the recommendations. Primarily these relate to consideration of a form of words for clear delegation to each of the Committees of the Governing Body.

The Governing Body is also asked to approve the terms of reference as approved by each of the committees prior to coming to Governing Body. The Governing Body is also requested to request a report in September/October 2018 once the governance structure for managing the contract with the Acute Sector is embedded. This will ensure staff understand where to seek approval for decision making without increasing bureaucracy within the CCG.

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

Annexes:

Report on Committee Structure

Terms of Reference for:

- Audit Committee
- Finance and Performance Committee
- Quality and Patient Experience Committee
- Executive Committee
- Remuneration Committee (under review)
- Primary Care Commissioning Committee

NHS Vale of York CCG

Committee Review

Introduction

NHS Vale of York CCG has recently undergone a period of significant structural and organisational change. This has included a redesign of the Governing Body and changes within the CCG Executive Team. This has therefore been an opportune time to review the committee structure the organisation operates within.

Current Arrangements

The CCG must have a constitution reflecting the current arrangements. In the case of NHS Vale of York CCG the membership is of Council of Representatives who delegate the primary functions of the CCG to the CCG Governing Body.

The current terms of reference are in part out of date because of the Governing Body reset and therefore the membership requires amendment in any event. Where there is discrepancy between the listed membership and those actually in attendance in this paper, this is the reason.

Governing Body

The Governing Body reset has, in large part been to ensure that the CCG is compliant with NHS England Guidance and equally to ensure that local clinical leaders are fully engaged with the CCG. The CCG has therefore moved from a Lay Chair to a Clinical Chair (Dr Nigel Wells) and has elected three GP members from each locality onto the Governing Body (Dr Helena Ebbs, Dr Ruth Walker and Dr Andrew Field). Clinical membership of the Governing Body was previously from two Medical Directors for the CCG and two GP members employed by the CCG part of the time.

Further changes to the Governing Body include the appointment of a new Chief Finance Officer to commence July 2018 with an interim arrangement between April 2018 and July 2018. A new Chair of the Audit Committee was appointed in June 2018 and will commence the role on 3 July 2018.

The Governing Body is supported by six committees:-

- Audit Committee
- Finance and Performance Committee
- Quality and Patient Experience Committee
- Executive Committee
- Remuneration Committee
- Primary Care Commissioning Committee

There are also some joint committees which the CCG are members of and these report directly into the Governing Body:-

- Acute Transformation Joint Committee
- Sustainability and Transformation Partnership Joint Committee

Audit Committee

Members	**Attendees**	**Quorum**	**Frequency**
Lay Member (lead for Governance)(Chair)	Chief Finance Officer (or Deputy)	2 Members	5 Meetings per annum minimum
Lay Member	Accountable Officer (or Deputy)		
Secondary Care Clinician	Executive Director for Nursing and Quality (or Deputy)		
	Internal Audit		
	External Audit		

The CCG is required to have an Audit Committee to link with internal and external audit and seek assurance from other areas of the CCG in terms of performance, governance and other matters.

The Audit Committee Chair will be a lay member of the Governing Body and cannot be the same person as the Chair of the Governing Body, although they can be a lay Chair. The Chair of the Audit Committee should also have suitable qualifications in finance to enable them to fully understand the role of financial scrutiny the Audit Committee has.

The Chief Finance Officer cannot be a member of the Audit Committee although they will be expected to attend and participate in the work of the Audit Committee.

The current Chair of the Audit Committee is Sheenagh Powell, lay member although her last meeting was May 2018 and a new audit chair was recruited in June 2018 commencing the role in July 2018.

Finance and Performance Committee

Members	**Attendees**	**Quorum**	**Frequency**
Lay Member x 2 (Chair)	Lay Chair (Lead for Governance)	3 Members to include a lay member, an executive member and the Chief Finance Officer or Deputy	Monthly
Accountable Officer	Director of Finance NHS England		
Chief Finance Officer Executive Director for Nursing and Quality			
Executive Director for Transformation, Complex Care and Mental Health			
Executive Director for Primary Care and Population Health			

The focus of this committee has been the financial recovery of the CCG from a position of significant deficit and legal Directions to a point where the CCG is now planning to exit legal Directions and potentially exit special measures by the end of this financial year.

The Finance and Performance Committee sits monthly and has scrutinised plans and financial arrangements. The committee is Chaired by a lay member and attended by the Executive Team and the Lay Members of the Governing Body.

Feeding into the Finance and Performance Committee is the Financial Recovery Board and QIPP monitoring.

The Finance and Performance Committee is also responsible for seeking assurance on the process for procurement exercises.

Quality and Patient Experience Committee

Members	Attendees	Quorum	Frequency
Lay Member (Chair)	Head of Quality Assurance and Maternity	5 Members to include Chair or Deputy Chair and a Member of the Quality Team and a Medical Director or nominated GP;	Bi-monthly
Secondary Care Doctor (Deputy Chair)	Head of Engagement		
Executive Director of Nursing and Quality	Designated Professionals for Safeguarding (Adults and Children)		
Deputy Director of Nursing and Quality	Patient Experience Officer		
Medical Directors	Head of Legal and Governance		

The focus of this committee is receiving reports relating to service quality and the experience of patients of CCG services. The committee is chaired by a Lay Member and attended by members of Public Health and Healthwatch, members of the Quality and Nursing Team which includes the Safeguarding Team.

The committee has previously had a role overseeing performance where it related to quality however following the decision to place the CCG into legal Directions in 2016, performance oversight was moved whole scale to Finance and Performance Committee. Whilst this has been welcomed in terms of ensuring the financial performance of the committee, the CCG have recently revised the Risk Management strategy and agreed that the focus of the Governing Body is on patient quality and performance of services where they relate to quality and performance.

The Quality and Patient Experience Committee now receives a risk register itself which includes risks specifically related to the work of the Committee and therefore the Committee needs to be empowered to focus more on scrutinising, challenging and seeking assurance on aspects of patient experience, quality and safety.

Executive Committee

Members	Attendees	Quorum	Frequency
Accountable Officer	Chief Officer – Acute System Transformation	3 Members	Fortnightly
Chief Finance Officer	Assistant Director for Delivery and Performance		
Executive Director of Nursing and Quality	Assistant Director for Acute System and Transformation		
Executive Director for Transformation, Complex Care and Mental Health			
Director for Primary Care and Population Health			

The Executive Committee has been used as a primary decision making body for the CCG. The Committee is Chaired by the Accountable Officer and includes the Executive Directors of the team with their Deputies attending on request. The Committee appears to be an amalgamation of a Board of Directors meeting and a Committee of the Governing Body without distinct separation of the functions. Both of these elements are required however it may be more effective and efficient to separate the two elements formally within the meeting.

The meeting has historically met monthly however now there is a meeting fortnightly as the volume of business for the Committee to consider was too significant to manage in a monthly meeting leading to delays in decision making.

The Executive Committee makes decisions on a variety of matters including the financial plan; end of year accounts; staffing and structures; policies and clinical thresholds, procurement decisions and business case approval.

The Executive Committee does not have a risk register at present which may, if managed effectively, reduce the number of papers going to Executive Committee.

Remuneration Committee

Members	Attendees	Quorum	Frequency
Lay Members x 3	HR representative	2 Members	When required
	Accountable Officer at request of Committee		
	Any other person at request of Committee		

The role of Remuneration Committee is to determine and approve the appointment of members of the Governing Body and to approve the salary and pay awards for these individuals. It appears that those employees not on agenda for change terms and conditions also have their cases discussed and determined at Remuneration Committee. The Remuneration Committee also has a role in approving policies relating to pay and conditions for the employees of the CCG.

Primary Care Commissioning Committee

Members	Attendees	Quorum	Frequency
Lay Member x 3	2 GPs from each locality	4 Members	6 Meetings per annum
Accountable Officer	LMC Representative		
Chief Finance Officer	Director of Public Health		
Executive Director of Nursing and Quality	Healthwatch Representative		
Director of Primary Care and Population Health	Health and Wellbeing Representative		
Representative from NHS England	Practice Manager		

The purpose of the Primary Care Commissioning Committee was to establish a committee with responsibility for the functions delegated to NHS Vale of York CCG from NHS England. The Committee is to make collective decisions on the review, planning and procurement of primary care services in the Vale of York area.

General Observations

The CCG has moved to try and demonstrate enhanced clinical leadership within the Governing Body arrangements and also is focussing on patient safety and quality. This is in part reflected in the risk appetite statement approved by the Governing Body in the refresh of the risk policy and also the nature of the discussions being had at Governing Body.

The CCG has requested that NHS England approve a process by which the CCG can move out of legal Directions. This is in part because the CCG has a robust financial plan and is making progress on this. NHS England have approved this plan and this is in large part a success arising from the focus of Finance and Performance Committee and the Executive Team on financial decisions and performance management. There is now an acceptance that whilst that work needs to continue at pace, there should be a focus on patient experience and quality of services moving forward.

To this end, the Quality and Patient Experience Committee should be empowered to scrutinise and understand these issues for all commissioned services including primary care and care homes and providers over and above the acute sector.

The Executive Committee is a valuable but time consuming committee. It appears to be an amalgamation of two functions; one a formal committee of the Governing Body and the second, a senior management meeting determining strategy and tactical planning. Both of these are appropriate functions of those in attendance at the meeting however the branding of Executive Committee has given rise to more bureaucracy and formality than is required for the senior management team function.

The Primary Care Commissioning Committee is a slight anomaly in that there is no specific committee of the Governing Body for commissioning acute care or community services both of which are significant elements of the CCGs work. This in part appears to be as a result of the delegation from NHS England to the CCG of the commissioning of primary care and some nervousness about conflict and primary care involvement in the commissioning of primary care services. The Committee does need strong links with Finance and Performance Committee and Quality and Patient Experience Committee whilst recognising that all committees are equal in terms of delegation from the Governing Body.

All of the Committees of the Governing Body report into the Governing Body. The current position is that much of the discussion of Governing Body is around the work of Finance and Performance Committee. As the CCG moves forward and looks to the long term, it may be beneficial to achieve greater balance in terms of focussing on patient experience and quality. One means of achieving this would be to reduce the frequency of the Finance and Performance Committee to bi-monthly, alternating with Quality and Patient Experience Committee. This would enable the Governing Body to focus on Finance and Performance one meeting and Quality and Patient

Experience the next. Clearly this is a long term ambition rather than an immediate recommendation.

Lastly, historically the CCG have tended to have the same membership broadly speaking for committees and the Governing Body. This could be seen as reducing the scope for challenge and scrutiny; for example decisions made at Finance and Performance Committee were then ratified at Governing Body; albeit with a different Lay Member Chair but with broadly the same people present in the discussion. This has now changed.

Recommendations

Delegation

The Governing Body should provide a form of words which describes the delegation of each of its committees. This should align to some degree to the strategic priorities of the organisation and the risk categories in the risk strategy.

- Audit Committee

NHS Vale of York CCG Governing Body delegates to the Audit Committee approval for signing off the Annual Governance Statement. The remit of the Audit Committee is also to seek assurance on the Governance and reporting arrangements of the CCG. The Audit Committee will receive reports from internal and external auditors and report these to the Governing Body.

- Finance and Performance Committee

NHS Vale of York CCG Governing Body delegates to the Finance and Performance Committee responsibility for scrutinising and agreeing the final draft of the CCG Financial Plan as well as Recovery Plans and QIPP plans. The Finance and Performance Committee will also receive and scrutinise reports relating to performance and compliance against constitutional targets and the Integrated Assurance Framework (IAF) indicators where these relate to financial and compliance matters. The Finance and Performance Committee will also receive and scrutinise plans for procurement of any project within the CCG.

The Finance and Performance Committee will be responsible for managing and mitigating risks reported to it and has delegated authority to take any action necessary to do this. Those risks which amount to a potential financial liability of between £500,000 and £1million pounds will be reported by the Committee to the next Governing Body meeting for approval.

The Committee will oversee Emergency Planning, with delegated permission to approve the Emergency Plan on behalf of the CCG.

The Finance and Performance Committee will receive and scrutinise, on behalf of the Governing Body, reports relating to performance and finance for all areas of

CCG business but specifically mental health, joint and integrated commissioning and acute transformation. The Finance and Performance Committee will be responsible for providing assurance to the Governing Body on these matters.

- Quality and Patient Experience Committee

NHS Vale of York CCG Governing Body delegates to the Quality and Patient Experience Committee responsibility for scrutinising all patient quality and safety elements of the CCG work. This includes receiving and requesting assurance from all providers of services to the CCG and managing and mitigating any risks associated with patient safety reported to the Committee. The Committee has delegated authority to take any action necessary to manage and mitigate the risks reported to it including formally writing to providers and partners on behalf of the CCG; instructing officers to undertake actions on behalf of the Committee and requesting reports and updates from providers as needed.

The Committee will have delegated responsibility for seeking assurance and information about quality of provision and specific quality and safety incidents in the acute sector including those concerns arising from the transformation project; primary care; mental health; integrated commissioning and community services, independent providers and the voluntary sector.

The Committee will be responsible for providing assurance to the Governing Body on matters within its remit.

- Executive Committee

NHS Vale of York CCG Governing Body delegates to the Executive Committee permission to approve the final draft of all CCG policies.

The Executive Committee will also have responsibility for approving Human Resources (HR) matters including recruitment to posts and structural or establishment changes. Where necessary Executive Committee will have approval to commit up to £500,000 to make these decisions provided the Chief Finance Officer or Deputy Chief Finance Officer are in attendance.

The Executive Committee will also have delegated responsibility for approving business cases on behalf of the CCG up to a value of £500,000 provided the Chief Finance Officer or Deputy is present.

The Executive Committee has delegated responsibility for approval of renewal of fixed term contracts, terms and conditions, remuneration and travelling or other allowances for member of staff of grade 9 (Agenda for Change) and below and members of staff who are not under Agenda for Change; who are not members of the Governing Body, including pensions and gratuities.

The Executive Committee has delegated responsibility for the approval of clinical thresholds and Medicines Management Committee recommendations provided that at least two clinicians (doctor or nurse) are in attendance at the Committee and are not conflicted out of the decision.

The Committee will also have delegated responsibility for approval of recommendations from the Clinical Research and Effectiveness Committee (CREC). Where approval is required urgently, two members of the Executive team can approve such recommendations provided one of these members is a clinician (nurse or doctor) and the decision is ratified at the next meeting of the Committee.

- Remuneration Committee

NHS Vale of York CCG Governing Body delegates to the Remuneration Committee approval of terms and conditions, remuneration and travelling or other allowances for Governing Body Members, including pensions and gratuities and those employees not on Agenda for Change terms and conditions. This will also include the detail of any severance, redundancy or exit package for these members.

The Remuneration Committee has delegated authority from the Governing Body to promote education and training of health service staff and oversee said training on behalf of the Governing Body. The Committee will receive a report on education and training annually.

- Primary Care Commissioning Committee

NHS Vale of York CCG has delegated authority from NHS England for Primary Care Commissioning. This is exercised through the Primary Care Commissioning Committee. As a result the Committee will have delegated responsibility for General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract); Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”); Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF); Decision making on whether to establish new GP practices in an area; Approving practice mergers; and making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes).

(Any procurement processes relating to Primary Care Commissioning will be discussed through Finance and Performance Committee rather than through Primary Care Commissioning Committee.)

Business of Each Committee

There is often overlap of committees in that papers navigate their way through several committees before final approval. There are a number of reasons for this

however, there is potential for different decisions to be made or for staff to be unclear where approval comes from and therefore not seek appropriate approval; or take a positive indication from one committee as approval which it cannot in fact give.

Each committee therefore needs to be clear in terms of remit and what is reported into it so that staff are able to understand this. Each committee also needs to understand the role that they have in terms of interconnectivity; for example, a paper will often go to Finance and Performance Committee who will then ask Executive Committee to consider before going to Governing Body. Whilst this is appropriate when certain expertise is needed or a specific issue is referred, it is not appropriate for the full paper to be rehearsed at each committee of the Governing Body. No one committee is more senior than another and all report directly to the Governing Body.

Each of the committees appear to have a number of other meetings feeding into them. Whilst some of these are not fully developed and will take some time to establish; the CCG Governing Body need to ensure that they understand the links into the Governing Body from these meetings. For example the Sustainability and Transformation Partnership Joint Committee has no delegated authority from the CCG Governing Body however appears to have historically made decisions on behalf of the CCG. The same applies to Health and Wellbeing Board. There are also, going forward, a number of groups and meetings which will feed into the work surrounding aligned incentives. These meetings will involve a number of senior managers from a number of organisations and therefore it is important that the groups and meetings feel empowered to make appropriate decisions but that there is proper governance around these decisions. I would suggest that the structures set up to support the system transformation are reviewed in September 2018 having had three months to be established and see which appropriately feed into the Joint Acute Commissioning Committee; which report to Finance and Performance Committee and which, if any, report directly to Governing Body.

Membership

Terms of Reference have already been circulated to Committees and are presented to Governing Body; these include any amendments to membership. The most significant relate to the removal of the Executive Director for Quality and Nursing from the Primary Care Commissioning Committee, as quality issues in primary care are now reported into Quality and Patient Experience Committee, and the addition of the Clinical Chair and Executive Director for Primary Care and Population Health to the membership of Quality and Patient Experience Committee to ensure primary care engagement.

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 & 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 23 May 2018
Approved by (including date)	Governing Body
Version Number	3.3
Review Date :	May 2018
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

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group (CCG) resolves to establish a Committee of the Governing Body to be known as the Finance and Performance Committee (FPC) (the Committee). The Committee has delegated decision making authority as set out in these Terms of Reference. The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires, from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference. The Committee may not delegate executive powers delegated with these Terms of Reference (unless expressly authorised by the CCG) and remains accountable for the work of any such group.

2 Purpose of the Committee

The paramount role of the Finance and Performance Committee is to oversee the financial recovery and performance of the CCG. ~~operating under legal Directions, effective 01 September 2016.~~

The Committee shall undertake the scrutiny of all financial recovery plans on behalf of the Governing Body of NHS Vale of York CCG and provide assurance to the Governing Body that appropriate actions are being taken in relation to financial and performance recovery. The Committee shall advise and support the Governing Body in scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's Strategic and Operational Plans.

The Committee shall pro-actively challenge and review delivery against the performance expectations for the CCG against the Constitution, NHS mandate and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate.

Specifically the Committee will consider a more in-depth analysis of :

- the financial position through challenge of variances from plan and ensuring action plans are put in place to rectify adverse trends to monitor performance of these action plans;
- performance delivery against the Improvement and Assessment Framework position through challenge of variances from plan, ensuring action plans are put in place to rectify adverse trends and monitor performance of these action plans.

In particular, the Committee will receive, assess and challenge performance management information associated with:

- Main provider contracts
- Voluntary sector contracts
- Community Services
- Jointly commissioning services between the CCG and Local Authority
- The CCG's Quality, Innovation, Productivity and Prevention Plan (QIPP)
- The CCG's strategic work-streams
- Other areas of significant risk to the achievement of performance standards and financial balance
- Delivery of the RightCare programme
- Review in accordance with the timetable, all financial information, including that submitted to the CCG Governing Body.

The Committee will scrutinise the financial position of the CCG and monitor the delivery of the Commissioning Plan.

The Committee will receive and scrutinise performance delivery information against key performance trajectories ensuring delivery and where necessary corrective actions are followed up.

As part of its deliberations and recommendations, the Committee will take into account the CCG's statutory service responsibilities and service levels.

The Committee shall initiate reviews in its own right and undertake, as directed, reviews on behalf of the Governing Body. Work shall be progressed by co-option of other key individuals.

The Committee shall determine what reports they would wish to see on a regular basis.

3 Remit

The Committee has remit over all areas of finance and performance, including, but not limited to, development and implementation of strategy, planning, reporting, delivery, recovery, management, governance and control.

- Review the Medium Term Financial Strategy, ensuring it is consistent with commissioning plans and is sustainable.
- Review the Financial Plan, including ensuring all planning assumptions are within the guidelines set by NHS England and that there is clear accountability throughout the plan.
- Ensure all financial plans are aligned with planned and contracted activity to deliver constitutional and statutory targets.
- Ensure key financial risks are identified and have clear mitigation plans.

- Review and scrutinise the organisation's in-year financial position.
- Review and scrutinise all financial forecasts, including forecasting methodology.
- Oversee the development of a medium term financial plan, in line with NHS England requirements, in order to support the delivery of an optimum underlying financial position for the CCG.
- Ensure the CCG operates within its Detailed Financial Policies (Standing Financial Instructions).
- Review, scrutinise and monitor CCG performance and associated recovery plans.
- Review performance information to ensure delivery of key constitutional and statutory targets.
- Receive regular contract performance reports from key partners.
- Review and scrutinise delivery of the organisation's QIPP programme, ensuring plans are appropriately phased and reflected in budgets. This will include review of associated business cases and procurement plans.
- Challenge delivery of rectification plans produced to achieve targets or reduce deficit.
- Review implementation of transformation schemes and receive updates outlining financial, activity and delivery against key performance indicators for each scheme.
- Make Quality and Patient Experience Committee aware of any safety concerns arising from this Committee.
- Oversee emergency planning – EPRR.

4 Risk Management

The Committee will review the risk register and update the Governing Body on key risks relating to Performance and Finance.

5 Frequency

The Finance and Performance Committee will meet monthly. ~~on the fourth Thursday of the month.~~

6 Membership

Two Lay Members, one of whom shall be the Chair
Accountable Officer
Chief Finance Officer
Executive Director of Nursing and Quality
~~Executive Director of Planning and Governance~~
~~Deputy Chief Finance Officer~~
~~Deputy~~ Executive Director of Transformation, Complex Care and Mental Health
~~Assistant Director of Delivery & Performance~~
~~Representation from Clinical Executive~~

~~Medical Director~~
Director of Primary Care and Population Health

In attendance :
Lay Chair of Audit Committee
~~Lay Chair of the Governing Body~~
~~*Interim Executive Director of System Resources and Performance*~~
~~*Interim Executive Director of Joint Commissioning*~~
Director of Finance, NHS England North (or deputy)
~~Head of Contracting~~
~~Head of Finance~~
Anyone else at the invitation of a member of the Finance and Performance Committee ~~the Accountable Officer~~

7 Quoracy

A minimum of three members are required for the meeting to be quorate to include a lay member, an executive director (or nominated deputy) and the Chief Finance Officer (or nominated deputy) ~~or Deputy Chief Finance Officer~~.

8 Accountability

The Finance and Performance Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Finance and Performance Committee minutes.

9 Decision Making

The Committee acts as an assurance and scrutiny group and provides the opportunity for discussions about financial and performance issues to enable policies to be shaped for approval by the CCG Governing Body. The Committee has specific delegated authority to :

- Develop the annual financial plan for approval by the Governing Body;
- Approval of disposals, condemnations, bad debts, losses and special payments to the value of £50,000 is enacted by the executive approval of the Chief Finance Officer (then taken to Audit Committee to note and review)
- Review the delivery of delivery partners' services and make recommendations to the Governing Body in respect of service delivery, quality, value for money and cost.
- When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.
- 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.

10 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

~~**10 Administrative Support**~~

- ~~Administration support to the Committee will be provided by the CCG's Executive Assistant who will work with the Chair to agree the agenda and all papers.~~
- ~~The papers for the Committee will be circulated five working days before the meeting.~~

11 Committee Effectiveness

The Committee shall review its effectiveness annually.

12 Review of Terms of Reference

The Committee shall review its terms of reference at least annually. ~~The Committee shall ensure that the specific focus on financial recovery whilst under legal Directions remains until such time that the CCG is formally notified of the removal of Directions.~~

Update by :	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Finance & Performance Committee
Approval Date	29 September 2016
Issue Date	
Review Date	October 2018
Version Number	0.7

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Finance and Performance Committee 23 February 2017
Approval Date	Governing Body – 02 March 2017
Issue Date	02 March 2017

Review Date	September 2017 - six month review
Version Number	0.6

NHS
Vale of York
Clinical Commissioning Group

QUALITY AND PATIENT EXPERIENCE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group resolves to establish a Committee of the Governing Body to be known as the Quality and Patient Experience Committee (the Committee). The Committee has delegated decision making authority as set out in these Terms of Reference. The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires, from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference. The Committee may not delegate executive powers delegated with these Terms of Reference (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

2 Purpose of the Committee

The overall objective of the Committee will be to ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement in line with the NHS Constitution (2011) underpinned by the CCG Quality Assurance Strategy. In line with the NHS Constitution, this also includes:

- Actively seeking patient feedback on health services and engaging with all sections of the population with the intention of improving services.
- As a membership organisation, working with NHS England, support primary medical and pharmacy services to deliver high quality primary care, including patient experience.

3 Remit

3.1 The Committee will monitor, report, provide information and share the learning, including mitigation and actions, on the following:

- Quality Assurance Strategy and progress against the Strategy and action plan.
- Patient ‘insight’ – primarily complaints, concerns, PALs and compliments on commissioned services and the CCG itself.
- Patient safety – which includes Health Care Associated Infections (HCAI) and Serious Incidents (SI) / Never Events.
- Manage risks where these are relevant to patient safety and service quality.

- Safeguarding Children and Adults.
- Quality concerns from commissioned services / affecting commissioned services including from sub-contract management boards with providers.
- Regulatory / national reports regarding quality (e.g., CQC, National Enquiries, NHS England reports and strategies).
- Information from and for NHS England Quality Surveillance Groups.
- Agree clear escalation processes, including appropriate trigger points, to enable appropriate engagement of external bodies on areas of concern.
- Agree escalation to the Governing Body.
- Have a forward work plan.
- Agree areas for discussion with the Primary Care Commissioning Committee.

The Committee will receive and scrutinise :

- Independent investigation reports relating to patient safety issues and agree publication plans.

3.2 The Committee shall review the establishment and maintenance of an effective system of quality assurance. This will mainly be through the Quality Assurance Strategy. Its work will dovetail with that of the Audit Committee.

3.3 The Committee shall pro-actively challenge and review the CCG's performance against the standards in the CCG Improvement and Assessment Framework (mainly the Better Care element), NHS Outcomes Framework (mainly domains 4 and 5 – 'ensuring people have a positive experience of care' and 'treating and caring for people in a safe environment and protecting them from avoidable harm') and against the strategic priorities of the CCG, agreeing any action plans or recommendations as appropriate.

3.4 In particular, the Committee will enquire, receive, assess and challenge quality and patient experience information associated with:

- Main provider contracts (including primary care).
- Voluntary sector contracts.
- Community Services.
- Jointly commissioned services between the CCG and Local Authority.
- Services which the CCG may not commission but which may impact on local people and services i.e. care homes.
- Benchmarking information regarding quality.
- Patient experience information relating to concerns, complaints, PALs and compliments from commissioned services and into the CCG.
- Lessons learned and actions taken to improve patient experience.
- Evidence from key clinicians and managers from commissioned services.

- HCAI and SI information (including Never Events) relating to the CCG commissioned services.
- The CCG's commissioning for Quality and Innovation schemes (CQUIN).
- Reports and feedback on any clinical quality visits.
- The CCG's strategic work-streams relating to quality.
- The Quality Premium (QP).
- Adult Safeguarding.
- Children's Safeguarding.
- Quality Impact Assessments (QIA) relating to commissioning plans and statements.

3.5 The Committee will ensure that quality is embedded in the CCG processes for development of Commissioning Statements (Value Based Commissioning).

3.6 The Committee will ensure the CCG is listening to patients to learn from their experiences and use the feedback to identify and inform areas for service improvement.

3.7 As part of its deliberations and recommendations, the Committee will take into account the CCG's statutory service responsibilities and service levels.

3.8 The Committee shall initiate reviews in its own right and undertake, as directed, reviews on behalf of the Governing Body. Work shall be progressed by co-option of other key individuals.

3.9 The Committee shall determine what reports they would wish to see on a regular basis.

3.10 The Committee will maintain appropriate liaison with regulatory bodies especially the Care Quality Commission, NHS Improvement and any relevant professional regulatory bodies in order to ensure appropriate information flows on matters within the committee's remit.

3.11 The Committee has delegated authority from the Governing Body to oversee the 'Choice' agenda and any quality implications for patients.

4 Risk Management

The Committee will review and manage the risk register on key risks relating to Quality, escalating to the Governing Body where appropriate.

5 Frequency

The Quality and Patient Experience Committee will be held bi-monthly.

6 Membership

- Lay Member of the Governing Body (Chair)
- Clinical Chair of the Governing Body

- Secondary Care Doctor (Deputy Chair)
- Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience)
- Executive Director of Primary Care and Population Health
- Deputy Chief Nurse

In attendance :

- Head of Legal Services and Governance
- Head of Quality Assurance and Maternity
- Head of Engagement
- Designated Professionals for Safeguarding – both adult and children
- Co-opted member of Scarborough Ryedale CCG as required
- Healthwatch representative
- Health and Wellbeing Board representative
- Patient Experience Lead

The Chair of the Audit Committee may also be asked to attend as appropriate, where the roles of both committees are seeking assurance that robust clinical quality is in place.

Anyone else at the invitation of the membership.

7 Quoracy

A minimum of three members will constitute a quorum, so long as this includes the Chair or Deputy Chair and a clinician (Doctor or Nurse)

8 Decision Making

8.1 The Committee shall make decisions on any remedial action required as a result of quality issues.

8.2 The Committee shall make recommendations to the Accountable Officer regarding the review of commissioned services and business cases for changes to commissioning in line with the CCG detailed scheme of delegation.

8.3 The Committee has delegated authority from the Governing Body with regard to all quality issues in line with the scheme of delegation (Accountable Officer level).

8.5 When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.

8.6 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.

9 Accountability

9.1 The Quality and Patient Experience Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Quality and Patient Experience Committee minutes. The Committee has delegated functions to manage and monitor issues in relation to quality in primary care.

9.2 The Committee will, by exception, escalate matters it considers should be brought to the attention at the full Governing Body.

10 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

11 Committee Effectiveness

The Committee shall undertake an annual review of its effectiveness.

12 Review of Terms of Reference

The Committee shall review its terms of reference at least annually.

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Quality and Patient Experience Committee 14 June 2018
Approval Date	Governing Body - TBC
Issue Date	7 June 2018
Review Date	December 2018 - six month review
Version Number	0.7-1

Update	Rachael Simmons Corporate Services Manager
Reviewing Committee	Quality & Patient Experience Committee

(including date)	12 October 2017
Approving Committee	Governing Body 02 November 2017
Issue Date	01 December 2017
Review Date	November 2018
Version Number	0.6

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Quality and Patient Experience Committee 08 February 2017
Approval Date	Governing Body - 02 March 2017
Issue Date	02 March 2017
Review Date	September 2017 - six month review
Version Number	0.5

NHS
Vale of York
Clinical Commissioning Group

EXECUTIVE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group Governing Body resolves to establish an Executive Committee which has delegated decision making authority as set out in these Terms of Reference. The Executive Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires from any employee and all employees are directed to co-operate with any request made by the Executive Committee. The Executive Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference.

2 Purpose of the Committee

The Executive Committee is responsible for making executive decisions which deliver the organisational objectives.

The purpose of the NHS Vale of York CCG Executive Committee is to provide the Clinical Commissioning Group Council of Representatives and Governing Body with assurance in relation to any assigned or delegated actions.

Guiding Principles

3 Remit

- ~~To ensure the CCG fulfils the functions, duties and responsibilities set out in the CCG's constitution.~~
- To review ~~ensure~~ processes are in place to deliver the Improvement and Assessment Framework expectations, including in-year targets, clinical, operational and financial.
- To ~~develop~~ implement, ~~and~~ monitor and review the CCG's Strategic and Operational Plan under the direction of the Governing Body.
- ~~Prioritise programmes of work,~~ Make recommendations about investment and de-commissioning proposals across the CCG and ensure appropriate resource allocation to the Governing Body.
- ~~To oversee the development of~~ To approve commissioning plans, strategies and intentions to develop the CCG as an effective healthcare commissioner and local leader building strong relationships with stakeholders and patient and public groups.
- Approval of HR, IG and corporate policies ~~and corporate policies~~.

- ~~Strategic management and clinical oversight of all CCG functions and statutory duties, including equalities.~~
- Equalities, diversity and human rights development and implementation of the action plan.
- Review service changes ensuring service developments and CCG processes and policies are compliant with national regulations and law, including equalities legislation.
- ~~To oversee emergency planning (EPRR).~~
- To ensure projects and plans are supported by adequate governance, i.e., QIAs, PIAs, EIAs, SIAs and CoI.
- To be responsible for and review the organisation's corporate risks.
- OD and staff engagement.
- To ensure day to day running of the CCG.

4 Frequency

The Executive Committee will meet at least once a month.

5 Membership

Accountable Officer (Chair)
Executive Director of Quality and Nursing
Chief Finance Officer
~~Medical Director x 2~~
Executive Director of Transformation and Delivery
Director of Primary Care and Population Health

In Attendance
Chief Officer – Acute System Transformation
Assistant Director of Delivery and Performance
Anyone else at the invitation of the membership. ~~Accountable Officer~~

6 Quoracy

A minimum of three members ~~one of whom is the Accountable Officer or an Executive Director,~~ will constitute a quorum.

7 Accountability

The Executive Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Executive Committee minutes.

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.

~~The Executive Committee gives delegated authority to the Clinical Executive to approve Medicines Commissioning Committee recommendations unless either or both of the Medical Directors believe the recommendation should be escalated to the Executive Committee.~~

8 Decision Making

The decision making authority of the Executive Committee is defined in the scheme of delegation within the constitution.

When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.

9 Effectiveness

The Executive Committee shall undertake an annual review of its effectiveness.

10 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

11 Review of Terms of Reference

The Executive Committee shall review its terms of reference at least annually and sooner if changing circumstances dictate.

Author	Rachael Simmons Corporate Services Manager
Committee Approved and Date)	Executive Committee 19 July 2017 / 16 August 2017
Ratification and Date	Governing Body 07 September 2017
Issue Date	11 September 2017
Review Date	September 2018
Version Number	5

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Executive Committee
Approval Date	Governing Body – 02 March 2017
Issue Date	
Review Date	
Version Number	0.4

NHS
Vale of York
Clinical Commissioning Group

REMUNERATION COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group Governing Body resolves to establish a Remuneration Committee which has delegated decision making authority as set out in these Terms of Reference. The Remuneration Committee is authorised by the Governing Body to approve any activity within its Terms of Reference. The Remuneration Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference.

2 Purpose of the Committee

The Remuneration Committee is responsible for determining the terms and conditions, remuneration and travelling or other allowances for staff.

3 Remit

The Committee shall approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.

The Committee shall make recommendations to the Governing Body on:

- The terms and conditions of employment for all employees of the Clinical Commissioning Group (the Group).
- Pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.
- Retention Premia.
- Annual salary awards [where applicable].
- Allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.
- The severance payments of NHS Vale of York Clinical Commissioning Group employees and contractors, seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money'.
- Policies and instructions relating to remuneration.

The Remuneration Committee has delegated authority from the Governing Body to promote education and training of health service staff and oversee said training on behalf of the Governing Body. The Committee will receive a report on education and training annually.

4 Frequency

Meetings shall be held as and when required upon receipt of a request to the Chair or Vice Chair. The Committee will meet a minimum of twice per financial year. Seven calendar days' notice will be provided of the meeting and any documents to be considered / discussed at the meeting will be circulated to the Committee at least two calendar days prior to the meeting.

5 Membership

The Committee shall be appointed by the NHS Vale of York Clinical Commissioning Group from amongst its Governing Body members. The membership of the Committee shall comprise the following:

- Lay Chair of Governing Body (Chair of the Remuneration Committee)
- Lay Member and Chair of Audit Committee (Deputy Chair of the Remuneration Committee)
- Lay Member and Chair of Finance and Performance Committee

Other directors and external advisers such as Human Resources representatives may be invited to attend for all or part of any meeting as and when appropriate. The role of other individuals who attend and external advisors will be to draw the Committee's attention to best practice, national guidance and other relevant documents as appropriate.

Full time employees or individuals who claim a significant proportion of their income from the NHS Vale of York Clinical Commissioning Group are not permitted to be voting members of the Committee.

No individual should be in attendance for discussion about their own remuneration and terms of service.

~~A Chair and Vice Chair must be appointed.~~

Voting : Each member of the committee will have a vote. The Chair shall have the casting the deciding vote.

6 Quoracy

The quorum shall be the Chair plus one other member.

Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the Chair of the meeting shall consult with the Chair of the Audit Committee on the action to be taken. This may include:

- requiring another of the Group's committees or sub-committees, the Group's Governing Body or the Governing Body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

- inviting on a temporary basis one or more Governing Body members to make up the quorum so that the group can progress the item of business.

7 Accountability

The minutes of the Committee meetings will be submitted by the Committee Chair within seven calendar days of the meeting.

The Remuneration Committee is accountable to the Governing Body by way of a report in the Clinical Commissioning Group's Annual Report.

8 Decision Making

All Members of the Remuneration Committee will have voting rights.

9 Administrative Support

A Secretary will be identified by the NHS Vale of York Clinical Commissioning Group. The Secretary will be responsible for supporting the Chair in the management of remuneration business. This will include arranging, formally minuting and archiving of all reports and documentation associated with the business of the Committee.

10 Committee Effectiveness

The Committee shall review its effectiveness annually.

11 Review of Terms of Reference

The Committee shall review its terms of reference at least annually.

Update	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	
Approval Date	
Issue Date	
Review Date	September 2018
Version Number	2

Author	Emma Collins HR Business Partner eMBED
Committee Approved (including date)	Remuneration Committee 26 January 2017
Approval Date	Governing Body – 02 March 2017
Issue Date	02 March 2017

Review Date	March 2018
Version Number	1

NHS
Vale of York
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

Terms of Reference

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 01 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the "NHS Act"), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Vale of York CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Vale of York CCG Primary Care Commissioning Committee (the "Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations :

   - NHS Vale of York CCG
   - NHS England
   - Healthwatch
   - Health and Wellbeing Board(s)
   - Director of Public Health

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the Governing Body of NHS Vale of York CCG in accordance with Schedule 1A of the NHS Act.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the Vale of York area, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Vale of York CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of ~~a desire to promote increased co-~~commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities :
    a) To plan, including needs assessment, primary care services in the Vale of York CCG area;
    b) To undertake reviews of primary care services in Vale of York CCG area;
    c) To co-ordinate a common approach to the commissioning of primary care services generally;
    d) To manage the budget for commissioning of primary care services in Vale of York CCG area.

Geographical Coverage

17. The Committee will comprise the NHS Vale of York CCG area.

Membership

18. The Committee shall consist of :
    Lay Chair of Quality and Patient Experience Committee (Chair)
    ~~Lay Chair of Governing Body (Chair)~~
    Lay Chair of Audit Committee
    Lay Chair of Finance and Performance Committee
    Accountable Officer
    ~~Executive Director of Quality & Nursing~~
    Chief Finance Officer
    ~~Chief Nurse~~
    Director of Director of Primary Care and Population Health
    Representative of NHS England
    (voting members)

19. The Chair of the Committee shall be the Lay Chair of the Quality and Patient Experience Committee ~~Governing Body~~.

20. The Vice Chair of the Committee shall be a Lay Member but not the Lay Chair of the Audit Committee.

21. The following standing attendees (non-voting) will be invited:

- Up to two GPs from each locality
- ~~Chair of Clinical Executive~~
- LMC representative
- Director of Public Health
- Healthwatch Representative
- Health and Wellbeing Board Representative
- Practice Manager

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Executive Support to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

24. The committee shall be quorate with the following attendance:

    - At least four members~~, one of which shall be a Lay Member and one a Chief Officer.~~

Frequency of meetings

25. The committee will meet six times a year with dates circulated to committee members in advance. Additional meetings may be convened at short notice if the Chair deems it necessary in accordance with paragraph 22 above.

26. Meetings of the Committee shall:

    a) be held in public, subject to the application of 26(b);

    b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

27. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide

objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

28. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. A Primary Care Commissioning Delivery Group ~~will~~ may be established to ensure the delivery of arrangements agreed by the Committee.

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

30. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

31. The Committee will present its minutes to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 28 above.

32. The CCG will also comply with any reporting requirements set out in its constitution.

33. The Committee shall review its terms of reference at least annually. The Committee shall undertake a review of its effectiveness at least annually.

Links to other Committees and Groups

34. Due to the nature of integrated governance, the work of the Committee dovetails with some functions of the Audit Committee. Both Chairs will work collaboratively to ensure that where objectives align, their work will complement rather than duplicate effort, bringing their own perspectives to agenda items.

Accountability of the Committee

35. The Primary Care Commissioning Committee is a delegated committee of the Clinical Commissioning Group Governing Body, and its powers are set out in the CCG's Constitution, including revised Standing Financial Instructions and Standing Orders.

36. For the avoidance of doubt, in the event of any conflict between the provisions of these Terms of Reference and the CCG's Standing Orders or Standing Financial Instructions, the latter will prevail.

Procurement of Agreed Services

37. The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's

constitution and the delegation agreement with NHS England. The Committee will adhere to these arrangements.

Decisions

38. The Committee will make decisions within the bounds of its remit.

39. The decisions of the Committee shall be binding on NHS England and NHS Vale of York CCG.

40. The Committee will produce an executive summary report which will be presented to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information.

Conflicts of Interest

41 ~~Conflicts of interest shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy.~~ 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.

Secretary

42 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

[Signature provisions]

Schedule 1 : Delegation
[Delegation from NHS England attached separately]

Schedule 2 : Delegated Commissioning Functions

Delegated commissioning functions are as follows:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation).

Item Number: 13

Name of Presenter: Michelle Carrington

Meeting of the Governing Body **Date of meeting: 5 July 2018**	NHS Vale of York Clinical Commissioning Group

Report Title: Quality Assurance Strategy 2018-2021

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

Reason for Report

The Strategy outlines the actions required to identify and measure the quality of services the CCG commissions in line with the values of the CCG and the NHS Constitution. It also sets out the governance arrangements within the CCG that ensure the Governing Body is informed on the quality of commissioned services, the assurance methods used, and the processes for escalation and additional support for quality and safety concerns. The Strategy has been approved by the Quality and Patient Experience Committee and has been shared with partners and stakeholders. It is important to note that there is an associated agile work-plan to deliver any actions and improvements related to the application of the Strategy, held in the Quality and Nursing Team.

Strategic Priority Links

☒Primary Care/ Integrated Care
☒Urgent Care
☒Effective Organisation
☒Mental Health/Vulnerable People
☒Planned Care/ Cancer
☒Prescribing
☒Financial Sustainability

Local Authority Area

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

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☐Financial ☐Legal ☐Primary Care ☐Equalities	
Recommendations To receive the Strategy.	

Responsible Chief Officer and Title	**Report Author and Title**
Michelle Carrington, Executive Director of Quality and Nursing / Chief Nurse	Michelle Carrington, Executive Director of Quality and Nursing / Chief Nurse and Debbie Winder, Head of Quality Assurance and Maternity

NHS
Vale of York
Clinical Commissioning Group




2018-21 Quality Strategy

Our overarching aim

We are committed to ensuring that the Vale of York community can experience services that are safe, of a high quality and deliver patient centred outcomes within the resources that are available.

Version	1
Author	Michelle Carrington, Executive Director of Quality and Nursing Debbie Winder, Head of Quality Assurance and Maternity
Approved by	NHS Vale of York Clinical Commissioning Group Governing Body
Date of approval	QPEC May 2018 Governing Body July 2018 -TBC
Review date	

Foreword

The CCG, as a statutory organisation, is required to commission the best possible services and positive outcomes for patients, within the financial resources available to it.

Ensuring people are safe and cared for when they require services is of paramount importance and the delivery of high quality care rests with each provider organisation. Under its statutory duty to secure continuous improvement within the services it commissions, and work to pursue assurance of safety and quality, the CCG's Quality Assurance Strategy builds upon the recommendations of reports by Francis, Keogh, Berwick and others, defining the CCG's vision for 'quality' and how the CCG will assure itself, and its stakeholders, that people within the local community will receive high quality care.

This strategy outlines the actions required to identify and measure the quality of services the CCG commissions in line with the values of the CCG and the NHS Constitution. It also sets out the governance arrangements within the CCG that ensure the Governing Body is informed on the quality of commissioned services, the assurance methods used, and the processes for escalation and additional support for quality and safety concerns.

The CCG is committed to openness and transparency when developing or assuring services and seeks to hear the voice of the local population and the impact of its decisions on people.

Quality is everyone's business and the CCG is committed to working with partners across the system to ensure the best possible outcomes and experience for patients and their carers and families.

Michelle Carrington
Executive Director of Quality and Nursing

Phil Mettam
Accountable Officer

Contents

''All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support" (Berwick 2013).

Introduction

This Quality Assurance Strategy and accompanying framework sets NHS Vale of York Clinical Commissioning Group's (the CCG) objectives, responsibilities, and governance arrangements for the monitoring and assurance of quality in the services it commissions. Clinical Commissioning Groups have clearly identified responsibilities in relation to commissioning for quality, informed by the NHS constitution (2011):

- To ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement
- To secure health services that are provided in an integrated way, working in partnership with the Local Authority
- To actively seek patient feedback on health services and engage with all sections of the population with the intention of improving services
- As a membership organisation, working with NHS England, support primary medical and pharmacy services to deliver high quality primary care.

The Health and Social Care Act (2012), states 'each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness'.

This strategy describes how the CCG will work with partners, identifying quality standards, measuring and monitoring quality and what actions it will take if there are concerns about the quality of services commissioned. This includes services commissioned by NHS Vale of York CCG and those it may not commission directly but which provide services to the population within the Vale of York. The CCG will review its quality priorities constantly to ensure quality remains the key focus and the Quality Assurance Framework will identify key objectives and methods of monitoring compliance against them.

Strategic objectives for quality assurance

Core strategic objectives

- The CCG will discharge its statutory functions with regards to quality
- The CCG will contract for quality and effectiveness, within resources, to ensure standards can be monitored, maintained and improved

Additional strategic objectives

- To seek and hear the patient voice, ensuring it is incorporated into the CCG commissioning plans and quality assurance processes
- To be transparent- openness and candour are key values for the CCG. Candour and honesty are integral to healthcare and quality assurance as well as service improvement
- To support the development of a strong safety culture
- To learn and support learning for improvement in the providers of services we commission, to act and share learning from safety incidents and patient experience
- To ensure awareness of and inclusion of national documents, reports and directives to influence and update the Quality Assurance Framework.

Background

Roles and responsibilities

The Health and Social Care Act 2012 makes it clear that all Clinical Commissioning Groups have the responsibility to ensure continual improvement in the quality of local NHS services for everyone, now and for the future. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between the CCG, provider organisations, other commissioners, system and professional regulators, local authorities and other national bodies.

This Quality Assurance Strategy sets out a number of measurable actions and related outcomes which will help ensure the CCG is commissioning safe, effective services that meet patient need. The strategy also describes the various mechanisms that are in place to assure quality. Defining quality is complex, this strategy will describe what the CCG means by the term quality and how it will assure itself that people within the populations it serves are receiving high quality care.

The core operating principles for Quality set out in the NHS constitution identifies the following behaviours the CCG seeks to apply:

- Patients and the public come first – not the needs of any organisation;
- Quality is everybody's business – from the ward to the board; from supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers;
- If we (health and care professionals, staff as well as patients and the wider public) have concerns we speak out and raise questions without hesitation;
- We listen in a systematic way to what our patients and staff tell us about the quality of care; and
- If concerns are raised, we listen and investigate and determine appropriate action.

Key drivers for quality

NHS Constitution (2014)
Sets out the standards of care and the rights that all patients have and should expect

Patient and Public Involvement (PPI)
The CCG is committed to working with patients, carers, community and voluntary groups and other partners to involve, engage and listen in order to identify commissioning priorities and inform service redesign.

The Next Stage Review: High Quality Care for All (2008)
The review placed emphasis on being more patient centred, clinically driven, valuing people and promoting lifelong learning and improving quality of commissioned services.

Quality Accounts (2010)
Every NHS provider organisation has been required by law to report its performance on the quality of care; incorporates views of stakeholders and published annually.

The NHS Outcomes Framework (2015)
A national framework to drive local improvements in quality and outcomes for patients. Covers five domains.

The CCG Outcomes Indicator Set
The aim of the set is to support and enable CCGs and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of commissioned services.

Quality schedules in contracts
Contracts with providers contain both national and locally set quality indicators which allow CCGs to monitor and measure performance. Contractual levers can be applied if quality is not achieved.

NHS Operating Framework (2016-17)
The framework sets out national priorities and performance targets to drive continuous quality improvement. It places quality as the organising principle through contracting and payment systems.

Care Quality Commission standards
All providers of health care are required by law to register their services with the CQC who are the regulator of health and adult social care in England. Registration is subject to compliance with a regulatory framework based on a series of 'fundamental standards' of quality and safety.

Statutory Duty of Candour
Since 2015, every healthcare professional are required by law to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Professionals are also required to be open and honest with colleagues and employers in order to promote a culture of patient safety improvement.

National Quality Board (NQB)
The National Quality Board (NQB) was established in 2009. It has no statutory responsibility. It is the only forum where all the national bodies with some responsibility for quality of care come together to provide strategic oversight and leadership on quality across the system.

Equality, diversity and human rights
Promoting equality, valuing diversity and upholding human rights is integral to the pursuit of quality and addressing gaps in health inequalities. The NHS Equality Delivery System (EDS) was launched in 2011 which the CCG self-assesses on performance of the nine 'protected characteristics' in the Equality Act 2010 to inform and drive quality improvement

NICE Quality Standards
Are a set of prioritised statements designed to drive measurable quality improvements in a particular area of healthcare. Guidance is derived from high quality independent input from a wide variety of health and social care professionals who consider patient experience, safety, equality and cost effectiveness in the development.

NHS England Accountability and Assurance Safeguarding Framework
The purpose of the framework is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care to protect people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place and hold them to account through contracting arrangements. CCGs are also responsible for securing the expertise of Designated Professionals on behalf of the local health system.

Learning from patient feedback
'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' was published post Francis Report highlighting changes required to ensure providers listened to patients and carers, looked for trends, disseminated lessons learnt and made changes to ensure care improved. The report also recommended that Healthwatch, as the patient and public champion for health services, should be as strong and effective as possible so that it can speak up for patients and provide independent support on complaints.

Learning from failure
National enquiries and reports often follow failures in care and come with recommendations to prevent recurrence such as that which followed the investigation into Winterbourne View and Jimmy Savile. The CCG scrutinises all such reports and incorporates into its accountable functions including holding providers to account for delivery of changes where required.

Facing the Facts, Shaping the Future

A draft health and care workforce strategy for England to 2027

This document outlines why a workforce strategy is needed and describes three key elements; education and training; retaining current workforce and recruitment to workforce. It also describes actions to grow capacity and capability across the public sector workforce.
Working with Health Education England the CCG has a responsibility to commission service that have robust workforce models to maintain quality and safety standards.

What is quality assurance?

Quality assurance is the systematic and transparent process of determining whether a product or service being developed is meeting specified requirements through a variety of measures.
The mechanisms for monitoring and escalation are further illustrated in **appendix 1.** These include:

- Clear expectations of quality defined through detailed service specifications and contracts
- Monitoring of provider performance through contract management board and associated quality meetings or groups
- Scheduled clinically led site quality visits to providers to follow the patient journey and assess care provision
- Assessment and monitoring of provider quality accounts which are published each year
- A Quality Surveillance Process discussed at regular Quality Surveillance Groups, led by NHSE, to have oversight of quality across the system
- Non-scheduled quality visits

As statutory bodies accountable to the public this strategy will be overseen by the Governing Body and the strategy describes how this will take place.

Context

Following a number of high profile reports and enquiries, particularly the Public Enquiry into the care at Mid-Staffordshire NHS Foundation Trust (2013) carried out by Sir Robert Francis, it was reiterated by the Department of Health (2014) that CCGs had key roles and responsibilities for continual improvement of quality in healthcare. During the last few years there has been a number of investigations of hospitals and care homes that have highlighted the tragic consequences of poor care and treatment, neglect and abuse. This has resulted in decisive action from the Department of Health (DH) including further in-depth inspections of poorly performing Hospitals/Care homes, a national review of patient safety, complaints and support worker training. The two notable reviews are Winterbourne View (2012), a Hospital for people with Learning Disabilities, and the Francis public inquiry into Mid Staffordshire Hospital (2013). As a result of lessons learned, policy changes and guidance have been introduced.

The recommendations accepted in the Francis report provide the framework for this document alongside recommendations in reports which followed, namely:

- The Munro Review into Child Protection: Final Report, (2011)
- Winterbourne and follow up Winterbourne View Concordat (2012)
- A promise to learn— a commitment to act. Improving the Safety of Patients in England, Berwick Report (2013)
- Safeguarding children and young people: roles and competencies for health

care staff – Intercollegiate Document (2014)

- Compassion in Practice. Nursing, Midwifery and Care Staff Our Vision and Strategy. (2012)
- Leading Change, Adding Value, a Framework for Nursing, Midwifery and Care Staff. (2016)
- Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015, (2015).

The main key quality recommendations from the Francis Enquiry and Winterbourne View can be found in **appendix 2.**

Strategic vision and plan

This Quality Assurance Strategy sets out the fundamental approach of the CCG to quality in the commissioning and monitoring of services. Building on the recommendations of the Francis, Keogh, Berwick and other reports the strategy defines the CCG's vision for 'quality' and how the CCG will assure itself and others that people within the populations it serves receive high quality care whilst outlining CCG responsibilities. It also sets out the governance arrangements within the CCG to ensure Governing Body is informed on the quality of services commissioned and the assurance methods used, as well as the process for immediate escalation of quality concerns.

Our strategy outlines the actions required to identify and measure the quality of services the CCG commissions in line with the values of the CCG and the NHS Constitution.

Our approach

Working proactively

The CCG will share gather and share information and intelligence as appropriate with relevant stakeholders about the quality of care so that it can identify potential problems early, prevent harmful impact and manage risk.

Reacting and responding (working reactively)

In the event of a potential or actual serious quality concern becoming apparent, the CCG will make and support informed judgments about quality and ensure that appropriate, timely responsive actions are implemented. It will also include other stakeholders as necessary placing patient safety at the centre of any decisions and subsequent actions.

Local context and CCG commissioned services

The CCG has 26 member practices covering a population of approximately 300,500 people. In total there are eight CCGs across North Yorkshire and the Humber, whose patients may also access Vale of York providers. The CCG has a responsibility to act on behalf of other CCGs in the monitoring of standards of quality provided by all providers, and provide assurance to them that care is of the highest quality possible.

The CCGs commission activity from providers that are registered with the regulatory body the Care Quality Commission (CQC), and, as part of contracting arrangements the CCG works closely with them to monitor standards and deliver continuous improvement.

Consultation and key stakeholders

To develop this strategy we have consulted with our partners and other stakeholders.

What is Quality?

Quality is difficult to define and incorporates many aspects of data, information of feedback from a wide variety of sources. Measuring quality and gaining assurance is complex. The Care Quality Commissions' definition includes organisational culture and leadership and responsiveness which are incorporated into the CCG's dimensions of quality. The key drivers for quality have been taken into account and are included within this strategy.

'Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning'.

Berwick Report 2013.

NHS Vale of York CCG - Definition of quality

Commissioning for quality

Commissioning is not one action but many, ranging from assessing the health-needs for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with simultaneous continuous quality assessment occurring. The role of commissioning, as a key driver of quality, efficiency and outcomes for patients, has become increasingly important to the health system in England.

How the CCG establish expectation of quality in its commissioned services

Commissioning involves a series of stages usually conducted in a systematic cyclical process over the course of a year which assist the CCG in deciding what services are needed and whether existing services require review. Quality assurance is inherent and integral to that process.

Contracting process

Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and subsequently hold it to account for the quality of care it (and any sub-contractors) delivers against those standards. The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care and any agree local quality requirements (NHS Standard Contract 2015). The contract is managed by Contract Management Boards and relevant sub contract groups (e.g. Quality and Performance Sub CMB). These forums address under performance against all quality requirements and either agree action plans for improvement and/or provide a process for escalation of quality or performance concerns which are impacting on quality.

Each commissioned provider is required, contractually, to submit information on recognised indicators of the safety, quality and effectiveness of services. This includes:

- Patient experience information from internal and external surveys, Family and Friends, complaints and PALS information
- Incident and Serious Incident reporting data, compliance with national and local reporting timeframes. Quality of reporting, analysis, including medication errors, never events and completed investigation reports
- Infection prevention and control measures, including clinical practice, environmental audit data and numbers of healthcare –associated infections and outbreaks of infections identified.

This information is reviewed and considered along with the context of other available data and intelligence, external agency reports and benchmarking against comparable organisations where appropriate. Where NHS Vale of York CCG is not the lead contract holder, for example with Yorkshire Ambulance Service, the lead CCG contact will provide Quality feedback, which will include feedback from NHS Vale of York CCG.

The CCG's Quality and Performance Committee (Q&P) receives monthly reports on provider performance against their respective quality and performance schedules including CQUINS and quarterly data packs describing performance over time. Current issues impacting on performance and plans to resolve compliance issues are also monitored.

The Quality and Patient Experience Group (QPEC) meets bi-monthly and produces a detailed quality report reviewing all aspects of quality for all providers. Reports and issues requiring escalation are then shared with the CCG's Governing Body at each meeting held in public. Reports on both adult and children's safeguarding are reported to QPEC each quarter and presented by the Designated Professionals working on behalf of the CCG.

A Primary Care Co-Commissioning (PCCC) meeting occurs bi-monthly and has a pivotal role in receiving information to provide assurance on the quality and safety of primary care services. It receives reports and updates providing information on compliance with Quality Outcome Framework (QOF), and meeting standards against CQC and patient satisfaction domains. The committee will produce a Primary Care Assurance report which will incorporate both local and national data including identification and correction of any gaps in available information. The committee will request and obtain data to continue to provide insight into quality and safety challenges and support resulting quality improvement programmes. QPEC will be kept informed of any issues as required as well as support any quality improvement projects.

Quality schedules

The NHS contract includes clauses which serve to focus the provider and commissioner on the achievement of quality improvement and places emphasis on avoiding harm. In addition to the terms within the main body of the contract there are also specific schedules which both parties work on collaboratively prior to sign off which are directly related to quality.

Key Performance Indicators (KPIs)

Key performance indicators assist the CCG to define and measure progress on a range of issues. 'In year' targets and trajectories are set to demonstrate ambition towards continuous improvement, in conjunction with existing and emerging national and local priorities. These will also consider areas where the CCG considers priority of need to improve where quality and performance issues have been identified during the year.

Commissioning for quality and innovation (CQUIN)

The National NHS Contract includes the CQUIN payment framework which allows commissioners to reward innovative solutions and/or quality improvements beyond the standard. There are two sets of CQUINS. One is nationally prescribed, the other is locally determined and can include as few or as many as are agreed. The financial reward equates to 2.5% of the contract value, with 0.5% attributed to the national schemes and Commissioners can determine the split of financial reward across the schemes weighting payments across the year as the objectives are met. The provider reports against CQUINS on a monthly or quarterly basis through the contract management route.

Quality, Innovation, Productivity and Prevention (QIPP)

"We need to fashion a vibrant, creative NHS that really fizzes with ideas of how to improve quality and how to reduce costs..... So, instead of relying on ever more funds flowing from the Treasury, we must look to ourselves to make savings.

This practical imperative is what QIPP is all about.....

We have the resources, we have the knowledge and we have the ability to give the people of this country a truly first class NHS and to deliver it within our means."

Earl Howe, Minister for QIPP

In the development of the CCG's QIPP schemes, the Quality and Nursing Team undertake Quality Impact Assessments (QIAs) to determine the risk to quality by any scheme and initiative. Finance and performance Committee review the CCG QIPP programme to make sure that the impact from a quality perspective has been considered alongside ensuring the delivering of schemes.

Patient safety

A fundamental priority for commissioners is to commission high quality care which is safe, prevents avoidable harm and risk to patient safety. This includes systems to not only protect patients but robust processes to investigate and learn from incidents. Quality Measures the CCG will routinely monitor include:

- Serious Incident Management
- Safeguarding
- Adverse outcomes such as pressure ulcers and falls
- Care of the Deteriorating Patient
- Medicines Management
- Summary Hospital –Level Mortality Indicators (SHMI)
- HCAI rates

Serious incident reporting

All Serious Incidents (SIs) are reported through the Department of Health's central Strategic Executive Information System (StEIS). Incidents are reported and investigated in line with providers and CCGs policy, which both reflect the National Framework (NHS England 2015). The expectation is that learning from incidents is shared across the whole of the provider organisation and if appropriate shared more widely.

Providers Serious Incident Investigation reports are reviewed at the combined CCG SI Panel to ensure comprehensive investigations with appropriate action plans demonstrating organisational learning have been completed.

QPEC Governing Body will receive regular reports summarising the Serious Incidents and incidents and any relevant themes, trends and learning.

Assurance of Learning from Serious Incidents

The CCG has a responsibility to obtain assurance following declaration and investigation of a Serious Incident. This includes robust quality scrutiny of the completed SI report to ensure all pertinent issues have been identified and considered within the report, and that relevant actions are included in an action plan which identifies SMART actions.

If the CCG is assured the Serious Incident report contains a robust action plan to reduce the risk of a similar incident from happening again the incident will be closed on StEIS .However the CCG must be assured of completion of actions and embedding of learning identified in the action plan the following assurance framework schedule, agreed with providers will take place.

Assurance Method	Frequency	Data	Lead
Monitoring of recurrent incidents and appropriate action as required on situational basis	Ongoing	STeis reports SI reports Other intelligence	SI team CCG Quality team- Head of Quality Assurance and Maternity
Robust quality review of completed investigations and action plans	Monthly	SI reports	SI team Clinical reviewers Head of Quality Assurance and Maternity
Scheduled planned Quality Site visits	As per agreed schedule	SI data from area Actions from SI action plans for area Patient relations intelligence Recurrent applicable themes	Head of Quality Assurance and Maternity
CCG attendance at Trust SI panels	As invited	SI report Analysis of recurring trends and themes	Head of Quality Assurance and Maternity
Assurance visits to Trust	Quarterly	Random number of SI's selected and audit of evidence of completion progress provided, e.g. ward visits, guideline updates, safety briefs	Head of Quality Assurance and Maternity
CCG attendance at Falls and Pressure Ulcer panels	Monthly	Collation of themes and trends	Head of Quality Assurance and Maternity

Duty of Candour

A duty of candour is included in the standard NHS contract (NHS England, 2015). Its function is to ensure patients and their families are told about patient safety incidents which affect them, receive an apology, are informed of the investigation plus its outcomes and provided with support.

Compliance with Duty of Candour is required to be included on all investigation reports. Submission of evidence of overall organisational compliance against all the aspect of the requirement occurs via quality schedule contracting processes.

Quality accounts

All NHS Foundation Trusts are required to produce reports on the quality of care (as part of their annual reports). Quality reports help Trusts to improve public accountability for the quality of care they provide (Monitor 2015). The CCG is responsible for providing scrutiny and a supporting statement which will be included in the account which is publicly available.

Cost Improvement Plans (CIPs)

CIPs are integral to all trusts' financial planning and require efficient, sustained performance in order to be achieved. CIP success varies among Trusts and no single approach works for all organisations. However, several factors are common in organisations performing well in CIP planning, delivery and sustainability. A successful CIP is not simply a scheme that saves money. The most successful organisations have developed long-term plans to transform clinical and non-clinical services that not only result in permanent cost savings, but also improve patient care, satisfaction and safety. The CCG has a duty to examine the Cost Improvement Plans of its main service providers and the process by which these are agreed and ratified. This is done as part of the contractual arrangements by the Contract and Quality and Performance Teams.

Quality in Care Homes and the domiciliary care sector

Ensuring quality in care homes and the domiciliary care home sector is challenging and complex. The CCG recognises it has an important role in supporting providers to deliver high quality services and improvement plans, in order to contribute to the sustainability of out of hospital care. These services provide care to frail, vulnerable people and often care is joint or wholly funded by the CCG under NHS responsibilities for continuing healthcare, a joint package of care, or through a contribution to the registered nursing care that a person who is a resident in a care home with nursing will receive.

The Refreshing NHS Plans for 2018 delivering the Five Year Forward View explains ways to progress towards system integration and achieving the deliverables identified in 'Next Steps on the NHS Five Year Forward View' published in March 2017 and the CCG will ensure quality remains inherent to all parts of that process in special measures and the CCG contributes to this support to care homes.

The CCG will work on a multi-agency basis to collaboratively deliver improvements in the quality of care in care homes and provided by domiciliary care, including medicines management, intermediate care and rehabilitation and through the CCG's 'Partners in Care' Forum. This Forum is a CCG led group which meets regularly with care home representatives to share best practice, implement initiatives and support continuous quality improvement.

The CCG will work with Local Authority colleagues on assurance visits to care homes, when visits are required for action/ improvement plans or where concerns are raised. This aims to provide supportive to the care homes and facilitates joint working between health and social care.

Care Home Closure

NHSE together with partners have published good practice guidance for Local Authorities, CCGs, NHSE, CQC, Providers and Partners. It helps partners to co-ordinate action, avoid duplication and prevent confusion from providers of health and care staff in the home closing or that receive residents from homes that close. Managing Care Home Closure aims to ensure that when closure arises, there is a joined-up and effective responsive from all partners to minimise as much is possible the impact on people using services, their families, carers and advocates.

The guidance can be found here:

http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/1577_QuickGuide-CareHomes_9.pdf

A Joint Working Protocol has been developed by NHS England (North) and partners to give guidance to organisations when a hospital, service or facility closes unavoidably at short notice. The memorandum gives clear guidance and direction to any organisation involved in a short notice closure to take appropriate and timely action in supporting patients and making sure they get the care and treatment they deserve.

The protocol is now available online at:
https://www.england.nhs.uk/publication/joint-working-protocol-when-a-hospital-services-or-facility-closes-at-short-notice/

Safeguarding

Robust safeguarding processes are integral to all aspects of patient care and patient safety. The CCG Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is supported in this role by the Designated Professionals for Adults and Children's Safeguarding. The CCG acknowledges its statutory function and responsibility as both a commissioner of services and as an employer and has clear governance processes in place for safeguarding children and vulnerable adults. Related policies are:

- Safeguarding Adults Policy
- Safeguarding Children Policy
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- Allegations Against Staff Policy

The CCG provides training for its staff and supports member practices by investing in capacity and has invested in providing nurse consultant and named doctor for safeguarding in primary care. The CCG works in partnership with local authorities to discharge its statutory functions and sits on relevant Safeguarding Boards. The CCG recognises the importance of 'parity of esteem' for those with mental health and learning disability needs. This applies to the monitoring and assurance of all commissioned services.

The CCG ensures that safeguarding requirements are integral to any contracts with providers and holds them to account for the delivery of those standards. through the receipt of compliance with staff Safeguarding training uptake, review of Safeguarding reports and participation in clinical site visits. Designated Leads for Safeguarding attend provider Quality meetings, sub Contract Management Boards, and Quality and Patient Experience Committee where reports and updates are received. Governing Body are informed of any safeguarding issues via the QPEC reports and directly for serious or urgent issues by the Chief Nurse.

How the CCG measures quality and prevention of harm

- Regular, routine measuring and monitoring of quality indicators and data within the contract, escalating and taking action where required as outlined in appendix 1
- Clinical visits / walk rounds/Scheduled and unscheduled Quality Assurance visits
- Hearing the voice of the person, their carers and families through complaints / compliments / surveys and development of key relationships with Healthwatch and other service user groups
- Scrutiny of Risk Registers- providers will be asked to share their Red rated risks through sub CMB which relate to or could have an impact on quality and safety of services
- Further development to allow the collection and scrutiny of soft intelligence from primary care through the CCG and by proactive partnership working across the STP
- Dialogue with Quality Leads across Yorkshire and Humber and participation in key pieces of regional work across the STP
- Contribution to inspections and monitoring of action plans from CQC and others
- Sharing of information and intelligence across the system and appropriate escalation via Quality Surveillance Groups (NHSE)
- Safeguarding processes

Primary care quality

The CCG recognises it has an important role in supporting primary care to deliver high quality services whilst acknowledging that assuring quality in primary care creates complex challenges. The CCG is establishing processes to receive reliable data on incidents, serious incidents, significant event audits and any patient experience feedback. This will include review and receipt of the Primary Care Assurance Report and Quality and Outcomes Framework figures by The Primary Care Commissioning Committee, QPEC will receive a summary of this.

The Quality Lead for Primary Care will develop a framework to support the offer of a schedule of quality visits, incorporating a range of quality assurance measures and including sharing any learning from incidents and from local primary care CQC assessments.

The CCG will develop a Safety Bulletin to share learning from events, incidents and Serious Incidents in Primary Care.

Infection prevention

Management of healthcare acquired (HCAI) and organisational approaches to infection prevention are not only crucial to maintaining patient and population safety, but ensure a continued focus on the management and reduction of all HCAI.

The CCG receives information and assurance on Infection Prevention and Control measures through a variety of means. It receives provider reports on HCAI reduction plans and provider DIPC reports which include antimicrobial prescribing and adherence, surveillance data and audits including hand hygiene. The Head of Quality Assurance participates in post infection reviews of cases of C-diff, MRSA as well as contributing to any outbreak responses. Themes and trends from PIR's are incorporated into the report received at QPEC including the number of declared HCAI cases against trajectory. Antimicrobial prescribing is monitored by Medicines Management team.

Combined CCG and Provider action plans are in place against emerging HCAIs which are reviewed through the shared CCG IPC Locality meeting.

Assurance on IPC in primary care will form part of the quality visit schedule. The shared community IPC resource will support this as well as education and IPC support in care homes.

Clinically led site visits

A schedule of planned clinically led visits will be devised on an annual basis in agreement with providers. This will involve a multidisciplinary team visiting a service or

ward and gaining more information to provide insight into both the patient experience and staff perspective.

Prior to the visit information will be collated regarding Serious incident themes, complaints, PALS and any performance issues which will inform some of the focus of the visit. A feedback letter will be sent which summarises the visit and an action plan devised for any resultant actions. This will be monitored at both the TEWV Performance and Quality sub CMB, YTH sub CMB and included in the QPEC report.
Site visits which require a more formal approach will utilise the guidance the STP have issued.

How the CCG will work with partners to quality assure services

> **'Quality…is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system.'**
>
> **National Quality Board 2014**

In addition to the CCG's work regarding quality, other local and national bodies and agencies are required to provide oversight, leadership and additional assurance into patient services. Local partners also have a responsibility to ensure people are protected from harm and failures in quality including neglect and abuse.

Roles and responsibilities of partners in the system

Providers

Providers have a responsibility to understand and identify what high quality care looks like and must strive to deliver this. They are required to have robust governance arrangements in place to monitor, manage and drive improvements and must publish an annual Quality Account (excluding primary care).

All providers are governed by legislation and regulated by various national agencies.

The CCG took over fully delegated commissioning responsibility from NHSE in April 2014. As such primary care is subject to the same monitoring of agreed quality indicators and potential action taken if quality is at risk.

Regulators

The Care Quality Commission (CQC) is the agency responsible for monitoring, inspecting and regulating services. The CQC ensures services meet fundamental standards of quality and safety and publish their findings, including performance ratings to help people choose care. The Quality and Nursing team offer support to Primary Care prior to inspections and promotes the sharing of good practices across the locality. The CCG scrutinises CQC inspection reports and monitors action plans for improvement. The CCG also supports the CQC when quality concerns are identified about a provider and is involved in supporting improvement work and monitoring patient safety. The CCG and CQC discuss providers to share information promoting a cohesive approach to both the regulatory and CCG function.

National Health Service Improvement (NHSI) acts as the main regulator of Foundation Trusts and NHS Trusts ensuring they are well-led, and have regard to whether their services are effective, efficient and of good quality. NHSI has been set up to support providers to deliver, helping the NHS meet its short-term challenges and secure its future.

Ofsted is the Office for Standards in Education, Children's Services and Skills. They inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages and publish their results. The CCG will participate in inspections and be part of developing and implementing any actions for children.

Professional regulators such as the Nursing and Midwifery Council (NMC), General Medical Council (GMC) and Health and Care Professional Council (HCPC) set standards, hold a register, quality assure education and investigate complaints. The CCG has the responsibility to ensure compliance with regulatory standards of the professionals they employ and report concerns of practitioners.

Planning and Advisory Bodies

Healthwatch is the national body that champions people who use health and social care and has a key focus on the design of integrated care. Each local authority has a local Healthwatch Group which feed into the national network. A Healthwatch representative attends the CCG Governing Body and meets with key members of the CCG to share patient feedback.

Health and Wellbeing Boards (HWB) were established as part of the Health and Social Care Act 2012 where leaders from the health and social care system come together to improve the health and wellbeing of their local population. Its main concern is to reduce health inequalities.

They have a statutory duty to involve local people in the development of the Joint Strategic Needs Assessment (JSNA) and the development of joint health and wellbeing strategies. The CCG attend and contribute to the HWB ongoing agenda.

Overview and Scrutiny Committees (OSC) were established under the Local Government Act 2000. They are made up of locally elected councillors who are independent of executive or cabinet parts of the council. They can investigate any area of concern in the local area and they have powers to require officers, including the CCG to attend meetings and answer questions and must comply with requests for information. They hold decision makers to account.

Local Safeguarding Boards - Section 13 of the Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children's Board (LSCB). The Care Act 2014 requires Local Authorities to establish Safeguarding Adults Boards (SABs). The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The CCG is a statutory partner on the Boards.

The Public Health function sits in Local authorities who tailor local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities. The Director of Public Health supports local political leadership in improving health. They champion health across the whole of the authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed. The CCG works closely with Public Health and the Director of Public Health is a key member of the CCG Governing Body.

NHS England

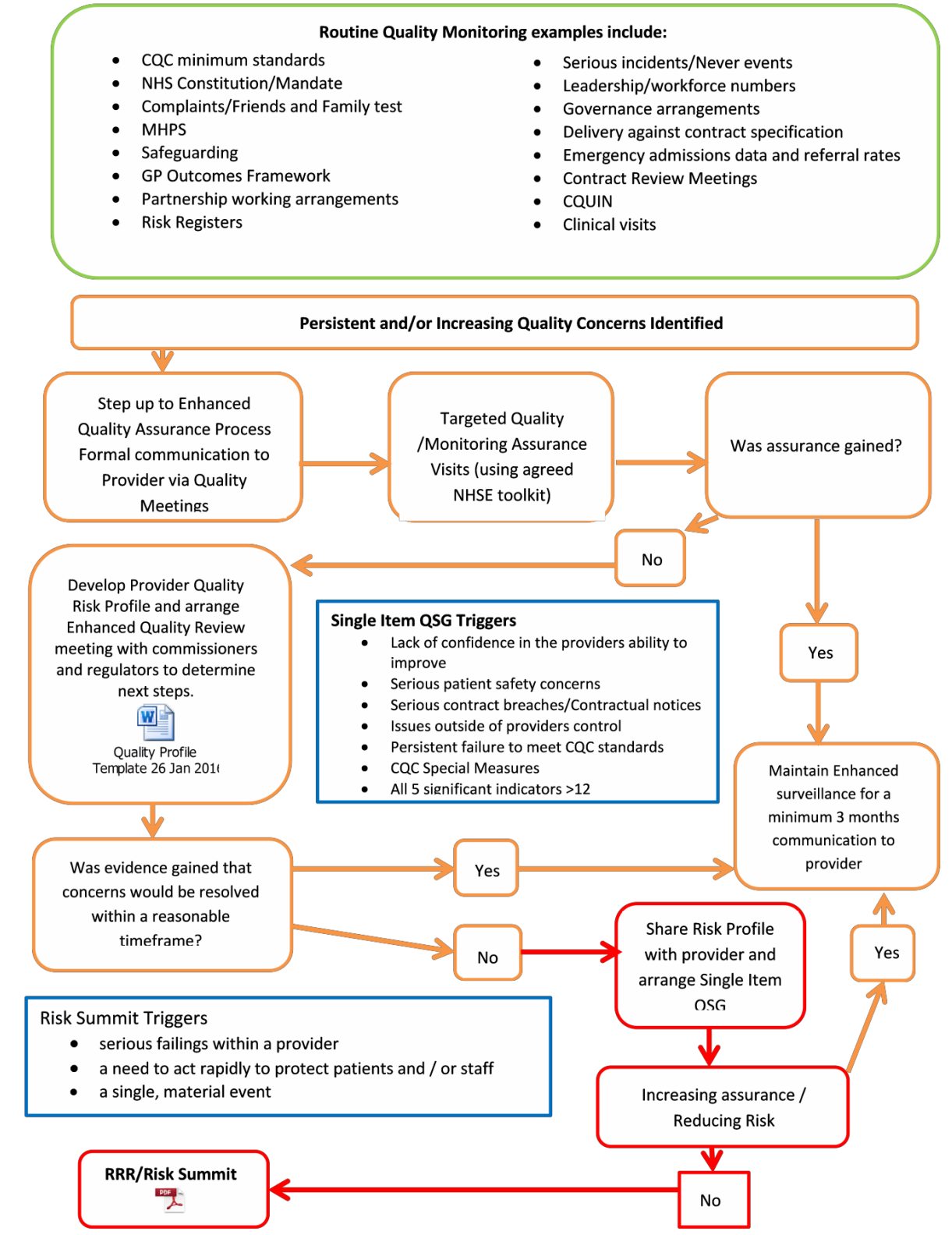
NHS England commissions specialised services, primary care (when CCGs do not have delegated authority), offender healthcare and some services for the armed forces. It has four regional teams but is one single organisation operating to a common model with one management board. The CCG works with NHSE to share quality surveillance information and to work together across the system to monitor and improve quality. Quality Surveillance Groups (QSGs) were established in advance of the new health and care system going live on 1 April 2013. They were introduced following the publication of the National Quality Board's (NQB's) report Quality in the New Health System: Maintaining and Improving Quality from April 2013. The NQB brings together the leaders of national statutory organisations across the health system, alongside expert and lay members. Members of QSGs, including the CCG should work together, as part of a culture of open and honest cooperation, to identify potential or actual serious quality failures and take corrective action in the interests of protecting patients.

The CCG also collaborates with education bodies such as the Health Education England, Academic Health Science Networks and local Universities.

The CCG's Governance Structure

Appendix 1: Quality Monitoring and Escalation Process

Commissioners Quality Monitoring and Escalation Process for Providers – Appendix 1



The escalation to a rapid response review or risk summit could be instigated at any point in the process if patient safety concerns require urgent action.

Appendix 2: Key Quality Recommendations from the Francis Enquiry and Winterbourne View

Francis Enquiry key quality recommendations:

- GPs need to undertake a monitoring role on behalf of their patients who receive acute Hospital or other specialist services.
- The Commissioner is entitled to and should, apply a fundamental safety and quality standard in respect to each item of service it is commissioning, and agree method of measurement and redress for non-compliance.
- Local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers services.
- In selecting indicators, the principle focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained.
- Commissioners – not providers – should decide what they want provided.
- Commissioners need to identify and make available alternative sources of provision.
- Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period. They must also have the capacity to undertake their own audits, inspections and investigations.
- Commissioners should be entitled to intervene in the management of an individual complaint on behalf of a patient where it appears to them, it is not being dealt with satisfactorily.
- Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.
- Commissioners should have contingency plans to ensure that patients are protected from harm, if they are risk from substandard or unsafe services.

Winterbourne key quality recommendations:

- **One shared vision**, driven forward by active senior leadership, based on the presumption that hospitals are not homes, and that people should be supported to live in the community.
- **One pooled budget**, allowing maximum flexibility for commissioners to fund what individuals truly need, and aligning the financial incentives on all commissioners to invest in community-based provision.
- **One robust plan** for commissioning on a whole life-course basis, supporting early intervention and support (from early childhood onwards), expanding the provision of community-based support and care, and reducing the number of inpatients and inpatient provision.

Commissioner site visit policy and procedure for Humber Coast and Vale Clinical Commissioning Groups

Policy and Procedure

Version number	Date changed
1.5	29.09.17
1.6	06/10/17
1.7	14/11/17
1.8	08/12/17

Contents

1. Purpose

The purpose of this document is to clearly define the commissioner site visit policy and procedure. To outline conduct and commissioner responsibility when organising, attending, contributing to and reporting a site visit. The document aims to align the commissioner approach to site visits across the Humber Coast and Vale Partnership and to enable cross-organisation effective collaborative working.

2. Scope

This procedure relates to all announced and unannounced site visits undertaken to the CCG's (commissioned) providers, this includes Acute Trusts, Primary Care, Providers who hold a contract or AQP (Any Qualified Provider Agreement) with the CCG, and Care Homes (Nursing and residential homes) including Continuing Healthcare placements.

3. Policy

Site visits are a tool to be utilised within the commissioning cycle and at every level of quality surveillance. The frequency, focus, key lines of enquiry and type of the visit will be determined by the level of quality surveillance and concern (as indicated by the intelligence we receive, which may include but is not limited to Customer Care, Public Engagement, Safeguarding and Incident intelligence, or by a drop or trend in performance or quality indicators).

It is helpful to frame and clarify the types and purpose of site visits are described below in 3.1, from a commissioner information gathering site visit, to a commissioner inspection site visit. It is recognised that a review of a service user journey on a commissioned pathway may be indicated.
This policy and process also applies to a site visit based on a patient/service users journey through the health and social care system, therefore this process can be applied across a range of service providers. The nature of these visits can be complex due to the involvement of more than one organisation; therefore, they are usually conducted as an information gathering or routine site visit, within an announced framework, as defined in table 3.1 overleaf, to easily facilitate the review of a service user's journey.

Providers, regulators or other stakeholders, such as the local authority, NHS Improvement, CQC or Healthwatch, may seek supportive site visits, either led by themselves or at their request by the Commissioner. Where Services or other organisations choose to lead a site visit and invite Commissioner representatives section 4.3 of the procedure is applicable and should be adhered to by the Commissioner. Where the organisation asks the Commissioner to lead the site visit

the full procedure applies but in addition to this the type of visit and section 4.2 of the procedure should be completed in collaboration with the Provider's designated lead (this must include sharing the briefing and the site visit reporting template)

4. Table to define the types of site visits

Type of visit:	Why undertake the visit?	Key visit principles:
1. Information Gathering	To gain information and learn more about how services are being provided and to give providers an opportunity to share any challenges or best practice.	Announced visit. This could include a commissioned pathway review (patient journey). The provider is normally under routine quality surveillance.
2. Routine	In response to an area of concern which requires further information/assurance on the services position.	Announced visit, however, there may be rare exceptions where an unannounced visit is indicated. This could include a commissioned pathway review (patient journey). The provider is normally under routine quality surveillance.
3. Inspection	This is in response to a serious concern or a significant service user safety risk.	Unannounced visit, however, there may be rare exceptions where the visit needs to be announced to the provider in order to safely facilitate the visit. The provider is normally under enhanced or summit quality surveillance. However, the provider could be on routine surveillance where significant concerns need investigating.

4. Procedure

4.1 Visit Indications

The types of visits are defined in the table above and the indications of a visit are outlined within. The key visit principles articulate the level of quality surveillance the provider is usually under with the Lead Commissioner.

For all visits the Commissioner must formally record the rationale for the visit.

4.2 Preparing for the visit

The first stage of preparing for a visit requires the Commissioner to confirm why the site visit is required, which type of visit, either 1, 2 or 3 is needed. This helps the commissioner to determine whether the visit is announced or unannounced. Unannounced visits should be rare and by exception limited to the undertaking of a visit where there are serious concerns about service user safety.

The Key Lines of Enquiry (KLoE) must be determined prior to the visit and recorded in the site visit template, for example under the Safe Domain Safeguarding Procedures may be a KLoE. The site visit template must be populated with the key lines of enquiry to ensure the visit meets its desired purpose. It is recognised that focused visits, and following a service user's journey through a commissioned pathway, requires the use of a template which is flexible to adaptation to meet the purposes of the visit. In addition, type one visits require a simple template to record information gathered on a non-complex visit. Therefore, the template found in appendix one of this document has been designed as a basic template to build key lines of enquiry within the CQC five domains for quality and safety.

The size of the site visit team needs to be determined. The size of the team needs to be appropriate for the scale of the visit and proportionate to the size of the Provider being inspected. The key lines of enquiry for the visit need to be clearly articulated and the skills/experience/specialism of the site visit team need to be appropriate for the purpose of the visit, for example where a KLoE is specific to safeguarding it would be appropriate to ensure a member of the site visit team is an experienced safeguarding practitioner. The organiser needs to be able to rationalise the involvement of each member of the site visit team. It is desirable and considered a gold standard to seek lay representatives on Inspection and Routine visits.

Announced site visits must be organised with the Provider, with a minimum of six weeks' notice, and a date and time for the visit must be mutually agreed upon. When organising the date of the announced site visit the reason for the visit, size of the team, and the lead commissioning contact must be shared with the provider. It is recognised that on a planned announced visit the Provider may choose not to inform

their staff that a Commissioner-Led visit is being conducted. It is key that the site visit team are made aware of this prior to the visit; therefore, it is essential that the Commissioner establishes the Providers position regarding this prior to the undertaking of the visit.

Prior to all Routine and Inspection site visits the Commissioning Lead must prepare a briefing to be shared, along with the Site Visit reporting template, with the site visit team and held as a record in the Commissioning Provider file which includes as a minimum; the rationale for the visit; any supporting intelligence (such as, but not limited to, audit results or performance/quality indicator data); the key lines of enquiry; roles of each individual (including identifying a Site Visit Team lead); reporting mechanism for urgent concerns and plans to report on the visit.

4.3 Conducting the visit

All members of the site visit team must be bare below the elbow, short nails (varnish free), hair off the collar, no open toe sandals, smart and presentable and be wearing identification (no lanyards). It is recognised that the site visit team will not have clinical contact with service users; however, the principles of good infection prevention and control practice and professionalism must be embodied by the team.

On all three types of site visit the Commissioning Lead must announce their presence; the purpose of the visit; determine visit boundaries (for example, when visiting an acute provider there maybe restrictions in access due to a patient on an imminent end of life journey); confirm the mechanism for escalating immediate concerns and agree a process for enabling a verbal feedback to the provider on the day at the end of the visit.

All members of the site visit team must act in accordance with their employers and where applicable, professional bodies, code of professional conduct. The team must be respectful to the organisation they are visiting, and the staff and service users accessing the setting. The site visit team will at all times; act professionally; respectfully; confidentially; sensitively and supportively. The team will be courteous at all times and be mindful of the privacy and dignity of patients; relatives and staff during the visit.

4.4 Reporting on the visit

4.4.1 Sharing visit findings on the day

Areas which pose a safety risk to any staff or service users must be escalated at the time of the site visit. All members of the team must escalate any safety risks to the Site Visit Team Lead; it is the Leads responsibility to address these with the appropriate senior representative from the Provider. It is anticipated that there will be extremely rare occurrences where a member of the inspection team identifies a significant immediate risk and has to escalate outside of this defined process to the

Provider, this must always be followed up by informing the Site Visit Lead of the risk and the immediate action taken to address it.

At the end of the site visit, on the day, the designated site visit lead will provide high level summary feedback to the Senior Provider representative. The summary feedback must include; any risks to service user safety; any significant positive and negative findings.

4.4.2 Sharing a formal site visit report

A formal documented report must be completed and agreed by the site visit team and shared with the provider within 10 working days of the site visit. The report must be tabled through the contract meeting process and a formal response from the provider must be sought via the contract process. Please note formal responses may range from; acknowledgement of the site visits findings; challenge to the findings or an action plan to address the findings. Each formal response must be considered in isolation to the findings, through the contract management process.

4.5 Seeking assurance from findings

Assurance from the findings may range from, but is not limited to; requesting particular intelligence or evidence (for example, audit results, an action plan or a particular policy); completing a follow-up visit or seeking (and monitoring) a providers action plan to address any areas which require improvement.

4.6 Informing level of quality surveillance

Site visit findings, triangulated with all other commissioner mechanisms for determining the quality of a services delivery, should be utilised to facilitate an informed decision of the level of quality surveillance the provider is subject to.

Appendix 2 on page 9 outlines the full process map from the initial planning to reporting and follow-up.

5. Glossary

5.1 Visit types

Information Gathering – Announced visit to gain information and learn more about how services are being provided and to give providers an opportunity to share any challenges or best practice.

Routine – A visit conducted in response to an area of concern which requires further information/assurance on the services position. This is usually an announced visit but may be unannounced.

Inspection - This type of visit is in response to a serious concern or a significant service user safety risk. The visit is usually unannounced but may be announced.

5.2 Announced and unannounced

Announced – The Provider has prior knowledge of the arranged site visit, in line with the standards outlined in this policy and procedure.

Unannounced – The Provider does not have prior knowledge of the arranged site visit, in line with the standards outlined in this policy and procedure.

5.3 Provider led site visit

A site visit is led, organised and facilitated by the Provider. The visit is subject to the Provider's governance arrangements for visits.

5.4 Commissioner led site visit

A site visit is led, organised and facilitated by the Commissioner. The visit is subject to this policy and procedure standards.

5.5 Service user journey

The visit focuses on reviewing a particular Service User pathway. This type of visit often intersects a number of services; therefore, it is usually conducted as an announced visit partly due to the planning implications to enable a full pathway review.

5.6 KLOE

Key Line of Enquiry also referred to as a KLOE. A specific area to focus attention on within the five domains; safe; effective; caring; responsive and well-led.

6. Appendix one – Blank site visit reporting template

15 step audit (five senses on first 15 steps into the site visit area)	
Domain	**Key Lines of Enquiry and findings**
Safe	
Effective	
Caring	
Responsive	.
Well led	
Summary of the highlights from the visit	
Positive exceptions	
Negative exceptions	
Risks requiring immediate attention	

7. Appendix two – Site visit process map

Site visit indicated

- **CONSIDER** and **AFFIRM**: Is information gathering OR a response to a concern OR a significant safety risk indicates the need for a site visit?

Prepare for the visit

- **CONFIRM** and **RECORD** the type of visit and why it is needed (**CREATE** the briefing document).
- **IDENTIFY** the Visit Team. **PREPARE** and **SHARE** the briefing.
- **PLAN** the visit and agree the **KLOE** and **ROLES** with the Team.

Conducting the visit

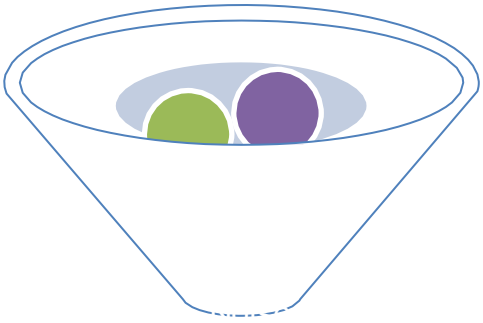
- **ANNOUNCE** your arrival.
- **CONFIRM** housekeeping for the visit.
- **ACT** professionally and report immediate safety risks.

Report on the visit

- **SUMMARISE** key findings - positive, negative and immediate safety risks - on the day.
- **COMPILE** and **AGREE** and **SHARE** site visit report within 10 working days of the visit.

Visit follow-up

- **SEEK** provider response.
- **CONSIDER** and review response.
- **AGREE** definition of any follow-up assurance needed with site visit team.



Level of Quality Surveillance

8. Appendix Three – Example of a site visit reporting template populated with the Key Lines of Enquiry

15 step audit (five senses on first 15 steps into the site visit area)	
Domain	**Key Lines of Enquiry and findings**
Safe	Infection Prevention and Control - Cleanliness of the environment with appropriate access to hand hygiene facilities Health and Safety – equipment Escalating Concerns
Effective	Policy and Guidelines – Is there a pregnancy testing in children policy? Can staff access it? Do staff know the policy?
Caring	Attitude of staff
Responsive	Providers response to feedback
Well led	Is clinical leadership visible on the shift?
Summary of the highlights from the visit	
Positive exceptions	
Negative exceptions	
Risks requiring immediate attention	

9. Appendix four - Example of a completed site visit report

15 step audit (five senses on first 15 steps into the site visit area):	
The Visiting Team found the appearance of the environment to be very pleasing. Carpets appeared clean; there was good signposting throughout the building to direct visitors to the reception area. Staff were welcoming. There were health promotional resources on display in the waiting areas and magazines available in for visitors to occupy their time whilst they waited. The environment was quiet and calm, and was welcoming to visitors.	
Domain:	**Key Lines of Enquiry and Findings:**
Safe	**Infection Prevention and Control - Cleanliness of the environment with appropriate access to hand hygiene facilities** Overall the environment appeared clean. The reception area would benefit from access to hand hygiene materials, such as an alcohol-gel dispenser, at the reception desk for staff and visitors. The visitor toilets for the building appeared clean but needed maintenance in the men's facility. Sharps bins were secured with appropriate content. **Health and Safety** The working environment was free of clutter and the paths to escape from the building were clear and accessible. Waste management appeared to be compliant with National Standards. The equipment we inspected was safety tested and appropriately labelled. **Escalating/De-escalating Concerns** Staff were able to articulate what to do if they had concerns. There was a documented process for managing safeguarding concerns which was readily available to staff. Staff informed us that they have a whistleblowing policy in place. We saw evidence of a formal mechanism for de-escalation – through staff meetings. Staff also told us that informally de-escalation occurred through meetings with their manager
Effective	**Policy and Guidelines – Is there a pregnancy testing in children policy? Can staff access it? Do staff know the policy?** A policy was in place, we asked three members of staff and they were able to locate and access the appropriate policy. Staff demonstrated knowledge of the policy contents and the application of it in practice.

Caring	**Attitude of staff** We found that staff were caring and considerate of each other and their patients. Staff told us they really enjoyed working here and that they were very proud to work for the organisation.
Responsive	**Providers response to feedback** The provider had a process in place for receiving patient feedback and learning from complaints. We did find that the provider needs to improve on the recording on informal concerns raised and the action they have taken in response to these. Staff were able to give us examples of where they have learnt from patient feedback and what they have done in response to the feedback given. Staff also informed us that they receive a significant amount of positive feedback from patients in the form of thank you's, cards and small gifts. FFT data was clearly displayed in patient and staff areas, including the response of the organisation. We followed two of the articulated responses and were satisfied that they had been completed.
Well led	**Is clinical leadership visible on shift?** Clinical Leadership was visible to both staff and patients. The Shift Lead was noted on a Board accessible to both patients and staff. Staff we spoke to felt supported and able to readily access supervision and support on a shift by shift basis.

Summary of the highlights from the visit

Positive exceptions

The visit to the service was extremely positive. We were welcomed by staff and patients. Staff were open and candid with the inspection team and were extremely confident when responding to enquiries raised by the Visiting Team.

Negative exceptions

The recording of informal concerns raised and the action taken in response to these needs to be improved to clearly evidence the feedback received and the action taken by the organisation.

Risks requiring immediate attention

None identified.

- End of document -

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Item Number: 14

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title: Quality and Patient Experience Report

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

Reason for Report
To update Governing Body about all the Quality Team's work streams and activity

Key Messages

- Specific quality risks for the Committee were highlighted, particularly with regard to mental health services.
- The Committee approved the Quality Assurance Strategy 2018-21
- The Committee renewed its terms of reference.
- The Committee emphasised that primary care engagement is essential across all commissioners and providers.
- The Committee noted the Care Home React to Red update and requested a further update at the next meeting.

Strategic Priority Links

☒Primary Care/ Integrated Care
☒Urgent Care
☒Effective Organisation
☒Mental Health/Vulnerable People
☒Planned Care/ Cancer
☒Prescribing
☒Financial Sustainability

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Recommendations
N/A

Responsible Chief Officer and Title	**Report Author and Title**
Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse	Quality Team

NHS Vale of York Clinical Commissioning Group
Quality and Patient Experience Report
– June 2018

Contents

Purpose of the Report

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

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

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

Quality in Primary Care

Quality Concerns
Following a number of quality concerns brought to the attention of the CCG, the Executive Director for Nursing and Quality has written to a Vale of York GP practice to seek assurance about how patient quality and safety is being managed and improved. Additionally, as part of their planned inspection regime the CQC inspected the practice in May 2018 and provided high level feedback to the practice and the CCG on their findings. Media publications about telephony and access issues have also been noted. On the back of the media interest, the practice has been invited to the City of York Council Health Overview and Scrutiny Committee in June 2018 and the CCG have been asked to attend.

The Quality Lead for Primary Care has met with the practice to offer support and the Head of Locality Programmes has attended the practice to help resolve the telephony issues.

Intelligence
Monthly intelligence meetings are being held to improve understanding of any issues affecting GP Practices. Any exceptions will then be reported into the Quality and Patient Experience Committee (QPEC). Issues discussed at QPEC will then be reported to the Primary Care Commissioning Committee.

A risk based approach will be developed after assessing a variety of information and this may lead to clinical visits.

Practice Nurse Forum (PNF)
PNF terms of reference have been written and will be approved at the next meeting. A register is now kept with a view to targeting and encouraging practices to attend. In response to practice nurse's requests professional speakers invited to future sessions include Nurse Consultant Safeguarding Children and Vulnerable Adults Primary Care, Regional Clinical Advisor, Senior Pharmacist – Prescribing Support Pharmacist, Public Health England (PHE) Physical Activity Nurse Clinical Champion,

Clinical Lead for Kidney Care & Cardiovascular Lead for VoY CCG, GP specialist in Women's Health.

Since the last QPEC the PNF have enjoyed a session delivered by Cancer Research UK Facilitator about Cancer Screening and another by the NHS Vale of York CCG Clinical Lead for Women and Children presenting: the menopause. Attendance at the Practice Nurse Forum counts towards participatory continuous professional development (CPD) learning for nursing and midwifery council (NMC) revalidation.

The Quality Lead for Primary Care now regularly attends the Nimbus Lead Practice Nurse bi-monthly meetings. This enables the opportunity for Nurse Leads to meet and discuss current issues affecting patients and practices. The Quality Lead for Primary Care is also sharing the Lead Practice Nurse contacts for the south and north localities to facilitate the same opportunity.

District Nurse and GP Communication

The Deputy Chief Nurse met with the York Teaching Hospitals Foundation Trust (YTHFT) Head of Community Services and a range of clinical community staff to progress issues raised at the Local Medical Committee (LMC). The issues relate to how services improve communication and understand what work is currently underway to address this.

It was recognised that there are a number of work streams that are supporting improvements, namely the anticipation of improved interoperability between Systm one (S1) and EMIS IT systems. However the service fed back that there are a number of District Nursing teams that do not have sharing permissions with their S1 practices. This will be fed back at LMC so that this can be understood and improved upon. Additionally the District Nurse Transformation Plan is about to be launched. Despite its delay, this is expected to positively affect communication between District Nurse teams and the services that they work with and QPEC will continue to report on this.

It was noted that a number of District Nurse teams have very good communication and working relationships with GP practice colleagues.

Development of a concise General Practice Nurse Strategy in support of the NHS Five Year Forward View 10 point plan

NHS England has recognised the CCG's submission to support this work and would like to use the CCG's response as an example of best practice.

The Quality Lead for Primary Care and the Deputy Chief Nurse have met with Lead Practice Nurses on the 7th June 2018 to discuss how the CCG can best support local workforce development in view of The General Practice Nursing 10 Point Plan.

Learning Disabilities (LD)

The Quality Lead for Primary Care provided an update at the latest Healthwatch York Assembly. The CCG will scope current practice in relation to the coding of the LD population on the GP register with a view to standardising and encouraging this practice across primary care.

The Quality Lead for Primary Care has met with the City of York Council (CYC) worker who has been commissioned to write a LD strategy for the City Of York to ensure that the CCG involvement in this work is recognised and embedded.

NHSE staff are currently liaising with Practices to ascertain intentions for those signing up to the Annual Health Check Designated Enhanced Service.

Workforce

Forty one physician associates placements have been offered following development of the HC&V PA preceptorship scheme 2018-19; a number being supported by Vale of York CCG GP practices.

April saw the launch of the Humber, Coast and Vale Excellence Centre in partnership with the National Skills Academy. An Excellence Centre brings together employers from the NHS, independent and voluntary sectors (and high quality training providers) to coordinate and implement high quality skills programmes. By working together it aims to provide more effective recruitment, development and progression for health and care staff.

The Excellence Centre framework will help to create system-wide solutions that can be implemented locally. This is a virtual learning platform that aims to bring together education for health and social care across the region. The Senior Quality Lead attends the steering groups to feed into the development of this centre and influence the links between workforce development across health and social care staff. Skills for care produce useful reports describing the social care workforce and allows a detailed insight into demographics, role profiles etc by region which are able to support this work.

Infection Prevention & Control (IPC)

York Teaching Hospital NHS Foundation Trust (YTHFT) team update
Meetings with the recently appointed Lead Nurse for IPC at YTHFT continue to take place with agreement for increased collaborative working.

From April 2018, the categorisation of methicillin-resistant staphylococcus aureus blood stream infections (MRSA BSI's) altered. Cases will be reported by time of infection onset as opposed to time of patient admission. Cases where the infection onset is greater than 2 days after admission will be considered hospital-onset cases; all other cases will be considered to be community-onset.

Whilst MRSA remains a zero tolerance measure in 2018/19 YTHFT reported one case of MRSA BSI in April which has been attributed to the YTHFT as it relates to a line infection. The patient had a cannula inserted for a procedure which was cancelled but appropriate on-going monitoring of the cannula did not occur. The multi-agency review agreed actions for the YTHFT were to consider inserting the cannula in the department immediately prior to the procedure. Staff on the ward are also receiving additional training on monitoring of cannulas.

Two community onset cases of MRSA BSI have been reported and been attributed to the CCG. Although both patients had previously been inpatients on the same ward following the post infection reviews it would appear the cases are not linked.

The yearly threshold for clostridium difficile for 2018/19 remains at 48, and overall the CCG have continued to see a rise in cases following the trend of the last few months. In April 2018 the YTHFT reported 4 cases of C difficile infection, 3 at York and 1 in Scarborough. All community cases are reviewed at the multi-agency Vale of York and Scarborough review meeting with any identified learning feedback to primary care-usually by medicines management when improvements to antimicrobial prescribing is identified.

Whilst there is no national objective for methicillin-sensitive staphylococcus aureus (MSSA) SRCCG and VOYCCG have included a trajectory which is a reduction of cases within the contract based on last year. However, 2 cases of MSSA were reported in April, both at York, currently this trajectory continues to increase; actions against this are picked up with the YTHFT IPC team.

4 cases of E-coli were reported in April, 3 at York and 1 at Scarborough with both the CCG and Scarborough and Ryedale CCG being over the monthly e-coli objective. Work against the multi-agency E-coli action plan continues.

Serious Incidents (SIs)

Key Issues from provider Trusts

York Teaching Hospital Foundation Trust

MRI waits for Children
YTHFT have informed the CCG that there are a number of children waiting for MRI scans due to the availability and capacity of the clinicians required to carry out the procedure. In response the CCG have asked for assurance about how YTHFT are assessing the clinical risk of those waiting as well as their plans to address the capacity short fall. This is being managed through the Quality and Performance sub Contract Management Board with YTHFT which the CCG chair. YTHFT have informed the CCG that over half of the children waiting will receive their scan at Sheffield Teaching Hospital in the short term. The remaining children on the waiting list are receiving regular reviews by their paediatrician.

Never Events (NE)
Following the updates provided in the previous reports assurance has been provided by the Chief Nurse at YTHFT that responses to the CCG's questions are being prepared.

Serious Incidents

Falls and Pressure Ulcers
It was reported previously that there was an increase during Quarter 4 in the number of reported slips, trips and falls resulting in harm which has resulted in the need for additional SI review panels to be organised to review these cases. The CCG

continues to attend and participate in these multi-disciplinary reviews of cases. The number of falls at York site reduced in April but increased slightly in Scarborough and the community.

The number of pressure ulcers also decreased in all care settings.

Duty of Candour
Evidence of YTHFT's embedding of understanding and of compliance with the duty of candour standards continues to improve with evidence of staff not only grasping the concept but instigating duty of candour. Organisational overview of directorate management of the duty of candour requirements continues through dashboards which are reported at sub contract management meetings.

Tees, Esk and Wear Valleys (TEWV)

Key Issues
Following the concerns previously reported relating to administrative management of serious incident processes a face to face meeting with the Head of Patient Safety has taken place and commitment to improvements were given. TEWV remain committed to improve processes and assurance.

TEWV completed 3 Serious Incident reports for the York & Selby locality which were approved by Directors panel and submitted to Commissioners between January and March with a total of 12 incidental findings from the 3 reports which fall into the following 3 main categories; record keeping; failure to follow trust policy; access to records.

CCG involvement at Directors panels continues where CCG participation is valued and aims to reduce subsequent queries being sent between organisations. TEWV are due to be inspected by the CQC to conduct a well led inspection imminently.

Clinical Quality Visits
The schedule of quality visits to TEWV services continues with CCG staff being made to feel very welcome and services valuing the opportunity to talk to commissioners. A day at the Learning disabilities services is planned for the end of June. Themes from any serious incidents formulate questioning for the visit to seek evidence of embedding of learning.

Quality Assurance from other providers

As the Quality and Nursing team at the CCG now has increased capacity within the team a Quality representative will attend the Contract Management Boards or Quality meetings of all the main providers. This, combined with the assurance framework identified in the Quality Assurance Strategy will increase assurance and identification of risks to both quality of care and patient experience

NHS 111/Yorkshire Ambulance Service (YAS) Sub Regional Quality Board

The CCG's Quality and Nursing team continue to attend this meeting on a regular basis to gain insight and assurance of these services from a quality perspective. The meeting is well attended with representatives from the 6 CCGs, NHS 111, YAS and Urgent Care providers. NHS 111 and YAS quality dashboards are discussed which present detail on incidents, complaints, patient experience and claims. At the last meeting an audit by NHS 111 and NHSE into emergency dental care provision was discussed as it has been acknowledged that variation exists and patient experience varies.

Assurance was provided at the meeting that if patients experience delays when using the NHS 111 service they will be called back and cases are reviewed to see what the outcome. In some cases a full end to end review is carried out to establish if the delay had any impact. National work is underway to try to get a Never Events framework for ambulance services in place.

YAS Communication with GP Practices

The CCG were alerted to incidents that had been raised by a GP practice regarding communication. The GP practice had not been informed of those patients that had been assessed by YAS staff but had not been conveyed to hospital. The new Lead Nurse at YAS was asked to carry out an investigation and has shared the outcome of this with the GP practice. A further meeting is planned to consider how short term improvements can be made and learning shared.

Nuffield Hospital

The team at Nuffield have done a large amount of work on development and implementation of the Local Safety Standards for Invasive Procedures which form part of a CQUIN. These are designed to support the NHS to provide safer care for patients undergoing procedures and reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. They do not replace the existing WHO Surgical Checklist but enhance it by looking at extra factors such as the need for education and training and enable trusts to review their current local processes for invasive procedures and ensure that they comply with the new national standards.

Nuffield was successful in achieving the 70% CQUIN target for staff flu vaccinations

Yorkshire Doctors Urgent Care (YDUC) and NHS 111

Data provided is detailed and informative whilst highlighting the challenges of the interdependencies of service provision. An increase has been noted in the urgency of responses requested of YDUC by NHS 111 and is to be reviewed again next month before any further action is taken.

Clifton Park Hospital

Clifton Park Hospital achieved the CQUIN outcomes for implementation and rollout of Local Safety Standards for Invasive Procedures (LocSSIPs) but were only partially successful in achieving the flu CQUIN with 60% of staff vaccinated.

The Contract Management Board received an update that they have recently undertaken some Human Factors training in theatres. A risk was highlighted relating to the challenges of recruiting to radiologist roles which is consistent with other providers and the national profile. Contingencies are in place to allow timely review and reporting of images.

Additionally, learning was identified from a complaint when a patient waited too long for a decision on undertaking surgery due to delay in recognising the limitations of the patients' social situation. The need for a comprehensive supportive rehabilitation plan which the organisation did not have the contacts to arrange was recognised. The learning is being shared nationally within the organisation.

The Retreat
The Quality and Nursing team have met with the senior management team at the Retreat following release of their communication describing the proposed changes to their services. Largely this focuses on reducing their bed base and developing a model for increased residential and community care. The staff consultation continues and the Retreat are committed to keep us updated.

Maternity

Work continues to progress the Local Maternity System. The CCG supported a recent engagement event, identifying service users that wanted to be involved in the Maternity Voices Partnership to support co-production of the Better Births work streams as well as identify which of the Better Births priorities have local importance. Perinatal mental health service provision was identified by women and their partners as requiring further development so the CCG was pleased to be able to update on the recent success in a recent bid submission which will result in development of existing services.

As is well known obstetric incidents can be catastrophic and life-changing, with related claims to the NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) scheme's biggest area of spend. Of the clinical negligence claims notified in 2016/17, obstetric claims represented 10% of the total spend on NHS claims and 50% of the value. Subsequently organisations providing maternity services were informed of a scheme to reward local services who take steps to improve delivery of best practice in maternity and neonatal services. Trusts able to demonstrate compliance against ten actions will recover an element of their contribution relating to the CNST maternity incentive fund. The CCG were required to review YTHFT's recent submission against the standards and provide written confirmation to NHS Resolution to support this.

Screening and Immunisations updates

2018/19 Flu Planning
Planning for the 2018/19 flu season continues with the York and North Yorkshire seasonal flu group continuing to meet regularly. The next meeting is planning the

communications strategy for next season's campaign. The CCG flu plan is being updated. This will set out the improvement trajectories in line with the Screening and Immunisation Local Improvement plan.

As national and local data vaccination uptake data demonstrates low flu vaccination uptake in the cohort of the under 65 year olds at risk, a deep dive is planned by PHE to understand the reasons for this.

The screening and immunisations team are planning to send all practices a survey monkey to identify barriers and challenges to vaccinating their patients and seek out celebrations and innovative practice. Vale of York CCG had already asked for this via practice communications and a Screening and Immunisations multiagency Operational group is being set up and several Practice Nurses have volunteered to be involved.

Breast Screening Programme
Due to a drop in performance in April and May for the Breast Screening programme further assurance was sought. This was due to a combination of the bad weather in March causing the cancellation of clinics and staff sickness.

In addition the CCG were made aware of a national incident relating to breast screening, where some women were previously incorrectly being randomised out of the programme. The service is running additional sessions to address this as well as ensuring that lessons are learnt from the investigation.

Radiology capacity has been highlighted as a risk previously at the Screening and Immunisations Oversight Group which also impacts on the capacity to read films. Newly qualified film readers are in post but require a second read of films by an experienced film reader; further recruitment continues.

Patient Experience Update

Vale of York CCG Complaints
7 complaints were registered in the CCG during March and April 2018:

- 1 complaint related to the BMI (Body Mass Index) and smoking threshold policy.
- 5 complaints related to communication/information and delays regarding Continuing Healthcare (CHC). Two of the complaints also included issues relating to CHC checklists carried out at York Teaching Hospital NHS Foundation Trust and a coordinated response was provided.
- 1 complaint related to a request for funding for a medication to be transferred between different CCGs

117 concerns/enquiries were managed by the CCG, including:

- 17 contacts referred to the CCGs decision regarding the prescribing of gluten free foods. Following consultation at the end of last year and having taken into account all the available information, the CCG decided to adopt the position

recommended by the DHSC (Department of Health & Social Care) which is, that gluten free bread and mixes will be available on prescription for patients with diagnosed coeliac disease. Whilst a few people who contacted Patient Relations were disappointed that the top up card scheme would cease, the majority of contacts were seeking clarification and most were pleased that there was still some provision for gluten free staples.

- 16 contacts were raising concerns and/or seeking clarity about the CCGs BMI/smoking thresholds for elective surgery.

- 5 contacts were from a persistent contactor which required no further action.

- 4 contacts were from GPs reporting NHS Standard Contract breaches by secondary care providers. The standard contract is crucial in ensuring that patients receive high quality care and making the best use of clinical time and NHS resources in both settings. Contract breaches occur when patients are being referred back to their GP because secondary care staff have discharged them without, for example, providing medication on discharge from hospital, failing to provide a fit note, not informing patients of the results of investigations/tests etc.

  To assist with this, NHS England have recently developed an information leaflet for GPs to give to patients when referring them to secondary care, which describes what they can expect when seeing a consultant or specialist at a hospital or community health centre.

- 2 compliments were received about GPs and shared with the staff involved at Elvington Practice and The Old Forge.

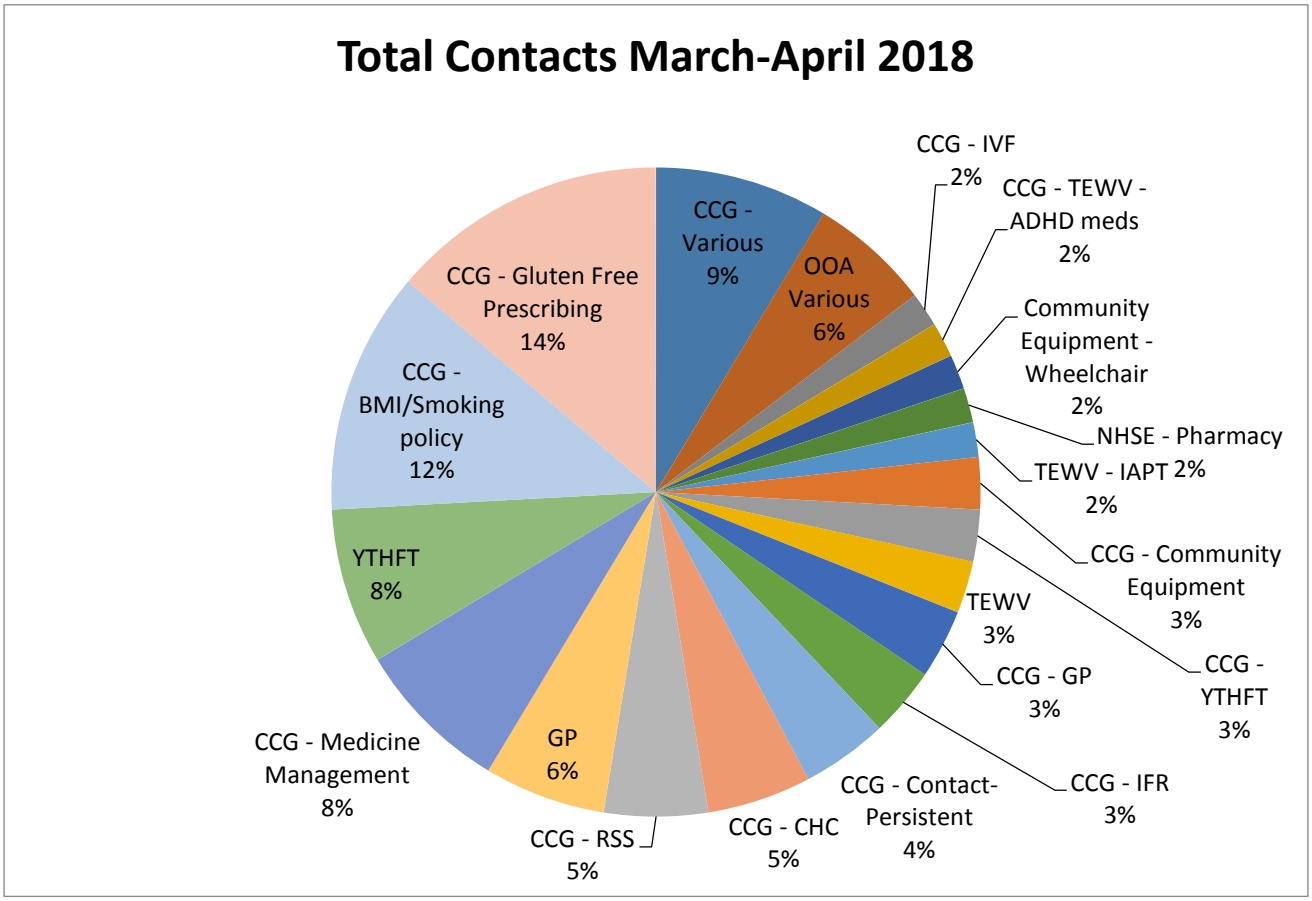
- 31 complaints/concerns were signposted to other organisations.

Action arising from complaints/concerns

- The CCG were contacted by a patient who was upset that their shoulder surgery was being postponed as they did not meet the BMI threshold. The CCG was able to confirm that hospital staff were correct in following the policy, however, on further investigation of the patient's circumstances it was found that the procedure was a continuation of surgery performed prior to the CCGs BMI threshold policy being implemented. The surgery was able to go ahead as planned.

- A patient contacted the CCG as surgery had been postponed in line with the BMI threshold, however, the patient explained that their BMI was higher due to muscle bulk. The CCG clarified the commissioning statement which explains that muscular people will have a higher BMI that is not thought to be a risk to health (muscle is denser than fat) and the patient met the criteria (on waist circumference) to have the procedure.

CCG activity for all types of contact during March and April is shown in the pie chart below.



Other Sources of Patient Feedback

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

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

Hospital	Rating (out of a score of 5)	Number of ratings
York	4.5	224
Scarborough	5	2
Malton	4	90
Nuffield York	3	3
Whitecross Court	5	1
Clifton Park	5	17
St Helen's	3	2

Patient Engagement Update

Internal stakeholder audit - 2018

In February 2018 an internal audit on stakeholder engagement was carried out. The aim of the audit was to evaluate the measures taken by the CCG to meet its legal obligations for stakeholder engagement, and how far those measures represent best practice.

The audit considered:

- How stakeholder are identified and engaged
- How the results of stakeholder engagement are utilised during decision-making
- Whether the CCG meets its objectives in engaging with the local population
-

The function was given **significant assurance**. The audit stated that it is clear that the CCG has reflected on the requirements to involve stakeholders within the commissioning process, in line with the Health and Social Care Act (section 14Z2) and Patient and Public Participation in Commissioning Heath and Care: Statutory Guidance for Clinical Commissioning Groups and NHS England. The CCG has demonstrated a proactive approach to developing its stakeholder engagement activities. It highlighted that the CCG has shown commitment to upholding the spirit of the engagement obligations, and has demonstrated that engagement is conducted and the results utilised in a meaningful way. That is, the CCG proactively seeks input from stakeholders, and that input is used as a consideration during decision making.

There were also a number of recommendations which focus on how the results of stakeholder engagement are reported and published, and clearer articulation of the link between the stakeholder engagement programme and the impact on health inequalities. These have been responded to and collated into an action plan which will be monitored by the audit team.

Recent engagement April, May and June 2018

We continue to get out and about and talk to our community and have presented at a number of forums and events:

- Tommy Whitelaw, Person-centred care and the ‘What matters to you?’ conversation, 7 June 2018
- Ageing Well Forum, 5 June 2018
- Mumbler event – talking to parents about maternity services and becoming involved in the Maternity Voices Partnership, 30 May
- Acomb Library Health and Wellbeing day, 18 May 2018
- Voluntary Sector Forum, 8 May 2018

- East Riding Carers' Advisory Group, 14 May 2018
- GP engagement session, North Locality, 26 April 2018
- Raising awareness of and support for carers, health and social care professionals' training, 30 April 2018
- Healthwatch Assembly, Talks given by Dr Kev Smith, Sarah Goode and Sarah Fiori, 24 April 2018
- Selby Posterngate Patient Participation Group, 10 April 2018
- York Older People's Assembly, 9 April 2018

NHS 70 - engaging with the local community about their health and wellbeing

On 5 July the NHS is turning 70 and we are holding celebrations across York. It is an opportunity to celebrate the achievements of the NHS, but also a call to action to help raise awareness around a number of key priorities. Within the context of NHS 70, we will collectively be engaging with our population on a number of themes including:

- How to keep yourself and your community healthy and well (self-care, prevention, exercise, diet)
- How to help support your own mental health and well being
- Tackling loneliness and isolation

We have held a number of meetings to work collaboratively across the council, health and voluntary sector. It was agreed to hold a number of joint events to engage with the local community about their health and wellbeing. A double-decker bus will visit various sites in York, Selby and Easingwold in the coming weeks, and members of the public are being invited to come along to receive healthcare advice, signposting and health check-ups. We are focusing on legacy and on what the population can do to help keep themselves and their community healthy and well. We are also encouraging our GP practices, Libraries and Care Homes within the patch to hold an event on the day.

Date	Time	Location	Event
1 June	9.30am-4pm	Central York and Acomb	Health and Wellbeing bus tour – with TEWV, The local authority and CCG
8 June	3.30pm-5pm	West Offices, York	Employers' meeting to talk about health and wellbeing of the workforce

11 June	11am-1pm	West Offices, York	Sign our NHS70 birthday card, complete am NHS70 pledge card
12 June	9.30am-4pm	The University of York	Festival of Ideas. One Planet York,
15 June	10am-3pm	Easingwold and York North	Health and Wellbeing bus tour – with TEWV, The local authority and CCG
18 June	10am-2pm	Selby	Health and Wellbeing bus tour – with TEWV, The local authority and CCG
2 July	10am-12pm	East Riding	Celebratory tea and cake at East Riding Carers Advisory Group
3 July	1.30pm-3.30pm	Pocklington	Celebratory tea and cake at Pocklington Carers Advisory Group.
2-6 July	TBC	Explore York Libraries	Explore York Libraries will be hosting NHS7tea parties at York, Burnholme, Clifton and Acomb.
5 July	1pm-3pm	West Offices York	NHS 70 celebrations at West Offices foyer.
7 July	1.30pm-4.30pm	Selby War Memorial Hospital	Sign our NHS70 birthday card, complete an NHS70 pledge card.
7 July	11.30pm-4.30pm	Copmanthorpe Carnival	Sign our NHS70 birthday card, complete an NHS70 pledge card.
10 July	10am-12pm	Pickering Library	Sign our NHS70 birthday card, complete an NHS70 pledge card.

Patient stories – forward plan 2018/19

As part of commitment to ensuring the patient, carer and public voice is heard within the organisation, we present a patient story as a regular item at the start of each Quality and Patient Experience Committee (QPEC).

Within the 2017-18 year we heard a patient story from a parent carer, a family member of a resident of a care home who was part of the continuing healthcare assessment and the voice of child in care.

Below is a table to illustrate stories that have been presented, and future themes for the agenda.

Date	Patient story theme	Presenter	Medium	Comments
December 2017	Parent carer and special schools services	Patient 1	Video	Completed
Feb 2018	Safeguarding children	Karen Hedgely	Person and video	Completed
April 2018	Continuing Health Care (CHC)	Patient 2	Person	Completed
June 2018	EOLC	Jenny Brandom	Video	On going
August 2018	Mental health	Patient 3	Person	On going
October 2018	Carers story (East riding)	Victoria Hirst or Elaine Pierce	Passage read out	On going
December 2018	TBC	TBC	TBC	On going
Feb 2019	TBC	TBC	TBC	On going
April 2019	TBC	TBC	TBC	On going

Future themes

- Mental health services
- Care home – staff/resident
- Maternity services
- Accessing services with a learning disability
-

Patient story action plan:

Names and initials:

- Jenny Brandom (JB)
- Victoria Hirst (VH)
- Karen Hedgley (KH)
- Leo Stevens (LS)
- Denise Nightingale (DN)
- Michelle Carrington (MC)

Parent carer patient story, December 2017

No.	Details	Lead officer	Comments/update	Date	Progress
1.	Arrange follow up meeting with patient one to discuss next steps	JB and VH	Patient one happy with experience of being able to tell her daughter's story. Difficulties are with approaching transition and with social care	Meeting held in February 2018	**Completed**
2.	VH to arrange for copy of video to be sent to patient one	VH	Asked LS to provide copy and send to HB	May 2018	**Completed**
3.	Patient one to be placed in touch with the team within social services regarding a number of communication issues and feedback regarding transition in services	JB	Patient one some frustrations with communication and provision of services from CYC social services team. JB placed HB in touch with social service to progress daughter's assessment and to formally request a carer's assessment. JB contacted Karoline		**Completed**

			Silcock a Practice Manager for the Children Health and Disabilities Team, based at Tang Hall, who also manages the Social Workers in the Transition team. Patient one's experiences around transition for her daughter and shared by other parent carers. The Practice manager will discuss at her next team meeting about how the Council might engage better with parents at this time.		
4.	Place patient story on website	VH and LS	Patient stories section on the website is to be created. New web officer in post as of beginning of June.	By July 2018	**On-going**
5.	Place patient story piece within the engagement annual report	VH	Patient stories section has been added as an achievement for 2017-18 within the engagement annual report.	By April 2018	**Completed**
6.	Arrange a meeting for December 2018 to look at one year one	VH	Will arrange a meeting/lunch with those who have provided patient stories to discuss one year on.	Dec 2018	**On-going**

Safeguarding children, February 2018

No.	Details	Lead officer	Comments	Date	Progress

1.	Place patient story on website	VH/LS	Patient stories section on the website is to be created. New web officer in post as of beginning of June.	By July 2018	**On-going**
2.	Place patient story piece within the engagement annual report	VH	Patient stories section has been added as an achievement for 2017-18 within the engagement annual report.	By April 2018	**Completed**
3.	Karen Hedgley to provide future feedback of engagement to VH	VH/KH	KH will provide information as and when engagement occurs.	On-going	**On-going**

Continuing Health Care, April 2018

No.	Details	Lead officer	Comments	Date	Progress
1.	Arrange follow up meeting with patient two to discuss next steps	JB and VH	To be arranged	July/August	**On-going**
2.	Collate trend and feedback from patient relations on CHC to triangulate with patient story feedback	VH	Feedback provided on 27 April 2018.	April 2018	**Complete**
3.	Pass on feedback from patient story and comments to Denise Nightingale (Denise Nightingale) Executive Director	VH and JB	VH spoken to DN in May 2018.	May 2018	**Complete**

	for Joint Commissioning				
4.	DN to provide some context around improvements and forward plan with CHC team, to share with patient 2 and public.	DN	Awaiting content	June 2018	**On-going**
5.	Arrange training/development day at West Offices for CHC team	VH/JB	VH sent email to Anita Griffith on 21.5.18 asking for potential dates.	July 2018	**On-going**
6.	Dedicate item on future QPEC to CHC as per minutes to April QPEC	JB/MC	To decide QPEC agenda item and date	August 2018	**QPEC agreed to bring item to August meeting**

Quality in Care Homes

Out of Hospital Steering Group

As part of the out of hospital Steering group work it has been agreed that the SRCCG and VOYCCG will identify key areas of work where collaboration and joint working is beneficial for preventing unnecessary admissions from care homes and promoting flow/ discharge. The key schemes identified include the Care home Bed State Tool, the Red Bag initiative and React to Red. Quality leads from both CCGs are working closely together to ensure a joint up approach.

Care Home engagement:

The Senior Quality Lead has continued to visit care homes and attend a number of successful engagement events, including a party for residents in a home who recently achieved a CQC 'Good' rating as well as attending the Health Watch Assembly. This work ensures the care home strategy reflects residents and carer's priorities, sharing progress and celebrating achievements.

React to Red and Safety Huddles:

To date 22 care homes are currently undergoing training for React to Red. This includes approximately 660 eligible staff. 8 homes have achieved full sign off with all (244) staff trained and competent. Certificates have been awarded to recognise the success. One care home has achieved 189 days since the last acquired pressure ulcer. There are a further 9 homes recruited for the next cohort of training, starting in

June. Pressure ulcer awareness sessions are also booked for tenants, relatives, carers and staff at 4 independent living communities.

Post training evaluation continues to be positive with care staff reporting the training easy to understand, improving baseline knowledge of pressure prevention, recognition and actions to take. Homes from the new cohort are following example by previous participants and are making pressure ulcer prevention training mandatory for care workers as an annual refresher.

A monthly Pressure Ulcer Prevention Newsletter continues to be produced and circulated across the Care Homes which provides brief updates and recognises achievements of the React to Red participants.

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

A poster was presented at the Tissue Viability Society Conference in April 2018 which describes the experience of implementing React to Red with Safety Huddles in the pilot homes across the CCG. This was received well and has since been accepted by the Patient Safety Congress to be held in London during July 2018.

Supporting Care Homes

The Senior Quality Lead aims to play an active role in work that prevents non elective admissions. This includes support for domiciliary care organisations as well as Care Homes.

A pilot to support care homes not to dip stick urine continues to be led by the Infection Prevention Team. This aims to reduce the use of unnecessary antibiotics, promote appropriate antibiotic stewardship and links with good hydration

A Quality Improvement project to support the early identification and communication of deterioration in care home residents has now started in two care homes. This includes the use of a softer signs tool combined with National Early Warning Score (NEWS) and Situation, Background, Assessment, Recommendation (SBAR) communication tool. Supported by the Improvement Academy it is anticipated to build on work published by Wessex Academic Health Science Networks (AHSN) and include sepsis awareness.

In May a conference entitled “Recognising and Responding to Deterioration in Care Home Residents” (RAPID) was successfully was successfully led and delivered by the Senior Quality Lead in collaboration with the Improvement Academy. This brought together over 60 frontline health and social care staff from across the region to share ideas and good practice. Specifically the day related to recognition and response to deterioration, showcasing best practice, sharing innovative ideas and forming the basis of a network to drive improvement. The event was hosted in York with key Note speeches by the CCG’s Chief Nurse and Dr Andrew Phillips. Feedback was overwhelmingly positive and the possibility of repeating the event at a later date to share progress of the RAPID pilot is under consideration.

A bid for funding has been submitted via the Q community, if successful up to £30k may be awarded from the Health Foundation. The bid is already generating interest from across the Q Community with a number of supportive messages recognising the value in this area of work. The bid hopes to achieve support for extending scope of the RAPID work into the domiciliary care setting. Preliminary work has commenced, collaborating with a domiciliary care agency who employ 120 staff and have an education centre willing to support implementation.

Preparations for the roll out of the Red Bag initiative is planned to commence in summer 2018. Initial conversations with stakeholders have started with a project plan and the bags have been supplied from NHS England in readiness.

Supporting Carers
The Senior Quality Lead supported the Partnership Development Officer within the Carers Centre to structure a 'wellbeing adult carer hub programme'. This programme aims to support unpaid carers of all ages in York. A successful session was delivered using the React to Red resources. This received positive feedback and generated valuable discussion with opportunity for questions, answers and signposting. Further training and awareness sessions have been arranged to spread the message across more carers groups including staff supervising in sheltered housing.

Care Home Bed State Tool
This is described as a 'web based capacity portal' developed by NECS North of England Commissioning Support) in conjunction with NHS England North region and is aimed at reducing delayed transfers of care. The tool has been procured by NHS England and is free. It aims to enables care homes to share 'real time' bed availability with NHS providers and Local Authorities. The tool is now live and progressing alongside colleagues from the East Riding. The CCG is leading on this initiative with support from colleagues in North Yorkshire County Council (NYCC), City of York Council (CYC), East Riding County Council and YHTFT. Scarborough and Ryedale CCG are also now launching the tool. At the current time the uptake of homes is 51%. The VOY CCG is contributing towards a user group to inform on development of the tool and to support adoption and spread. Capacity reports which can be pulled from the system are not included in this paper as the data is not valid at the moment due to reporting anomalies.

The Partners in Care forum
The May meeting had a full agenda with good attendance from all stakeholders including colleagues from TEWV who will commence monthly standing agenda items alongside colleagues from York Hospital NHS Trust and the CHC Team. The Partners in Care Lessons Learned Bulletin continues monthly with contributions from the social care sector to ensure it is relevant and appropriate to the audience.

Health and Social Care Joint Working
The Senior Quality Lead continues to link with local authority colleagues as required to support action and improvement plans or where concerns are raised. This is

proving supportive to the care homes, ensuring appropriate interventions can be facilitated. Opportunities for joint working continue to be explored.

Equipment Selection in Community
This work continues led by the Chief Nurse for Hambleton, Richmondshire and Whitby CCG. The process for selection has been streamlined to simplify and standardise best practice whilst also realising significant financial savings. This work will extend to include the use of pressure relieving cushions and overlays. The Senior Quality Lead will lead on the mattress review group. A wider piece of work to ensure the quality perspective and good governance processes are integral in the commissioning agreements is progressing. It has been agreed that quality issues are to be shared in relation to the equipment contract and to ensure contracting arrangements reflect the needs of service users.

A case study looking at the benefits of using the Mercury Hybrid mattress within a Nursing Home commenced in early December. The home currently has 32 mattresses to trial and a number of cushions. A care home setting has not published a trial like this as yet and it is hoped will help inform on best practice.

Safeguarding Children

North Yorkshire Safeguarding Children Board:
The North Yorkshire Safeguarding Children Board last met on 19 March 2018.
The partnership data set was presented with some key messages:

Areas of strong performance or improvement:

- 12% reduction of in the number of inpatient admissions as a result of unintentional injuries;
- 17% decrease in the number of domestic incidents where a child was present;
- Re-referral rate remains low (14.7%) despite an 18% increase in the number of referrals to Children's Social Care.

Areas to be monitored:

- 18% increase in the number of referrals to Children's Social Care (to 1233 referrals), the quarterly average this year is 1115 per quarter, compared with 922 per quarter last year;
- 9% increase in the number of Child Protection Plans, at 490 was higher than any quarter in the last six years;

- For the year to date there has been a 75% increase in the number of hospital admissions related to alcohol-related harm, although the number of admissions remains relatively low (49 admissions).

Complex Case Processes
Unusually, NYSCB have three sets of complex case procedures running at the present time.

- **Ampleforth Abbey and School** - The Charities Commission has taken the unusual step of appointing an Interim Safeguarding Manager amidst ongoing concern regarding safeguarding arrangements at this establishment. The school and college have also been subject to an inspection by the Independent Schools Inspectorate. The inspection reports have now been published and highlighted significant failings with regard to safeguarding.

- **Army Foundation College, Harrogate** – it was reported in the national media that the court martials in respect of the instructors at AFC Harrogate were halted by the judge due to problems around evidential quality. Regardless of this disappointing outcome, the LSCB LADO process is ongoing, and partners will continue to work with the Tri-Service LSCB and Head of British Forces Children and Families Division to support improved safeguarding arrangements and processes. The army has commissioned a Non-Statutory Inquiry into the management of the allegations made in 2014. The Independent Chair for NYSCB has been invited to attend the Tri-Service LSCB meeting in June when the Inquiry report will be presented. Additionally, the Tri-Service Head of Safeguarding will be reviewing the safeguarding arrangements in all military settings where there are recruits under the age of 18. The outcome of both of these actions will be shared at a future meeting of this Board. Locally, work is ongoing with the regional nurse lead for military healthcare to strengthen safeguarding arrangements at key establishments for 16 and 17 year old recruits.

Serious Case Reviews/ Learning Reviews:

- The draft report for the SCR in relation to young person who took her own life whilst in a T4 CAMHS setting has been received from the author. There are some concerns from partners regarding the quality of the report and its presentation. Therefore it has been returned to the author with a request for further amendments to the report and a return to the LSCB within a short agreed timescale.
- The final draft report into the death of a baby where there were concerns regarding neglect has been shared with partner agencies as part of the consultation process. Once the final report is agreed actions will be monitored via the NYSCB Learning and Improvement sub group.
- Agreement has been given by the LSCB Executive to commission a Learning Lessons Review into the case of the Northallerton boys who have been convicted of conspiracy to murder. Terms of Reference for this review will be developed in conjunction with the Safeguarding Practice Review Group

City of York Safeguarding Children Board:

The Board last met on the 11th of April. A key item on the agenda was the draft proposals for the partnerships arrangements to be introduced prior to April 2019. The Chief Nurse has represented the CCG in the discussions with the LA and North Yorkshire Police regarding the development of these arrangements. The proposals were welcomed by Board members and further work is now underway to develop the plan for transition from CYSCB to the York Safeguarding Children Partnership.

Serious Case Reviews/ Learning Reviews

- LR (KR) Significant Incident Investigation: Key stakeholders continue to receive monthly progress reports from the review team. The Designated Nurse has received confirmation that NHS England will host a multi-agency action planning meeting to consider the recommendations arising from the report.
- AR Learning Lessons Review: The Designated Nurse is working with CYSCB Business Manager to secure the involvement of a suitably experienced Independent Reviewer to lead the review process. It is expected the Review will begin late July 2018.

Multiagency Information Sharing Agreement

The Designated Nurse continues to lead a task and finish group to ensure effective information sharing between NHS providers (TEWV, YTHFT and Yorkshire Doctors) and the Health Child Service, CoY LA. Progress is good with information sharing regarding children's attendance Out of Hours (Yorkshire Doctors -VOCARE) planned to commence mid- June.

Child Protection Information Sharing Project (CP-IS)

The NHS England CP-IS supports information sharing between certain unscheduled care settings and local authorities regarding children or unborn infants who are subject to Child Protection Plans or who are looked after.
As of May, York LA have 'gone live' with the project joining NY LA and the majority of local NHS providers.

Children in Care

Children in Care from Out of Area Placed within North Yorkshire:

There have been no further significant developments in terms of the private provider of residential care in Selby.

Timeliness of Health Assessments for Children in Care:

A detailed report regarding timeliness of both IHAs and RHAs can be found at Appendix *1.* The data indicates that the slight improvements in timeliness of IHAs in Q3 have not been sustained. Analysis of the data suggests that the delays continue to be seen in receiving requests for assessments and the necessary paperwork from the LAs. Once received the provider (YTHFT) has been responding within agreed timescales, these improvements have been sustained since Q2. Timeliness of RHAs demonstrates a similar pattern in that delays are largely due to administrative issues with CoY LA. The Designated Nurse continues to work with colleagues in both NY and York LA to address these underlying issues.
5.3 Health Passports for Children in Care**:**

The Designated Nurse has worked with York LA colleagues to agree a relaunch of Health Passports for all Children in Care, as of August 2018. This work has been

delayed due to review of the HCS and a need to secure agreement with public health colleagues regarding the HCS involvement in this project.

Primary Care:

Multi-Agency Risk Assessment Conferences (MARAC):
It has been recently brought to the attention of the Nurse Consultant that the sharing of MARAC conference minutes with GP Practice post conference has not been completed routinely since February 2018. This is due mainly to the difficulty in identifying the GP of the victim and any associated children but has been exacerbated by the change of the MARAC coordinator. This gap in information share and the risks associated with this is currently being addressed as a priority, whilst work continues to ensure that such issues do not arise in the future.

CQC Children Looked After and Safeguarding Review CQC Children Looked After and Safeguarding (CLAS) Reviews
North Yorkshire**:** Further updates against provider and CCG CQC CLAS action plans have now been received and submitted to CQC.There were 62 recommendations in total with the latest update indicating 43 have now been fully completed. Where action plans have not been fully completed there are some commonalities. For example where the recommendation requires changes of documentation and/or IT systems – such whole-scale changes necessitate engagement and action from a number of directorates or those which involve capital building projects.

City of York**:** A further update against the combined action plan has been requested. Progress against the plan will be shared at the next meeting of this committee.

Safeguarding Adults

Learning Disability Mortality Review programme (LeDeR)

The LeDeR annual report has been published alongside a stakeholder briefing paper

Annual Report Summary in brief:

The Learning Disabilities Mortality Review (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. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017. The programme is led by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that

further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24 years or from a Black or minority ethnic background) receive multiagency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. The most frequent role of those notifying a death was Learning Disability Nurse (25%), most commonly working in a Community Learning Disabilities Team.

Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

- Just over half (57%) of the deaths were of males
- Most people (96%) were single
- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement

Successes:

- The programme is a world first
- It involves families and carers from the outset and gathers information from across health and care organisations to understand what led to the person's death.
- Improvement in health pathways is being undertaken.
- In 2017 there was published guidance on reasonable adjustments and diabetes
- A dysphagia pathway published soon which seeks to reduce causation of aspiration pneumonia
- Following later in 2018 there will be pathways for sepsis and constipation

Local Picture

A multi-agency panel process to complete a review is being trialled in York. An options paper is being written to decide on the best way forward to progress reviews across North Yorkshire. Some funding will be made available to CCGs to support reviews.

The database has been cleansed and updated and the CCG has one reported child death and nine reported adult deaths.

Sexual Assault and Abuse Services

NHS England launched their strategic direction for sexual assault and abuse services (2018- 2023) in April. The Safeguarding Designated team contributed to the information gathering to inform the strategy in 2017.

A key focus for the Strategic direction is considering how pathways of care need to change to ensure those who have experienced sexual assault and abuse have appropriate and timely access to services throughout their lifetime. It also outlines how services need to evolve to ensure that as much as possible can be done to safeguard individuals and to support them at times of crisis and in particular, at the point of disclosure.

Underpinning the strategy are six core priorities:

- Strengthening the approach to prevention
- Promoting safeguarding and the safety, protection and welfare of victims and survivors
- Involving victims and survivors in the development and improvement of services
- Introducing consistent quality standards
- Driving collaboration and reducing fragmentation
- Ensuring an appropriately trained workforce

The delivery will be supported by a detailed delivery plan which will be published later on this year. (The accompanying letter is available as Appendix 2)

Local Picture

The CCG was invited to a multi-professionals meeting chaired by Rachel Maskell MP in February 2018 – the CCG was represented by the safeguarding designated nurses. Highlighted at the meeting was that there was a lot going on in the City to support people but it lacked a joined up approach.

In May 2018 the Designated Professional for Adult Safeguarding facilitated a meeting between TEWV head of service for adults; TEWV trauma-informed care lead nurse and Survive (charity dedicated to supporting survivors of sexual abuse, assault and rape) Chief Officer. The meeting proved to be a useful exchange of information around each other's services and actions were formulated around how they will work better together going forward.

Prevent

CONTEST – UK's Strategy for Countering Terrorism - revision published June 4th 2018

The new CONTEST strategy is the result of a fundamental review of all aspects of counter-terrorism following the attacks in London and Manchester during 2017 and the lessons learned from them.

The CONTEST framework comprising Prevent, Pursue, Protect and Prepare work strands, remains an effective way to organise our counter-terrorism actions. Each of these connected work strands reduces an element of the risk from terrorism (intent, capability, vulnerability and impact) and collectively they provide a balanced and comprehensive end to end response to the threat faced by the UK.

The revised objectives of Prevent are to:

1) Tackle the causes of radicalisation and respond to the ideological challenge of terrorism - make communities more aware of and resilient to terrorist narratives, with responses tailored to local risks and that there are no safe places for terrorists online.

2) Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support - all parts of the statutory system can address the risks of radicalisation appropriately, with the continued provision of the right timely support for those at risk of being drawn into terrorism.

3) Enable those who have already engaged in terrorism to disengage and rehabilitate - aims to reduce re-offending and improve the reintegration of those already engaged in terrorism or who support it.

No change to Channel processes and no change to Dovetail programme (enabling local authorities to hold and manage database of referrals)

Three Multi-Agency Centres (MAC) led by police and MI5 will be established to trial a new domestic operational model that addresses the shift in threat, those on 'watch list'. The MAC pilots will test multi-agency approaches, at both national and local level and trial different ways of sharing information with a broader range of partners, including government departments and local authorities.

Local Picture:

Prevent Strategic Board met 10th April

Key points from meeting:

- The draft counter-terrorism local profile (CTLP) was discussed
- Information sharing/gathering for the CTLP will continue on quarterly basis to make it a 'live' document
- Far-right extremism will be a focused priority for the Board based on the extent of identified risk

There will be a Channel development day held in June 2018 for both North Yorkshire and City of York panel members.

A train the trainer programme is being planned for roll-out of the Prevent graphic novel with accompanying short-films. A briefing is included in this year's 'hot topics' training for primary care.

City of York Safeguarding Adults Board met on June 1st 2018.

Key points:

- Safeguarding stories from CYC and NY Police
- Updates on the business and delivery plans
- Safeguarding week w/c June 25th – list of activities to be circulated
- Revised safeguarding operational guidance signed off
- Initial proposal for public engagement by SAB agreed as requiring further discussion

North Yorkshire Safeguarding Adults Board next meeting is June 20th 2018

NYSAB announced the appointment of a new SAB Chair – Dr Sue Proctor.

Current safeguarding reviews with CYC SAB and NY Community Safety Partnership

- The fatal incident occurring in North East Lincs involving an elderly man allegedly killed by his grand-daughter is now progressing under the Serious Incident Framework. The grand-daughter had a history of complex mental health problems but was not in care services at the time of the incident. It was not deemed to fit the criteria for an independent statutory review.
- The Domestic Homicide Review of the death in Selby is progressing; an independent author has been recruited; and regular panel meetings established.
- A learning lessons review is in progress in respect of the death of a vulnerable man with complex health issues who died following an attack outside a York pub in 2016. Chronologies are almost completed and dates for a workshop being arranged.
- A review is progressing following the death of a young woman in hostel accommodation in York. She had diabetes, a mild learning disability and a history of drug & alcohol misuse. A professionals meeting is being arranged for those involved in her care.
- The coroner's inquest into the death of young man with a learning disability and epilepsy reached a verdict of natural causes with no neglect. His care in Mencap services was jointly funded by CYC and the CCG. The coroner made

reference to poor communication between the Mencap; CYC and the family. A meeting has been arranged with the family for later in June to develop plans for an independently facilitated (Foundation for Families) learning workshop.

Mental Health

Children and Young People

CAMHs (Child and Adolescent Mental Health Services) and Community Eating Disorder Service

Discussions are still in hand with TEWV regarding improvement in performance against national and local indicators: TEWV is preparing a demand and capacity gap analysis against the benchmark of the staffing model drawn up by the Royal College of Psychiatrists. There remains concern regarding waiting lists for treatment once assessments have been completed, and the CCG will invest £50,000 in the emotional pathway (depression, anxiety, self-harm etc) in 2018/19. TEWV will recruit two Band 6 staff to work with patients on the waiting list. TEWV is also diverting £50,000 funding into the emotional pathway to fund a psychologist to work on earlier assessments and therapies. From June 2018 there will be group work with some of the young people on the emotional pathway waiting list. All these will have positive impacts on waiting time and outcomes for children and young people.

Reports about CAMHS and autism assessments will be considered by Finance and Performance Committee in June 2018 and the outcome of discussions will be reported to Committee in August 2018.

Early discussions are under way about a GP training event around CAMHS pathways: each of the local authority areas within the CCG has differing service offers wrapped around the CAMHS service, which is a source of confusion. The training event will offer the opportunity for improved engagement across the system of support for children and young people.

Work is being undertaken to evaluate and make recommendations around psychology liaison at York Hospital: psychology liaison services work with patients with long term conditions, eg epilepsy, diabetes, cystic fibrosis to support their emotional and mental well-being in managing their condition. The support at the hospital is limited mainly to diabetes, although nearly 1000 children and young people are identified as potentially benefitting from support. The work being undertaken will aid an evaluation of the long term benefits, and potential cost savings, of a more broadly based service.

A workshop on performance improvement for eating disorders is being held on 28 June, to finalise an action plan to consider performance issues, and also wider system issues around therapy timetables and length of time spent working with individual patients.

Special Educational Needs and Disabilities (SEND)
Work continues on improving provision of annual health checks for those over 14: work with selected GP practices has seen an increase in attendance for annual health checks improve to over 80%.

A workshop on transitions, 'What would good look like', is planned for late June 2018, and will be fed back through the North Yorkshire and York SEND Health network, to inform how children's and adult services work better together to provide a smooth transitions into adult services. Transition into adult health services can be a difficult period for young people and their families/carers with differences in availability, access standards and approaches towards care differ between paediatric and adult services.

Preparations continue for the anticipated joint CQC/OfSted inspection of City of York area inspection of SEND; this will examine the joint arrangements locally for identify SEND, providing high quality support, and improving outcomes for children and young people.

Senior Quality Lead – Children's and Young People
The Quality and nursing team are currently out to advert for this post. The post holder will lead on developing a Children's Strategy, working with a number of key stakeholders, parents and children across the Vale of York CCG geography. In addition the post holder will lead on key pieces of work including development and transformation of the community nursing service working closely with the Health Child Programme services.

Adult Mental Health

IAPT (Improving Access to Psychological Therapies)
The CCG worked with Tees and Esk and Wear Valley NHS Foundation Trust (TEWV) in supporting an external review in 2017 by NHSE for the IAPT services. As a result a significant action plan was put in place to address a whole range of issues related to the service model, waiting times and access. The service has made significant progress achieved the agreed local target for access by the end of March 2018 at 15%. In clearing the waiting list a large number of patients (around 40%) did not take up the service. TEWV are in the process of auditing the reasons for this to inform future practice and waiting list management.

Early Intervention in Psychosis (EIP)
The CCG has invested additional funding for the EIP service to expand the range for therapies available for patients and their families in the EIP team. This will move the service closer to providing fully NICE compliant service. TEWV are currently in the process of recruitment.

Research and Development

The CCG have served notice on the Research and Development (R&D) service currently provided by East Riding Clinical Commissioning group. The quality and

nursing team are planning to recruit to the post, internally and will be recruiting to a year's secondment to ensure that we are compliant with this statutory function.

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Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Audit Committee

Date of Meeting	26 April and 23 May 2018
Chair	Sheenagh Powell until 23 May 2018 Phil Goatley from 3 July 2018

Areas of note from the Committee Discussion

26 April

- The Committee approved the Detailed Scheme of Delegation.
- The Committee received the draft Annual Report and Accounts 2017-18 (including the Remuneration Report, Annual Governance Statement and Head of Internal Audit Opinion).
- The Committee had a pre-meet with External Audit at which no adverse issues had been raised and they had noted a good working relationship with CCG staff.

23 May

- The Committee approved revised terms of reference subject to minor amendments.
- The Committee received the Annual Counter Fraud Report 2017/18.
- The Committee approved the updated Scheme of Delegation.
- The Committee received the External Audit Audit Completion Report.
- The Committee received the Head of Internal Audit Opinion.
- The Committee approved the Annual Report and Accounts 2017/18.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 26 APRIL 2018 AT WEST OFFICES, YORK

Present

Sheenagh Powell (SP)	Chair
David Booker (DB)	Lay Member and Chair of Finance and Performance Committee
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust - Secondary Care Doctor Member

In attendance

Cath Andrew (CA)	Senior Manager, Mazars
Helen Kemp-Taylor (HK-T)	Head of Internal Audit
Mark Kirkham (MK)	Partner, Mazars
Anne Ellis Playfair (AEP)	Audit Manager, Audit Yorkshire
Tracey Preece (TP)	Chief Finance Officer
Keith Ramsay (KR)	Lay Member, Outgoing Chair of the CCG
Michèle Saidman (MS)	Executive Assistant

Apologies

Abigail Combes (AC)	Head of Legal and Governance

Preceded by two meetings: Committee members with TP for the annual review of Internal Audit and Counter Fraud effectiveness, followed by meeting of Committee members with External Audit.

STANDING ITEMS

1. Apologies

As noted above.

2. Declarations of Interest

There were no declarations of members' interests in relation to the business of the meeting. Declarations of interest were as per the Register of Interests.

3. Minutes of the meetings held on 7 March 2018

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

The Committee:

Approved the minutes of the meeting held on 7 March 2018.

Unconfirmed Minutes

4. Matters Arising

SP referred to the minute regarding the draft *Consideration of 'Going Concern' Status 2017-18* and noted that, although the full report *Consideration of Directors' Declarations including 'Going Concern' Status 2017-18* was not included with the meeting papers, she had received the report which had been approved by the Governing Body on 5 April 2018 and forwarded to the external auditors.

Constitution, Scheme of Delegation and Detailed Financial Policies: The Committee asked that AC feedback on progress at the May meeting.

Annual Review of Internal Audit Charter and Working Together Protocol: HK-T proposed, and members agreed, that the "user friendly" version be produced when SP's and TP's replacements were in post.

Periodic Report and Internal Audit Reports: DB advised that he had not yet discussed the role of pharmacists with the Joint Medical Director. In view of the CCG's new structure TP suggested that he discuss this with the Executive Director of Primary Care and Population Health.

Internal Audit and Counter Fraud Effectiveness Review: SP referred to the pre-meet reported above and noted that it had been agreed that the questions were relevant to the Committee but not to the wider organisation. TP would write up the comments for her successor and for reporting to the Committee as appropriate.

Control Mechanisms for Business Cases – clarification regarding the process for Prescribing Indicative Budgets: TP reported that an internal CCG meeting had considered the Scheme of Delegation was appropriate for all primary care budgets. She noted that the Primary Care Commissioning Committee had received an update on Prescribing Indicative Budgets and had a standing agenda item on primary care budgets. TP explained that all spend on primary care would be reported to the Primary Care Commissioning Committee and that as such Prescribing Indicative Budgets would also be reported. SP confirmed that she was content as long as conflicts of interest were considered in public.

Partnership Commissioning Unit Transition Audit Plan: SP reported that she had received no further response from the North Yorkshire CCGs' Audit Chairs but noted receipt of reports on the Partnership Commissioning Unit.

Procurement Policy: TP advised that she would ask AC to progress inclusion of the Integrated Support and Assurance Process in the CCG's Procurement Policy. *Post meeting note: TP emailed AC 27 April.*

Audit Yorkshire Minutes: KR sought assurance that one of the CCG's Lay Members would be invited to represent NHS Vale of York CCG at Audit Yorkshire Board meetings to replace SP. In response to TP noting that she did not receive the meeting papers despite being SP's deputy, HK-T agreed to discuss the CCG's representation with the Accountable Officer. SP also referred to the fact that the Committee did not receive the Audit Yorkshire Board minutes due to a number of commercial in confidence items and suggested that these be considered in a separate private meeting so that the main minutes could be shared. HK-T agreed to progress this approach.

The Committee:

Noted the updates and associated actions.

5. Internal Audit Progress Report and Internal Audit Reports

In presenting the progress report which included a summary of performance against the 2017/18 plan, AEP confirmed the expectation that the programme would be delivered in full to inform the Head of Internal Audit Opinion. AEP noted that the Information Governance Toolkit had received a Significant Assurance Opinion; a number of recommendations related in particular to data flows, readiness for the General Data Protection Regulation and the new toolkit.

SP referred to the Partnership Commissioning Unit Continuing Healthcare that was still outstanding for the four North Yorkshire CCGs noting that NHS Vale of York CCG had, in addition to seeking assurance on data quality and financial payments, requested three other facets. AEP confirmed that the reports on these facets – transition governance, continuity of services moved in-house and data management – were in progress and would each receive a separate audit opinion.

AEP reported that the opinions on the four draft audit reports were: Significant Assurance for Quality Assurance, Limited Assurance for Continuing Healthcare Data Quality, Significant Assurance for Budgetary Control and Key Financial Systems and Significant Assurance for Stakeholder Engagement. She confirmed that these were not expected to impact on the Head of Internal Audit Opinion.

HK-T advised that she expected the Head of Internal Audit Opinion to be Significant Assurance overall but with only certain remaining audits having Limited Assurance due to the ongoing work.

AK referred to the audit of the Commissioning Plan including QIPP currently in progress and suggested that the QIPP audit would be more timely earlier in the year so that lessons learnt could be incorporated in the following year's planning. Members supported this proposal.

The Committee:

Received the Internal Audit Progress Report and Internal Audit Reports noting the expectation that the full plan would be completed to inform the Head of Internal Audit Opinion.

6. Annual Report and Accounts 2017-18

Draft Annual Accounts

TP reported that the draft Annual Accounts for 2017-18 had been submitted to NHS England on 23 April, before the national deadline of 24 April. From the financial performance perspective the accounts were in line with the £20.1m deficit position; the financial indicators were detailed in Note 19.

TP highlighted that changes had been made in the Hosted Services notes in the accounting policies in line with organisational changes throughout the year. This would be subject to scrutiny by External Audit with particular reference to accurate reflection of the part-year and full-year effects, for example the Partnership Commissioning Unit Continuing Healthcare being brought in-house from 1 February 2018.

TP expressed a level of confidence in respect of Purchase of Healthcare and Primary Care under the Key Areas of Estimation Uncertainty but expressed concern about Continuing Healthcare due to the Limited Assurance audit report and the ongoing transition. In respect of the latter TP reported that the QA system was currently being established in-house, led by the Head of Contracting and Analytics and supported by a specialist interim agency staff member and, although there would be no material variations to affect the bottom line, there could be some impact through 2018-19. She referred to the previously reported methodology agreed by the four North Yorkshire CCGs' Chief Finance Officers and noted that errors would be corrected for 2018-19. CA added that there were no major errors from the early audit work on Continuing Healthcare.

Draft Analytical Review

TP reported that the main variances were explained in the analytical review. She additionally clarified that the three compulsory redundancies at Note 4.3 related to Partnership Commissioning Unit exit packages, separate provision had been made for the estimated costs of the Governing Body restructuring and a number of unnecessary lines and columns had been removed. There had been no negative responses in respect of the Related Parties Note and there were no Better Care Fund issues. TP highlighted that for 2018-19 all information would be in the CCG's ledger in relation to those areas previously with the Partnership Commissioning Unit which would provide a greater level of assurance.

Review of losses and special payments

TP presented the report which informed the Committee of the losses and special payments included in the 2017-18 annual accounts which had been notified to the CCG finance team as part of the year end procedures. The entries in the accounts were for 37 cases of administrative write-offs totalling £41,101.39 and one compensation payment of £1,026.91. The former related to the 50% risk share with York Teaching Hospital NHS Foundation Trust for unrecoverable overseas visitors' charges in accordance with national guidance. TP confirmed that all possible efforts had been made to pursue the costs and that assurance on the York Teaching Hospital NHS Foundation Trust's debt recovery policy had been sought and received through Contract Management Board. The latter related to the actual cost of an Employment Tribunal being higher than the compensation payment in the 2016-17 year-end accounts. Following the Committee's approval of the losses and special payments the Chief Finance Officer would sign the official form and entry in line with the Scheme of Delegation and policy.

Draft Annual Report (including Remuneration Report, Annual Governance Statement and Head of Internal Audit Opinion) and Annual Report Checklist

TP explained that the draft Annual Report and Annual Governance Statement had been considered by the Executive Committee noting that the checklist was also presented to provide assurance. She reported that notification had been received the previous day of the requirement to include trade union time but noted that this was zero for the CCG. The draft Annual Report had been submitted on 20 April in line with national guidance.

Members sought and received clarification about the off-payroll services and associated notes.

TP reported that the Annual Report could be further updated prior to the final submission in May. The final version would be formatted for publication.

HK-T referred to the earlier discussion on the Head of Internal Audit Opinion.

TP noted that the Governing Body had delegated authority to the Audit Committee meeting on 23 May to approve the final and audited Annual Report and Accounts 2017-18. The national submission date for final documents was Tuesday 29 May at 9am for the accounts templates and 12 noon for the Annual Report and Accounts, immediately after a bank holiday. The CCG was therefore aiming to make all submissions by close of play on Friday 25 May.

The Committee:

1. Received the draft Annual Accounts and Analytical Review.
2. Noted and approved the entries on the Losses and Special Payments Register.
3. Received the draft Annual Report noting that amendments could be made prior to submission.
4. Expressed appreciation to the staff who had worked on the Annual Accounts and Annual Report.

7. Detailed Scheme of Delegation – Updated and Aligned

TP referred to the fact that since the Committee had last approved the full Detailed Scheme of Delegation in April 2017 a number of minor amendments had been made to align job titles, include the disestablishment of the Partnership Commissioning Unit, include the outputs of internal audit reports and ensure alignment with other policies. These smaller changes had been reported to the Committee either through a 'changes only' paper or verbally and recorded in the minutes. The current full Detailed Scheme of Delegation with a few further minor amendments to ensure full alignment with previous approvals and decision-making and to keep job titles up to date was now presented. It would be updated accordingly as the new governance structures evolved.

TP highlighted a particular addition under section 3.Non Pay Expenditure to allow for the specific delegation to North of England Commissioning Support, the CCG's provider for Individual Funding Requests.

Members sought and received clarification on a number of aspects of the Scheme of Delegation. KR additionally highlighted previous concerns raised at the Remuneration Committee regarding consultancy appointments. TP explained that the Scheme of Delegation in this regard was aligned with NHS England guidelines. The Executive Committee had overall control and management of deployment of running costs budgets to deliver the CCG's objectives within resources. The Remuneration Committee would only have a role in the event of off payroll employment at Governing Body level. In response to SP referring to her previously concerns about the fact that there was no lay membership on the Executive Committee and the level of delegation, TP noted that the Scheme of Delegation could be changed if the current levels were considered inappropriate.

The Committee:

Approve the Detailed Scheme of Delegation.

8. Key Messages to the Governing Body

- The Committee approved the Detailed Scheme of Delegation.
- The Committee received the draft Annual Report and Accounts 2017-18 (including the Remuneration Report, Annual Governance Statement and Head of Internal Audit Opinion).
- The Committee had a pre-meet with External Audit at which no adverse issues had been raised and they had noted a good working relationship with CCG staff.

The Committee:

Agreed the above would be highlighted by the Committee Chair to the Governing Body.

9. Next meeting

1pm on 23 May 2018 at West Offices.

SP expressed appreciation to TP for her work for the CCG and contribution to the Committee and wished her well in her new role as Finance Director at the Joseph Rowntree Foundation.

NHS
Vale of York
Clinical Commissioning Group

MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 23 MAY 2018 AT WEST OFFICES, YORK

Present

Sheenagh Powell (SP)	Chair
David Booker (DB)	Lay Member and Chair of Finance and Performance Committee
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust - Secondary Care Doctor Member

In attendance

Cath Andrew (CA)	Senior Manager, Mazars
Michael Ash-McMahon (MA-M)	Acting Chief Finance Officer
Abigail Combes (AC)	Head of Legal and Governance
Jamie Darnton (JD) – items 1 to 7	Local Counter Fraud Specialist, Audit Yorkshire
Helen Kemp-Taylor (HK-T) - part	Head of Internal Audit, Audit Yorkshire
Mark Kirkham (MK)	Partner, Mazars
Phil Mettam (PM) – item 23	Accountable Officer
Steven Moss (SM) – items 1 to7	Head of Anti-Crime Services, Audit Yorkshire
Anne Ellis Playfair (AEP) - part	Audit Manager, Audit Yorkshire
Keith Ramsay (KR) – item 23	Lay Member, Outgoing Chair of the CCG
Michèle Saidman (MS)	Executive Assistant

Unless stated otherwise the above are from NHS Vale of York CCG

The agenda was discussed in the following order.

1. Apologies

There were no apologies.

2. Declarations of Interest

There were no declarations of members' interests in relation to the business of the meeting. Declarations of interest were as per the Register of Interests which SP noted including her declaration as Vice Chair and Chair of Audit Committee for NHS Harrogate and Rural District CCG.

3. Minutes of the meetings held on 26 April 2018

The minutes of the meeting held on 26 April were agreed.

The Committee:

Approved the minutes of the meeting held on 26 April 2018.

Unconfirmed Minutes

4. Matters Arising

Constitution, Scheme of Delegation and Detailed Financial Policies: AC advised that a report on the committee structure would be presented to the Governing Body at its meeting on 5 July. She reported that the CCG's Constitution and Scheme of Delegation had been updated and submitted for approval to NHS England noting that she had requested permission to publish the unapproved version in view of the new committee structure.

Procurement Policy: AC explained that a Procurement Strategy was being developed which would include detail and requirements of the Integrated Support and Assurance Process (ISAP) instead of incorporating this in the Procurement Policy as it was not relevant to all procurements.

Audit Yorkshire: DB reported that he had agreed to attend the Audit Yorkshire Board until the new Audit Committee Chair was in post.

A number of matters were noted as complete, ongoing or not having reached the scheduled date.

The Committee:

Noted the updates and associated actions.

5. Audit Committee Work Plan

In referring to the work plan MA-M reported that the Governing Body had requested addition of cyber security assurance. It was agreed this would be included under Corporate Governance and reported annually unless events required additional reporting. AC noted that a formal Information Management and Technology Strategy was also required in this regard. *Post meeting note: This has been added to the work plan with a proposed date of the November/December meeting.*

In response to SP enquiring how a cyber attack would be reported AC advised that eMBED would notify the CCG. A data protection breach would be reported through the General Data Protection Regulation and a minor breach, such as absence of patches on a machine would be managed through contracts. Overall it was agreed that management of cyber security fell within the remit of the Governance Team with the support of others.

SP noted she had agreed that the annual review of the Internal Audit Charter and Working Together Protocol be deferred until the new Audit Committee Chair and Chief Finance Officer were in post.

Meeting dates would be added to the work plan when the new Audit Committee Chair was in post.

The Committee:

Noted the update on the Committee work plan.

6. Audit Committee Terms of Reference

AC presented the revised terms of reference noting that cyber security assurance would be added to the key duties as above. Following discussion of the proposed amendments and further additions requested by members, AC agreed to circulate a revised draft for final approval prior to the terms of reference being included in the committee structure report to the Governing Body on 5 July 2018. *Post meeting note: The revised terms of reference were circulated immediately after the meeting.*

The Committee:

Agreed amendments to the revised terms of reference which would be circulated for final approval.

COUNTER FRAUD AND SECURITY

7. Annual Counter Fraud Report 2017/18 (including CCG's Self Review Tool for 2017/18)

SM referred to the report which was presented in accordance with the requirement for an annual report and provided a summary of proactive, strategic and reactive counter fraud work performed during 2017/18. He noted that the CCG's Counter Fraud Self Review Tool, outlining the organisation's self-assessment against the NHS Counter Fraud Authority's Standards for Commissioners, was included as an appendix.

In respect of the Counter Fraud Self Review Tool, submitted at the end of March 2018, SM highlighted that the overall assessment was 'Green' as the CCG felt it had fully met 18 of the standards, partially met five and recorded a neutral response against three. He advised that work was taking place to address the issues identified in the five standards assessed as partially compliant.

The Committee:

Received the Annual Counter Fraud Report 2017/18

SM and JD left the meeting

FINANCE GOVERNANCE

8. Review of Losses and Special Payments

MA-M advised there were no losses or special payments to report.

The Committee:

Noted there had been no losses or special payments.

9. Update and Assurance on Key Financial Policies

MA-M noted that this would be covered at agenda item 11 below.

10. Review Progress Against Financial Recovery Plan

MA-M reported that a draft Financial Recovery Plan had been submitted as part of the Operational Plan submission at the end of March and that feedback had been received from NHS England requesting that this be refreshed, mainly in respect of accessing the Commissioner Sustainability Fund and plans to reach a 1% cumulative surplus. The draft Financial Recovery Plan had been updated accordingly and the CCG planned to return to an in-year breakeven position in 2018/19 with receipt of Commissioner Sustainability Funds and in 2020/21 to an in-year 1% surplus without this support in any future year. With this continued level of improvement the cumulative deficit was planned to be repaid in 2026/27 with the CCG then reaching a 1% cumulative surplus. MA-M reported that the updated draft Financial Recovery Plan would be presented to the Finance and Performance Committee the following day and noted that it also took account of the context of the PwC reporting on the York and Scarborough Health Economy. A further draft Financial Recovery Plan would be submitted to NHS England at the end of May.

MA-M referred to the CCG's £14.0m control total for eligibility for the Commissioner Sustainability Fund and explained that there were three conditions/measurements to access this: deliver a financial plan consistent with the financial control total for 2018/19; agreement of a milestone-based recovery plan with NHS England by the end of quarter 1 if not already in place; and hit the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3. The Commissioner Sustainability Fund would be paid quarterly, provided that the CCG achieved its year-to-date plan. The phasing of the payments and impact on each quarter's financial position was: 10% in quarter 1 with £5.3m planned deficit, 25% in quarter 2 with £3.5m planned deficit, 30% in quarter 3 with £3.0m planned deficit and 35% in quarter 4 with £2.3m planned deficit. MA-M noted that if a quarterly payment was missed the next payment would not be lost and that a lost quarterly payment could be earned back if the cumulative total was met the following quarter.

MA-M reported that QIPP (Quality, Innovation, Productivity and Prevention) had been set at £14.5m, 3.1%, for 2018/19 in the draft Financial Recovery Plan noting a potential risk in the context of 3% QIPP being the recommended maximum for any CCG. He explained that the profile of spend and allocation growth reduced to 2.5% over 2018/19 and 2019/20 when a significant allocation increase was expected but not yet confirmed. The cost reduction programme was for 2.5% to 2% each year to deliver the position.

MA-M provided an update on progress with the Aligned Incentives Contract. He reported that the three commissioners – NHS East Riding of Yorkshire, NHS Scarborough and Ryedale and NHS Vale of York CCGs – had made a formal offer to York Teaching Hospital NHS Foundation Trust for an Aligned Incentives

Contract and associated principles. This had been discussed at a meeting with NHS England and NHS Improvement earlier in the week and would be considered by York Teaching Hospital NHS Foundation Trust's Board at their meeting on 30 May 2018.

MA-M explained that the York Teaching Hospital NHS Foundation Trust plan assumed £351.0m income and included £1.5m winter pressures which the system had agreed may not need to be included due to measures already in place and because these funds were not separately identified in CCG baselines. The Aligned Incentives Contract offer was for a revised contract value post QIPP of c£340.0m across the three CCGs against the £334.0m Payment by Results contract signed at the end of March 2018. MA-M reported that the offer was within the parameters approved by the Governing Body and noted that 12 payments would be made following agreement of profiling for the cost reduction programme.

MA-M confirmed that the Payment by Results contract would remain in place until the Aligned Incentives Contract had been formally approved. He also noted that activating the risk share principles would mean failure for the system as a whole and added that a number of consultants were already progressing with Aligned Incentives proposals.

In response to SP seeking clarification about future reporting against the Financial Recovery Plan MA-M and AC agreed to develop separate risk reporting in this regard.

The Committee:

1. Noted the update.
2. Requested that separate risk reporting be established in respect of the Financial Recovery Plan.

11. Update on Scheme of Delegation

MA-M presented this report in view of further updates being required to the Detailed Scheme of Delegation since the last meeting due to the fact that the transition period for the former Partnership Commissioning Unit had now ended and all functions had transferred to the CCG. MA-M clarified the amendment which related to Specific Non Pay Expenditure Items for Complex Care: the Executive Director of Transformation and Delivery had delegated authority of up to £250k and the Executive Director and Chief Finance Officer had delegated authority over £250k, the requirement for the latter being exceptional.

Members sought and received clarification on a number of aspects of the Scheme of Delegation. With regard to approval of contracts MA-M explained that all contracts were required to be within the CCG's approved Financial Plan and should also be reported. It was therefore agreed that the Contracts Register be added to the Committee's work plan for annual presentation. *Post meeting note: This has been added to the work plan with a proposed date of the May meeting.*

The Committee:

1. Approved the changes to the Scheme of Delegation.
2. Agreed to receive the Contracts Register annually.

CORPORATE GOVERNANCE

12. Update and assurance – review other reports and policies as appropriate

AC reported on work with Caroline Alexander (CA), Assistant Director of Delivery and Performance, to develop the CCG's Board Assurance Framework noting that CA had reviewed the Improvement and Assessment Framework indicators on the basis of four categories: Being achieved by the CCG, Not causing concern to the CCG, Concerns about delivery and Concerns about delivery not within the CCG's control. AC was now progressing the Board Assurance Framework on the same basis with any additions as required. Each committee would have a work plan aligned with the Board Assurance Framework and the Audit Committee would receive progress reports against all indicators and work plans.

In terms of timescale AC noted the potential for the Board Assurance Framework to be included with the Constitution and committees report to the Governing Body but consideration may be given to delegating work plans to the committees.

The Committee:

Noted the update.

HK-T joined the meeting during item 13

13. Managing Conflicts of Interest – CCG Improvement and Assessment Framework

AC referred to the quarterly and annual self-certification returns to demonstrate compliance with the requirements of the revised statutory guidance on managing conflicts of interest for CCGs. These had been submitted to NHS England within the required timescale.

With regard to the statutory Conflicts of Interest training AC reported that NHS England and Internal Audit had agreed an approach of face to face training for the majority of staff. Approximately 85% of the CCG's staff, whose presence had been recorded, had attended a session where a powerpoint of the online test had been presented. The remainder of staff were required to complete the training online. Compliance was expected with the completion date of 31 May 2018.

AC noted that she would circulate the Deloitte's Conflicts of Interest report and the CCG's responses. *Post meeting note: The report was circulated on 24 May 2018.*

The Committee:

1. Received the Conflicts of Interest Indicator: Part one (annual assessment) and Part two (quarterly assessment).
2. Noted the update on compliance with Conflicts of Interest statutory training.

EXTERNAL AUDIT

14. Audit Completion Report

See item 23.1 in Annual Report and Accounts

MINUTES FROM OTHER MEETINGS

The Committee noted as received minutes from the following meetings:

15. Finance and Performance Committee: 22 February and 22 March 2018

16. Quality and Patient Experience Committee: 8 February and 12 April 2018

17. Executive Committee: 3 and 17 January, 7 and 21 February, 7 and 21 March, 4 and 18 April 2018.

18. Emergency Planning, Business Continuity and Information Governance Steering Group: 22 March 2018

19. Audit Yorkshire Board

HK-T reported that the Audit Yorkshire Board had approved the 2018/19 Business Plan and a number of projects. Discussion had also included staffing. HK-T noted that the annual report would be presented to the 6 June 2018 meeting.

The Committee:

Noted the update.

ANNUAL REPORT AND ACCOUNTS 2017/18

23. Annual Report and Accounts 2017/18

23.1 NHS Vale of York CCG Audit Completion Report

MK presented the report which comprised an Executive summary, Significant findings, Internal control recommendations, Summary of misstatements and Value for Money conclusion. Three appendices respectively comprised the Draft Management Representation Letter, Draft Audit Report and Independence confirmation. MK reported that the CCG had effective arrangements for preparing financial reporting but that the Value for Money conclusion would be qualified due to failure to maintain expenditure within available resources.

With regard to significant risks and key areas of management judgement outlined in the Audit Strategy Memorandum CA noted that she would forward the letter regarding resolution of two outstanding matters from 2017/18. These were in respect of detailed testing of payables and journals where an error of £299k had been identified in the prescribing accrual and in the Remuneration Report. The former had been offset by the fact that the actual was less than the estimate and was not considered to be material and the latter had related to information awaited for inclusion in the Annual Report.

SP referred to the Draft Auditors' Report and expressed concern about aspects of the wording relating to the basis for the qualified conclusion on 'arrangements for securing economy, efficiency and effectiveness in the use of resources'. Whilst recognising this would require a qualified conclusion SP emphasised that the CCG was fully aware of the reasons for the financial position and, particularly in the context of previous reporting to the Committee, felt the implication was that the CCG had neither financial control nor performance management which did not seem a true reflection. Additionally, with regard to the lack of an updated Constitution, there had again been regular discussion at the Committee and was currently awaiting NHS England approval, as reported by AC at item 4 above. This was therefore outwith the control of the CCG.

In response to SP's concerns, shared by others present, MK explained that the auditor's report was subject to National Audit Office and Value for Money criteria and sub criteria, also noting that the draft report had been subject to independent peer review and sign off by a Partner at Mazars. He assured members that there had never been any doubt about the CCG's awareness of the financial challenge and agreed to consult with the Partner whether the wording could be amended to account for the concerns expressed.

With regard to requests for information CA reported that the response rates of the finance and governance teams were second to none which was very much appreciated. The Committee added their appreciation to all involved in the annual accounts process.

The Committee:

1. Welcomed MK's agreement to consult about amending the wording of the basis for the qualified conclusion to account for the concerns expressed.
2. Expressed appreciation to the finance and governance teams for their work on the annual accounts.

AEP joined the meeting

INTERNAL AUDIT

20. 2017/2018 Internal Audit Annual Report and Head of Internal Audit Opinion

HK-T presented the report which summarised the activity and achievement against the 2017/18 Internal Audit Operational Plan and included the Head of

Internal Audit Opinion for 2017/2018. She reported that a total of 113 days were delivered against a plan of 123 agreed by the Committee. Ten days would be carried forward to 2018/19 in relation to the Conflicts of Interest Audit (initially planned to be undertaken by Internal Audit, however then undertaken by Deloitte as part of their random sample of CCGs) and the balance of the Partnership Commissioning Unit Transition audit days.

In relation to the Head of Internal Audit Opinion for 2017/18 HK-T confirmed that an overall opinion of Significant Assurance had been awarded. This was based on assessment of the design and operation of the underpinning Assurance Framework and supporting processes and on 11 audit outcomes, 10 of Significant Assurance and one Limited Assurance, the latter relating to Continuing Healthcare financial data quality. HK-T noted there had also been two advisory reports relating to the Vale of York Clinical Network and Repeat Prescribing Policy; these had not been subject to audit opinion.

With regard to Internal Audit Performance Indicators HK-T highlighted achievement of all except the percentage of management responses received within 15 working days of issues of the draft report. This was at 89% against the 100% target which was noted as an improvement from the 71% in 2016/17. Only one report had been late and the improving trajectory and improved engagement and control were welcomed.

The Committee:

Received the 2017/2018 Internal Audit Annual Report and Head of Internal Audit Opinion.

21. Internal Audit Finalised Reports

AEP reported that since the last Committee meeting four reports had been finalised and issued: Quality Assurance – Significant Assurance, Budgetary Control and Key Financial Controls – Significant Assurance, Stakeholder Engagement – Significant Assurance and Commissioning Plan / QIPP – Significant Assurance. Three reports had been issued in draft: Continuing Healthcare, Governance Arrangements (now finalised) and Partnership Commissioning Unit Transition (across the four North Yorkshire CCGs). HK-T advised that draft reports would not be included in the Head of Internal Audit Opinion.

In response to AK commenting on the areas audited SP explained that the Committee approved the Audit Plan on the basis of organisational risks at a point in time. HK-T added that the Plan could be reviewed on an ongoing basis and aligned with prioritised risk areas. Additionally, the Board Assurance Framework would provide a summary of risks.

The Committee:

Received the Internal Audit finalised reports.

22. Audit Recommendations Status Report

In presenting this item AEP noted that two, not 25 as per the report template, recommendations had been closed since the last report. Twelve new recommendations had been added and of the 35 open recommendations nine were dependent on the ongoing review of committees.

With regard to the 'High' recommendations which related to Commissioning Support contract management, MA-M reported that reviews had now taken place emanating in a proposal that the work be embedded in the CCG. AEP advised that the system had been updated in this regard.

The Committee:

Received the Audit Recommendations Status Report.

PM and KR joined the meeting

ANNUAL REPORT AND ACCOUNTS 2017/18 - CONTINUED

23. Annual Report and Accounts 2017/18

23.1 NHS Vale of York CCG Audit Completion Report

MK referred to the discussion above and in summary advised that the accounts would receive an unqualified audit judgement and the Value for Money conclusion would be qualified as in previous years. KR sought and received further clarification on the Value for Money conclusion.

23.2 Annual Accounts and Changes made from draft accounts to submission

MA-M reported that amendments to the draft accounts since the last meeting related to additional narrative and clarification and were detailed at the end of the accounts. CA confirmed that these reflected the Audit Completion Report.

23.3 Analytical Review

MA-M advised that the analytical review provided explanation of the accounts.

23.4 Annual Report (including Remuneration Report, Annual Governance Statement and Head of Internal Audit Opinion)

PM highlighted that the Annual Report described the challenging position faced by the CCG in 2017/18, the stability achieved in year and the determination to build on this. He additionally noted the development of the Commissioning Intentions in response to patient engagement. Assurance would be provided through governance mechanisms and audit in the year ahead.

PM noted that Paula Evans's contribution would be recognised at the Annual General Meeting and expressed appreciation to everyone who had contributed to

the Annual Report. PM expressed particular appreciation to Tracey Preece and MA-M advising that the preparation of the accounts had been commended in both his years at the CCG.

MA-M explained that the formatting of the Annual Report was being finalised and described a number of amendments including updating of the underlying financial deficit. Members additionally sought and received clarification on a number of areas which would be updated accordingly prior to submission to NHS England the following day.

23.5 Annual Report Checklist

The checklist was as presented at the previous meeting.

23.6 Management Representation Letter

The Management Representation Letter would be sent to MK following approval by the Committee. *Post meeting note: The letter was sent on 24 May 2018.*

The Committee:

Approved the Annual Report and Accounts 2017/18, subject to the amendments discussed, and associated documents on behalf of the Governing Body in accordance with the delegated authority.

ADDITIONAL ITEM

SP reported that at the recent Audit Chairs Forum discussion had taken place regarding a letter from the Head of Primary Care at NHS England to Audit Chairs and Accountable Officers highlighting that an audit of primary care co-commissioning would be required. A framework for this audit was being developed and there would be a requirement for days to be included in Internal Audit programmes to audit commissioning and procurement in this regard. AEP confirmed that there was availability in the plan to accommodate the latter.

24. Key Messages to the Governing Body

- The Committee approved revised terms of reference subject to minor amendments.
- The Committee received the Annual Counter Fraud Report 2017/18.
- The Committee approved the updated Scheme of Delegation.
- The Committee received the External Audit Audit Completion Report.
- The Committee received the Head of Internal Audit Opinion.
- The Committee approved the Annual Report and Accounts 2017/18.

The Committee:

Agreed the above would be highlighted by the Committee Chair to the Governing Body.

25. Next meeting

To be arranged.

As this was SP's last meeting she wished the organisation success in the challenging times. Members thanked SP for her significant contribution to the CCG.

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Vale of York
Clinical Commissioning Group

Item 16

Chair's Report: Executive Committee

Date of Meeting	4 and 18 April, 2 and 16 May and 6 June 2018
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee has agreed a number of policy decisions in relation to gluten free food, funding dementia diagnosis in primary care, the referral for expert opinion pathway, and a number of commissioning statements. The Committee also agreed to progress procurements in respect of minor eye conditions.

Additionally the Committee supported the proposal to focus the 2018/19 quality premium on RightCare musculo-skeletal and on mental health services for children and young people.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

Minutes of the Executive Committee, meeting held on

04 April 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Tracey Preece (TP)	Chief Finance Officer
Dr Kevin Smith (KS)	Director of Primary Care and Population Health (via conference call)
Dr Andrew Phillips (AP)	Medical Director
Dr Shaun O'Connell (SOC)	Medical Director

Apologies

Michelle Carrington (MC)	Executive Director of Quality and Nursing
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health

In Attendance

Fiona Bell (FB)	Deputy Director of Transformation and Delivery
Shaun Macey (SM) 9.2 item	Head of Transformation & Delivery
Audrey Mattison (AM)	Management PA
Jenny Brandom (JB)	Deputy Chief Nurse
Simon Cox (SC)	Chief Officer – Service Transformation (via conference call)
Michael Ash-McMahon (MAM) 9.2 item	Deputy Chief Finance Officer
Louise Horsfield (LH) item 8	Commissioning and Transformation Manager

The agenda was discussed in the following order:

12. Acute Transformation Update

SC provided update to the Committee on the Acute Transformation Board which is being established across both Vale of York and Scarborough and Ryedale (SRCCG) CCGs. Discussion took place on the approach to quality. The Committee agreed that further work is required in terms of consolidation and contracting team functions. The Committee agreed MC/SC/JB finalise the overall approach.

TP is in the process of reviewing AIC and is looking to have the proposal in place by the end of April 2018 for sign off by the Executive Committee.

SC informed the Committee that the first draft of the SRCCG capability and capacity review is expected which may affect the outcome of the AIC.

The Committee held an extensive discussion about how the CCG review capacity so that there are dedicated resources available to support work across the core programme areas including acute reconfiguration, Mental Health and Primary Care. The

Committee agreed that further discussion is required in relation to business agreeing joint work programmes with partners.

The Committee discussed Out of Hospital and Planned Care and agreed these need to be prioritised within the transformation programme.

FB led a discussion in relation to the unplanned care and out of hospital programmes and it was agreed clearer and improved governance is required.

11. Improving Access to Primary Care

SC discussed the approach being taken by SRCCG, Primary Care Commissioning Committee in relation to implementing the improving access to primary care service. KS commented to the Committee that Vale of York CCG have worked through a local interim solution on a locality foot print to potentially move to procurement at a later stage. The Committee agreed that Abigail Combes and Anna Bourne meet to discuss and report back by the end of April 2018. Service specifications are currently being drafted.

The Committee discussed whether there was an opportunity to have a common approach, specifically thinking about Ryedale.

Committee agreed for GP extended access to be added as standing agenda item for the Executive Committee as this work progresses.

FB asked the Committee for clarity around the place based plans for estates as it is not yet clear who will be signing off the plans. The Committee agreed FB, SC, and KS to meet to discuss how place based primary care request for estates development will be linked in.

SC left the meeting

4. Joint Commissioning Update

PM gave a brief update to the Committee. The Joint AD with the CoYC has proceeded to advert. Vale of York CCG will be involved in the recruitment and selection process.

Elaine Wylie will present the Joint Commissioning paper to the Governing Body meeting in April 2018.

5. HR Policy - GDPR (General Data Protection Regulations) Amendments

JB summarised the report to the Committee regarding the forthcoming changes in European and national legislation which will have tighter controls over personal data. Going forward organisations will only be able to contact individuals for purposes to which they have given their express consent. Therefore HR policies need to include specific text to cover the provisions of the new regulations.

The Committee approved the updating of policies wording for the HR policies.

9.1 Data Protection Officer (DPO)

TP summarised the report to the Committee

Due to these changes the CCG is required to appoint a Data Protection Officer (DPO).

A proposal has been received from eMBED based on the four North Yorkshire CCGs taking the service (Vale of York; Hambleton, Richmondshire and Whitby; Harrogate and Rural District (HaRD); and SRCCG) which has been approved.

The Committee approved the proposed eMBED DPO role.

TP updated the Committee in relation to the IG training that reached 95% compliance by the end of March 2018. The IG Toolkit is now approved and the audit is completed.

6. GP in A&E

TP fed back to the Committee and advised on the review of the service which requires an extension to the existing contract. Becky Case is in the process of putting together the decision paper which will be brought before the Executive Committee on 18 April 2018.

10. Audit Chair

PM advised the Committee that the Lay Member Audit Chair interviews were held last week but the successful candidate has declined the offer. Work is on-going looking at a different plan and system solution.

PM advised the Committee that the CFO interviews are being held next week. The process will include a stakeholder panel and formal interview.

Shaun Macey and Michael Ash-McMahon joined the meeting

9.2 Data Quality Proposal

SM and MAM summarised the Data Quality proposal to the Committee
The GPIT Operating model specifies what the GPIT funding, allocated to CCGs, should be spent on and specifies that core and mandated GPIT services must be the first call on this revenue funding. In the previous GPIT Operating model, Data Quality (DQ) was not a core and mandated service and subsequently it was not procured by the CCG.

The GPIT Operating model was updated for 2016-18 (implemented April 2017), which now states DQ is a core and mandated service and CCGs should procure it on behalf of GPs.

The proposal is split into five different areas to include all aspects of data quality, including the following key areas:

- DQ support, including two visits per practice annually
- DQ training in all elements/areas

- Development, creation, sharing and amending of templates
- Writing and testing of clinical system reports
- Providing a hazard review process for clinical templates

The Committee was asked for their approval for the proposed Data Quality service specification for a Data Quality service put together by eMBED. The Committee agreed the service proposal.

7. Minor Eye Conditions Service

It is proposed that a single provider model Minor Eye Conditions Service (MECS) is procured by Vale of York CCG and SRCCG to replace the PCT legacy Community Eye Care Local Enhanced Service (LES).

SOC and LH advised the Committee that the existing Minor Eye Condition Service (LES) contract is not sustainable in its current form. Risk has been identified with the clinical governance for monitoring compliance and the workforce is not sustainable.

The Committee was asked for their approval to go out to for procurement of a replacement service jointly with SRCCG.

The Committee approved.

8. Gluten Free Foods

SOC and LH updated the Committee with regards to the DHSC recommendations to remove gluten free flour from the national drug tariff. Previously it was agreed to keep the existing prescribing policy which allowed patients to receive bread and flour. The proposal is to provide patients with bread and mixes in line with the DHSC recommendations.

The top-up card pilot will end as agreed by the Committee in previous meetings.

Communications have been sent to Primary Care, patients, and other key stakeholders such as Coeliac UK advising them of the changes.

The Committee approved the above recommendation.

13. Any other Business

Disclosure UK

SOC provided an update to the Committee with regard to the Disclosure UK whichis an online database showing payments and benefits in kind made to NHS staff and organisations by the pharmaceutical industry for key collaboration.

To support NHS England the Committee was asked their approval to progress with these five proposals:

1. Understand how clinicians who benefit from pharmaceutical sponsored education meetings should report that benefit
2. Establish a policy whereby any speaker at a CCG education event must have given consent for their details to be published on Disclosure UK if they have any benefit from pharmaceutical company, or declare that they have not done so (A specific conflict of interest form for CCG organised education events)
3. The CCG discusses with the Medical Directors of our main providers (YTHFT and Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) the extent to which their organisations are encouraging implementation of NHS England's aims with their clinicians
4. The CCG discusses with the senior pharmacists / finance directors in our main providers the extent to which their organisation reports the benefits it receives from the Pharmaceutical Industry.
5. The CCG subsequently considers contractual clauses with providers to ensure full participation with the Disclosure UK database.

The Committee discussed the proposal and approved.

Meeting closed 11:14am

Minutes of the Executive Committee, meeting held on

18 April 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Tracey Preece (TP)	Chief Finance Officer
Dr Kev Smith (KS) *via dial in*	Director of Primary Care and Population Health
Denise Nightingale (DN)	Executive Director of Transformation

In Attendance

Andrew Phillips (AP)	Joint Medical Director
Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Fiona Bell (FB)	Deputy Director of Transformation and Delivery
Simon Cox (SC)	Chief Officer, Scarborough & Ryedale CCG
Dharminder Khosa (DK)	Director of Turnaround & Delivery
Becky Case (BC) item 5.1 & 7.2	Head of Transformation & Delivery
Andrew Bucklee (AB) item 7.5	Head of Commissioning & Delivery
Jo Baxter	Management PA
Rachael Nice	Team Administrator (training)

The agenda was discussed in the following order:

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

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

3. **Minutes from the previous meeting**
   The minutes of the Executive Committee held on 7 March & 21 March were approved.

4. **Acute System Review York System**

   SC updated the committee on recent system meetings, with particular focus on a meeting held with PM, SC and the Chief Executive of York Teaching Hospital NHS Foundation Trust. Agreement had been reached at the meeting on the areas to focus on which would be taken to the next System Transformation Board.

The priority programmes agreed included Outpatients, Surgery , Place Based Urgent Care, Orthopaedics & Specialisms which would lay the foundations for the medium term programme.

PM suggested that a more formal governance model was needed going forward which could involve an independent chair.

TP also reported back on limited progress with the Aligned Incentive Contract in recent meetings.

5. Finance, QiPP and Contracts

5.1 Emergency Department Front Door

FB presented the paper which provided the options on the out of contract Emergency Department Front Door, this followed the expired pilot of contract variations with York Teaching Hospitals Foundation Trust and Yorkshire Doctors Urgent Care on the 31st January 2018.

The committee discussed the options and agreed that an extension to the contract maintaining the current model would allow further time to complete a full evaluation and consider new options. This would include the development of more robust monitoring system.

The committee agreed that model 1 to extend the contract for 12 months would be the most appropriate at the current time, understanding that the data review and emphasis on improved joint working as described in model 2 would also be applied. This would be a one off extension. It was understood that the ongoing work from this point would be resourced and fit with the requirements of other aspects of the Integrated Urgent Care Specification including ongoing UTC implementation and the impact of Improving Access from October 2018. It was anticipated that the data review would be completed within 4 months.

7.2 Community IV Proposal

BC provided the background to the paper which had followed a recommendation from the CCG's Medicines Commissioning Committee to the Clinical Executive in July 2017 on the use of IV Zoledronic Acid for postmenopausal breast cancer patients. Work had taken place to explore how this could be delivered closer to a patient's home, ideally in a hub type configuration.

In January 2018, interest had been sought from GP practices regarding their involvement in helping to scope the potential to provide the service in a number of Primary Care/Community Hubs across the Vale of York area. A surgery had

subsequently expressed an interest in becoming a community hub and discussions had therefore taken place with them and York Teaching Hospitals NHS Foundation Trust to explore the opportunities.

The committee reviewed the paper which outlined the options and how the proposed community model would be delivered. There were a number of queries and challenges from the committee and it was agreed that KS/MC would investigate further outside of the meeting and agree the next step. To be brought back to the Executive Committee to ratify in due course.

5.3 17/18 Year End Update

TP advised that the 17/18 year end figure had now been finalised at £20.1m deficit, this was an improvement of £2.5m following the release of the 0.5% central risk reserve and the Category M price benefit that had previously been held centrally by NHS England.

PM expressed appreciation to TP for her work on this.

5.4 18/19 Plan Update

A draft financial plan for 18/19 was now in place with a £14m deficit that delivered the associated control target and would allow the CCG to secure NHS England support through the Commissioner Sustainability Funding. The Council of Representatives would be taken through the plan by TP on the 19th April. The Finance & Performance Committee would then be asked to approve the plan on behalf of the Governing Body on the 26th April.

TP highlighted that the plan could still be amended prior to final submission at the end of April and that NHS England was being kept informed of the risk review.

Restructuring of the Contracting and Analytics functions

This item was received as a late paper and was not on the agenda.

TP presented the draft paper which outlined a revised structure and approach for the contracting and analytics functions. The changes would support the strategic direction of the CCG and the system in terms of the acute transformation and the increased support into both Mental Health & Primary Care. TP advised the proposed structure was within the existing budget.

The committee sought clarity that the new structure was aligned to all strategic priorities, with a focus on delivery which TP confirmed. TP also advised that the

proposed structure allowed flexibility with regards to the further alignment of the team and resources across the York-Scarborough footprint.

The committee approved the vacancies outlined in the paper and the final structure for the single acute team would be brought back to the Executive Committee in May.

5.5 Market Management

Following the in-housing of the Vale of York Continuing Health Care Team from the Partnership Commissioning Unit, inconsistencies had been identified in commercial processes following assessment decisions. DN outlined the paper and summarised the areas where it was felt a comprehensive review of current arrangements was required.

The committee discussed the options and approved option 1, to recruit an interim commercial project manager for 6 months. TP confirmed the funding to support this would be sourced from non-recurrent vacancies.

The committee were in principle supportive of options 2 & 3, however felt that further conversations with the Local Authorities were required in the first instance. PM and DN to take forward and bring back to the Executive Committee

6. Performance & Delivery

6.1 Update on Refreshed Planning

Approval of the operation plan had been delegated to the Finance & Performance Committee to meet the 30th April deadline. CA advised further refreshing of the draft plan and system alignment were continuing to ensure NHS England and Humber, Coast & Vale STP requirements were met.

CA would be working with the Business Intelligence and relevant Executives/Heads to confirm the baselines, trajectories and financial opportunity for each indicator within the Quality Premium and preparing a draft submission to NHS England in line with their timescales. This would then be incorporated within the Operational Plan.

An update would be given to System Transformation Board on the 23rd April.

6.2 Sleep Studies Pathway & Equipment Change Request

The committee discussed and approved the proposed change in pathway and equipment. TP to investigate if the purchase of equipment could be classed as a nominal Personal Heath Budget.

7. Service, Quality & Safety

7.1 Psychology Services

The CCG had been made aware of a recent psychology case which had highlighted the gap in the provision of psychology services. MC acknowledged the service had been developed around specific disease pathways resulting in some patients not having access, for example stroke services. MC sought the views of the committee to explore this further.

The committee discussed and agreed that no changes would be made at present, however Paul Howatson would be asked to complete a benchmarking exercise and report back to the Executive Committee.

7.3 The Retreat York – Strategic Review

The committee were asked to note the update from MC regarding the strategic review currently taking place at The Retreat York. MC advised the impact could be significant and further discussions would take place once more information was available.

7.4 York Foundation Trust Staff Survey

The survey had been circulated to the Executive Committee for information and would be reviewed in full by the Quality & Patient Experience Committee.

DK/SC/CA left the meeting

7.5 Diabetes Local Enhanced Service

The committee reviewed the options regarding the Key Performance Indicator (KPI) payments in respect of the Diabetes Local Enhanced Service. It was agreed to reinforce the requirement of achieving KPI4 for 18/19 payments to all practices.

8. Strategy and Planning

8.1 Healthy Hearts Website Update

The committee noted the upcoming launch of the “Vale of York Healthy Hearts” website.

8.2 Humber, Coast & Vale Cancer Alliance Year End Report

The committee received the report which would be reviewed at the Finance & Performance Committee.

8.3 Humber, Coast & Vale STP Place Based Plans

This item was discussed in conjunction with item 6.1

8.4 Bootham Park Hospital Site

TP provided the committee with a background to the old Bootham Park Hospital site. The CCG and NHS England had both declared the site "surplus to healthcare use" some time ago and NHS Property Services had subsequently commenced marketing the site with a number of bids received.

Correspondence had recently been received from City of York Council, York Teaching Hospital NHS Foundation Trust and Humber, Coast & Vale STP requesting a delay to the sale of the site to allow time to prepare a proposal. NHS Property Services had therefore sought clarity from the CCG on its position highlighting the CCG would be liable for the associated void costs for any pause in the process.

The committee discussed and raised concerns around potential void costs and agreed it would be added to the next System Transformation Board agenda.

Post meeting note

The response from NHS Property Services to the Chief Executive of York Teaching Hospital NHS Foundation Trust was circulated after the meeting.

10. Joint Commissioning

10.1 CYC AD Joint Commissioning role update

The short listing of candidates had now taken place for interview on the 30th April. PM and MC were participants on the interview and stakeholder panel.

10.2 Future of Commissioning Letter NYCC/CYC

The committee noted the letter from Richard Flinton, Chief Executive North Yorkshire County Council & Mary Weastall, Chief Executive York City Council regarding the future of commissioning. PM had responded on behalf of the CCG.

11. People, Support & Development

11.1 Carry over annual leave requests

The committee approved the 2 exceptional cases to carry over 5 day's annual leave with payment for the remaining days. The individuals would be advised that this was a one off.

12. Corporate

12.1 Annual Report

Further progress had been made with the annual report which included the suggested amendments from a previous meeting. The committee approved the draft report.

12.2 CCG 360° Stakeholder Survey

The committee discussed the next steps regarding the 360° Stakeholder Survey results and agreed to add the item to the next System Transformation Board agenda**.** A further exploration of views expressed would be undertaken with GP practices and Local Authority.

12.3 Attain Proposal Turnaround

The committee approved the revised Commercial Proposal which reflected the comments from a previous Executive Committee. It was felt that the proposal should also formally include support to the Financial Recovery Board and all associated QiPP delivery processes and reporting, with support in this regard to the Interim Chief Finance Officer over the next 3 months.TP to liaise with Attain.

13. Any Other Business

13.1 Governing Body Draft Agenda May

The committee approved the draft agenda.

13.2 Individual Personal Health Budgets

As per policy, all individual Personal Health Budgets required the approval of the Executive Committee.

Following a request from DN, the committee agreed that approval of future Personal Health Budgets could be approved by DN & MC outside of the meeting.

Next meeting Wednesday 2nd May

Minutes of the Executive Committee, meeting held on

2 May 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Dr Kev Smith (KS)	Director of Primary Care and Population Health
Denise Nightingale (DN)	Executive Director of Transformation
Michael Ash-McMahon (MAM)	Interim - Chief Finance Officer (by phone)

In Attendance

Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Fiona Bell (FB)	Deputy Director of Transformation and Delivery
Dharminder Khosa (DK)	Director of Turnaround & Delivery
Shaun O'Connell (SOC) Item 6.1	Medical Director
Paul Howatson (PH) Item 7.5	Head of Joint Programmes
Sarah Corner	Management PA (Minutes)
Rachael Simmons	Corporate Services Manager

The agenda was discussed in the following order:

1. **Apologies**

   Simon Cox (SC) — Chief Officer, Scarborough & Ryedale CCG

2. **Declaration of Interests**

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

3. **Action Tracker and Minutes from the previous meeting**

   The minutes of the Executive Committee held on 18 April were approved.

   21/3/18 Delayed Transfer of Care for Mental Health - Current recording system

   The Committee considered current issues with the recording of joint funded packages and also discussed the different approaches organisations were taking to resourcing support for discharge and any related delays.

   DN has sent emails to City of York Council (CYC) about the on-going problems and copied in TEWV but no response has been received.

   A letter is to be sent to CYC by PM on behalf of the Finance and Performance committee about on-going concerns and the requirement for consistent governance.

4/4/18 Improving access to primary care

The Committee discussed how to develop a more strategic approach to developing primary care estate, it was also noted that contract for premises at Amy Johnson Way expire in one year and discussions are on-going with TEWV about estate planning and where the CHC team could be based.

4. Acute System Review York System

CA updated the committee on recent system meetings including the Joint Commissioning Committee last week and the Planned Care Steering Group held earlier this week, which had gone well. There are a significant number of challenges, especially around orthopaedics, with York Teaching Hospital NHS Foundation Trust (YTHFT) looking at back fill for evenings, weekends and Bank Holidays. The medical and surgery beds are most affected (particularly urology). This is impacting most on Scarborough Hospital surgical beds.

A review is taking place with YTHFT to look at the orthopaedic surgical supply and associated costs.

A longer term surgery model would be needed and it is proposed to have a core review group with oversight of the project.

It was suggested that the core group should have an independent chair who was a member of the Royal College.

It was also suggested that the complex discharge work stream and out of hospital care should be reviewed.

A new pathway is required for the large volume of patients who do not fit the criteria for community beds; i.e., stroke patients who become stranded. FB and YTHFT to review the number of readmissions and the details of each case and take learning from this to move forward.

The Committee was briefed by MAM on progress being made to secure contract agreement for services in Malton. It was also noted that KS is developing a proposal to review all community services over the summer period.

MAM left.

5. Finance, QIPP and contracts

5.1 Turnaround Update

The Committee noted that the financial recovery plan is closed to finalisations. The QIPP audit that was submitted to NHS England at the end of April was well received with positive feedback, further detail now being developed.

CA proposed that the main focus over the next 6 months is going to be on Mental Health and Cancer, improve leadership, progress the operational plan and work more effectively with our partners to help embed performance and improve the financial recovery.

It was agreed to use the Exec Time Out on 15.05.208for discussion and bench marking and to also look at how we work with:
City of York Council
Use the North Yorkshire County Council area
How to share our plans, articulate and get engaged with other agencies.

DK to produce a framework for discussions at Exec Time Out.

FB and DK left

5.2 Procurement Programme and Service 2018/19

The proposal is slightly over budget but Exec are aware and it was agreed to approve the budget. Exec approved the extension for procurement specific capacity for eight months.

7.3 Request approval to carry forward funds for additional payments for dementia diagnosis work in primary care

It was agreed that the underspend in winter monies at the end of 17/18 be carried forward to support dementia diagnosis in primary care.

6.2 Urgent Treatment Centre Selby

The proposal to use resources from the underspend on winter for additional hours was also approved.

7.4 Amber Drugs LES Update

The cost impact of the drugs change is an increase of £13,500 to the CCG.
The Exec approved the cost impact.

7.2 Pre-treatment ECG testing for adults with ADHD

The Committee received a briefing on ECG capability at the Tuke Centre.

The committee agreed that private prescriptions were a pragmatic short term solution but the wider pathway needs urgent review.

5.3 Confirmation Quality Premium

The Committee supported the proposal that two local indicators should be: Right Care MSK and MH for children and young people.

11.4 Staff Briefing

It was proposed to focus on primary care and on mental health at the next briefing.

CA left

SO'C joined for this item.

6.1 RSS Memorandum of Understanding

SO'C proposed a review of the RSS function to strengthen it going forward with regard to functionality (including GDPR). It was noted that Scarborough & Ryedale CCG currently pay £400,000 a year for using the RSS Service.

6.2 Urgent Treatment Centre development in Selby

The Committee considered options to develop GP led urgent care in Selby. The Committee approved option 2.

6.3 BCF Evaluation and Review

The Committee considered how the BCF was being developed in each of the three localities of the Vale. It was proposed that FB and PH provide an overview including an assessment of the effectiveness and value for money of the respective schemes.

6.4 Local Transformation Programme

The local fourth quarter report has been submitted to NHS England and a response is awaited which will be shared with the Exec in due course. An updated risk register was attached with the papers.

7.1 Medicines Commissioning Committee Recommendations April 2018

KS outlined the Committee recommendations. All were supported.

7.2 Pre-treatment ECG for adults with ADHD

This was discussed earlier. Approved.

PH arrived

7.5 Individual Funding Requests and Mental Health.

The Committee received a briefing on the management of IFR cases, and were re-assured regarding the development of related commissioning statements. The Committee asked for a further paper including an option appraisal in August 2018.

PM left

7.6 Trieste

PH to provide an update to a forthcoming staff briefing.

11.2 Holiday Guidance

MC outlined the situation regarding annual leave entitlement. Here are 3 options to cover part time workers to start from 2018/19:
1 From holidays from Jan to Jan so always have 8 Bank Holidays
2 Give people a choice
3 Use formulas

It was decided to use the formula from eMBED HR with calculating leave on the basis of how many bank holidays fall within the holiday year. MC to send out a briefing note.

AOB
PM advised Simon Bell will start with the CCG as Chief Finance Officer on 29.7.2018.

The on-call rota was discussed with regards to the number of senior staff on the rota. It was proposed to expand the current rota but do so at minimum cost.

ACTION : MC to speak to PM regarding the reimbursement numbers.

Next meeting Wednesday 16 May

Minutes of the Executive Committee, meeting held on

16 May 2018 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Michael Ash-McMahon (MAM)	Acting Chief Finance Officer
Dr Kev Smith (KS)	Director of Primary Care and Population Health
Denise Nightingale (DN)	Executive Director of Transformation

In Attendance

Caroline Alexander (CA) to item 5	Assistant Director of Delivery and Performance
Fiona Bell (FB) to item 5	Deputy Director of Transformation and Delivery
Laura Angus (LA) items 7.1 & 7.2	Lead Pharmacist and NICE Medicines and Prescribing Associate
Shaun O'Connell (SOC) for item 9.1	GP Lead for Acute Service Transformation
Helen Franks (HF) for item 9.1	Commissioning and Transformation Manager
Abby Combes (AC) for item 13.1	Head of Legal and Governance
Jo Baxter	Management PA

The agenda was discussed in the following order:

1. Apologies

There were no apologies.

2. Declaration of Interests

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

3. Minutes from the previous meeting

The minutes of the Executive Committee held on 4 April were approved. The action tracker was discussed later on the agenda

4. Acute System Review York System

4.1 Update

The committee discussed the operational challenges of working in an aligned incentives system and the need to look at how this work could be described in a way that would engage all partners. It was hoped the Mid-Term System Financial Recovery report supported by PWC would be shared with all Boards/Governing

Bodies by the end of the month which would out the urgent case for transformation and reform.

A broad discussion was held on the challenges involved in reducing orthopaedic capacity across the system over time to be affordable within the system financial envelope. A proposal for optimising orthopaedic activity flow across NHS and Independent Sector Providers was being developed and York Teaching Hospital Foundation Trust (YFT) would be confirming their proposal to repatriate a proportion of external activity. A letter from the CCG had been sent to YFT to formally request this. A meeting was planned with the CCG and Ramsay Hospital to explore their ability to deliver additional activity at sub tariff.

Nuffield Contract

This item was not on the agenda and was received as a late paper.

The committee discussed the options regarding the current Nuffield Hospital contract and agreed that further work was required prior to a decision being made. This would include discussions with regulators and would be linked to the orthopaedic optimisation proposal.

MAM, CA and Dharminder Khosa, Director of Turnaround & Delivery to progress and bring back to the Executive Committee at the appropriate time.

STP Elective Network Group Feedback

CA advised that the STP were refreshing the representatives on each of their collaborative programmes to support the 18/19 forward planner. The approach would be for each of the CCG representatives to cascade out actions, results and feedback from those network meetings. CA would be the representative for the CCG's with Simon Cox as Executive lead.

HCV STP Focus Meeting

The committee noted the letter from NHS Improvement & NHS England on STP progress and feedback. PM had calls planned with both regulators to discuss in more detail and would feedback.

6. Performance and Delivery

6.1 Update on Quality Premium

Discussions were ongoing with NHS England regional team following the first submission of the Quality Premium local indicators for Rightcare, MSK and Children and Young People Mental Health. Further information and evidence had been

provided to NHS England upon their request and the committee would be updated once the final agreed indicators were confirmed with NHS England.

CA/FB left the meeting

5. Finance, QiPP and Contracts

5.1 Turnaround Update

MAM provided an update on the financial recovery plan which was currently being updated following feedback from NHS England. The feedback had highlighted more detail was required around future recovery and the need to demonstrate how and when the CCG would get back to a 1% cumulative surplus. It was hoped the re-submission of the plan would be made by the 25th May.

A discussion followed on access to the Commissioner Sustainability Funding (CSF) in 2018/19 based on the plan and MAM shared the following criteria and summary table with the committee which captured the key targets:

1. Demonstrate commitment to delivery of financial control total - Deliver a financial plan consistent with the financial control total for 2018/19.
2. Repayment of cumulative debt - Agreement of a milestone-based recovery plan with NHS England by the end of quarter 1 if not already in place.
3. Delivery of the financial plan for the year - Hit the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3. As per the below:

	Q1	Q2	Q3	Q4	Total
Planned Deficit (£m)	(5.25)	(3.47)	(2.97)	(2.32)	**(14.00)**
CSF %	10%	25%	30%	35%	**100%**
CSF (£m)	1.40	3.50	4.20	4.90	**14.00**
Position after CSF (£m)	**(3.85)**	**0.03**	**1.23**	**2.58**	**0.00**

Through discussion, the committee agreed it would be helpful for MAM to provide a brief summary on the areas, actions and key decisions required throughout the year to access the CSF and provide assurance.

MAM advised the committee that the Financial Recovery Board meeting was to become a joint meeting with Scarborough & Ryedale CCG with effect from June. The committee discussed if it would be more beneficial to split the meetings into Acute & Non Acute. MAM to seek the views of Dharminder and report back.

Matters Arising/ActionTracker

Administration of Intravenous Drugs in the Community (Zoledronic Acid)

Details were currently being worked through with a practice in the North Locality who had agreed to pilot the proposed community model.

Digital Transformation (LDR)

A meeting was planned with CA & Steven Dodd, Programme Manager NHS England (seconded to STP Digital Board) to ascertain the support required for the CCG/System. CA to update at the next meeting

5.2 Healthy Hearts Website Promotional Campaign

The committee approved the budget proposal of £3323 for campaign materials to promote the Vale of York's Healthy Hearts Website. It was hoped that this could be absorbed within the current Communications budget.

5.3 Health and Social Care Network (HSCN) Contract & Budget Update

Approval had been received at a previous Executive Committee for NYNet to become the preferred HSCN across the Vale of York network. The work to complete the rollout was now underway with a number of practices successfully migrated over to the new HSCN provision.

MAM presented the paper to the committee and explained that as part of the current roll-out, it had now become clearer that there were a number of practice sites that did not previously have a NYNet connection, but did require an HCSN connection and therefore needed to be added to the original contract.

The committee agreed to the additional contract variation with NYNet for £111,900 for the next three years to ensure a full roll out of HSCN across the Vale of York practices.

In addition, the paper also highlighted that the migration process had identified a potential in-year cost pressure relating to early termination contract penalties for existing BT connections inherited from NHS Digital. Work was underway to calculate the potential penalty payments. The committee discussed and agreed MAM would raise with other Chief Finance Officers to ascertain if there were similar issues elsewhere and if there would be support for a joint letter to NHS Digital for further support.

5.4 QA+ Data Cleanse & Implementation Project

DN presented the paper which requested funding for the project team to complete the final stage data cleanse and QA+ implementation project.

The committee supported the proposal and approved the funding.

7. Service, Quality and Safety

LA joined the meeting

7.1 Continence Prescribing and Cobweb

LA provided a background to the paper which followed the piloting of a centralised web-based prescription management system for continence products, known as Cobweb, since July 2016 in a number of GP practices. The paper outlined the reasons the pilot had not progressed to full implementation and provided the options to consider for community prescribing of continence products.

The committee discussed the failings of the pilot and acknowledged further work was required prior to approving either option.

It was agreed to cease the Cobweb model whilst undertaking a benchmarking exercise to understand the options and benefits available in more detail. LA to work with Louise Horsfield and bring back to the Executive Committee in due course with support from the Quality and Nursing Team.

7.2 Medicines Optimisation in Care Homes

LA provided a brief update on the Medicines Optimisation in Care Homes programme, a detailed paper would be brought to the Executive Committee once the full detail of the model was established.

The committee suggested further discussions were required with Finance regarding the impact on Prescribing Indicative Budgets and how this would be managed within the scheme and to consider the legal guidance re Providers.

LA to take forward with MAM & Abigail Combes, Head of Legal and Governance

KS/LA left the meeting

9. Primary Care

SOC/HF joined the meeting

9.1 Anticoagulation Service Warfarin Monitoring and Management in Primary Care

SOC and HF presented the paper and updated the committee with the progress made on the anticoagulation service project.

2018/21 anticoagulation contracts had now been issued to the 22 practices who had agreed to take the service and notice letters to those who had declined.

SOC confirmed that York Teaching Hospital Foundation Trust had agreed to continue managing the patients from the practices who had declined until the contract for the default provider commenced, it was hoped this would be by the end of January 2019.

The committee welcomed the update and confirmed support for the proposed next steps. It was agreed that due to the slight delay of contracts being issued, the proposed deadline of the end of June for practices to describe their plans for patient access out of hours could be extended to the end of July if necessary.

A further update would be provided to the committee in July.

8. Strategy

8.1 Expert Patient Programme

The committee discussed the letter regarding the Expert Patient Programme and agreed this would be an action for the Contracting team. Liza Smithson, Head of Contracting & Analytics would be asked to confirm back to the committee that the actions were complete.

10. Joint Commissioning

10.1 Delayed Transfers of Care

The committee noted the briefings regarding the target for reducing Delayed Transfers of Care and the Improved Better Care Fund.

DN sought the views of the committee on the continuing discussions with City of York Council on the reporting issue around delayed transfers of care and who the delay was attributable to. The committee acknowledged the associated impacts the proposed reporting would cause and agreed to escalate the item to the Finance & Performance Committee. The Executive Committee agreed to the definitions of attribution as described by DN.

11. People, Support and Development

11.1 HR Policy Relocation Expenses

The committee approved the updated policy.

11.2 Recruitment to Research and Development Manager

The committee discussed the paper and approved the request to recruit a Research and Development Manager. This would generate a saving within running costs following notice being served to the current service provider hosted by East Riding of Yorkshire CCG.

KS re-joined the meeting

11.3 Recruitment to a Children and Young Peoples Senior Lead

The committee approved the recruitment of a Children & Young Peoples Senior Quality Lead.

11.4 NHS70 Nominations

The nominations were reviewed and agreed for the NHS70 events on the 5th July.

11.5 On-Call Rota

Following a review of affordability on the various options for the on-call rota, the committee were unable to extend the rota beyond the Executive team. The committee thanked staff for their support.

13. Any Other Business

Clinical Summit

The committee agreed that the Clinical Summit would not be held in 2018**.** Work would continue to develop clinical networks to support the clinical transformation programme.

AC joined the meeting

13.1 Committee Structure

AC provided an update and sought feedback on the work she was undertaking to review the committee meetings. Work would continue on the structure of the Executive Committee meetings and “Heads of “ would be asked for feedback on how the structure and frequency of the “Heads of “ meeting was working for them.

Next meeting Wednesday 6th June

Minutes of the Executive Committee, meeting held on

6 June 2018 at West Offices, York

Present

Michelle Carrington (MC)	Executive Director of Quality and Nursing
Michael Ash-McMahon (MAM)	Acting Chief Finance Officer
Dr Kev Smith (KS)	Director of Primary Care and Population Health
Denise Nightingale (DN)	Executive Director of Transformation

Apologies

Phil Mettam (PM)	Accountable Officer

In Attendance

Dr Shaun O'Connell (SOC) items 12 & 13	GP Lead for Acute Service Transformation
Stacey Oglesby (SO) item 5	HR Manager
Jo Baxter	Management PA

The agenda was discussed in the following order:

STANDING ITEMS

1. Apologies

As above.

2. Declaration of Interests

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

3. Minutes from the previous meeting

The minutes of the Executive Committee held on 16 May were approved. The minutes from the 2 May were deferred to the next meeting.

4. Action Tracker/Matters Arising From The Minutes

The Action Tracker was updated by the Committee.

Expert Patient Programme (EPP)

The Contracting team had advised that as the Primary Care Trust decommissioned EPP and the CCG did not commission a service, there was no requirement to request licenses and the action could be closed.

CORPORATE

6. HR Report Q4/Year End 2017-18

The committee reviewed the HR report which was now in a new format following feedback.

Upon reviewing the sickness absence figures, MC advised that a sample audit of staff files would be carried out to ensure absences were being correctly and consistently managed in line with the Managing Attendance policy. The findings from the audit would go to "Heads of" to review.

The committee would also consider if training was required for all line managers.

Dialogue was continuing around Statutory and Mandatory training and how the uptake of training could be increased. "Heads of" would be asked to take forward.

BUSINESS CASES AND COMMISSIONING STATEMENTS

SOC joined the meeting

12. Refer for Expert Opinion Pathway

SOC presented the paper which sought approval for progression of the Refer for Expert Opinion Pathway with system stakeholders.

The pathway had been presented to the Council of Representatives and York Teaching Hospital NHS Foundation Trust who were both supportive.

Once agreement in principle was reached with all system partners the formulation of a full suite of project documentation and a mobilisation plan would commence with the expectation that Cardiology, Rheumatology and Dermatology specialities would be considered first.

The committee confirmed their support to progress with the pathway.

DN joined the meeting

13. Commissioning Statements

SOC updated the committee on the planned changes to the 3 commissioning statements for Varicose Veins, Carpal Tunnel Syndrome and Hysterectomy for Menorrhagia. The changes reflected the harmonisation to align all commissioning thresholds with Scarborough & Ryedale CCG. SOC confirmed QIA's had been completed by the Quality Team and their assurance was confirmed.

The committee approved in principle and requested sight of the full commissioning statements following the meeting.

Post meeting note

The committee received the statements in full after the meeting and reviewed and confirmed their approval of the 3 commissioning statements.

SO joined for this item

5. National Staff Survey Results

SO presented the results from the survey which had seen a 56% response rate from the CCG. The committee reviewed the key performance and development areas and requested further details behind the results on a number of areas to add context to the figures. Stacey agreed to provide this.

The committee discussed various options to deliver the results to staff and agreed for MC to take forward with Victoria Hirst, Head of Engagement with the involvement of the Staff Engagement Group. The group would also be asked to consider the communication used for the next survey to see an increase on the response rate.

7. Head of Legal and Governance maternity leave cover

MC outlined the proposals for the impending maternity leave cover for the Head of Legal and Governance.

The committee reviewed the options and approved in principle to cover the whole of the post 2/3 days per week with external legal support. MAM to review the costing's and report back to the committee.

8. LIVEX event invite

The committee discussed attendance at the LIVEX event organised by York Teaching Hospital NHS Foundation Trust. The invite would be forwarded to the Lay members as the Executive team were unable to attend. The CCG had 2 representatives including the Emergency Planning lead involved with the day's events.

10. NHS Smokefree Pledge

The committee agreed to sign the NHS Smokefree Pledge.

11. Attain Support – Backfill Performance

Attain had submitted a revised proposal which provided a re-profiling of resources and days to allow for the introduction of an additional resource to support system work.

The committee approved in principle, subject to confirmation that this was within the original approved budget. MAM to confirm outside of the meeting.

14. Medicines Commissioning Committee Recommendations

The committee approved the May 2018 Medicines Commissioning Committee recommendations. It was noted that the TA518 Tocilizumab recommendation should be formally communicated to York Teaching Hospital NHS Foundation Trust via the Contract Management Board as per the usual process.

FINANCE AND PERFORMANCE UPDATE

15. Finance Update

MAM advised the committee that work to finalise the month 2 position was still ongoing, there were still some challenges in particular around Continuing Health Care and Special Rehabilitation Brain Injury.

The resubmission of the Financial Plan and Recovery Plan had now taken place. This included a change of £120,000 recurrent investment into Child and Adolescent Mental Health Services. Detailed feedback received from NHS England was now being worked through.

MAM also informed the committee that an Aligned Incentive Contract had been agreed with York Teaching Hospital NHS Foundation Trust, subject to a small number of minor caveats. A joint communication was planned to share around organisations that would explain the new contract and focus on cultural change and the joint commitment to cost reduction within the system.

ASSURANCE AND RISK

17. Q4 IAF Review Letter

The committee noted the positive letter from NHS England summarising the recent annual review meeting. It was agreed that the letter would also be shared with “Heads of”.

18. Update Risk Refresh

Work was continuing on the Risk Refresh and an update would be brought to a future Executive Committee.

Next meeting Wednesday 20th June

Vale of York
Clinical Commissioning Group

Item 17

Chair's Report: Finance and Performance Committee

Date of Meeting	26 April and 23 May 2018
Chair	David Booker

Areas of note from the Committee Discussion

26 April

- The Committee recorded appreciation of the achievement of the stabilised financial position at year-end and wished to thank all members of staff, the Governing Body and associated committees for their exceptional contribution in the past year. However, the Committee also noted the continuing challenges for the new financial year.
- The Committee approved the Financial Recovery Plan 2018/19 emphasising that the CCG was intent on moving from Payment by Results to create an Aligned Incentive Contract / Block and Risk Share with York Teaching Hospital NHS Foundation Trust as a matter of priority.
- The Committee approved the Operational Plan 2018/19 for submission to NHS England on 30 April 2018.

23 May

- The Committee noted and welcomed the beginning of the process to move to an Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust and requested additional information at the next meeting on areas, including orthopaedics and delayed transfer of care, that were affecting progress across the system.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

NHS
Vale of York
Clinical Commissioning Group

Minutes of the Finance and Performance Committee Meeting held on 26 April 2018 at West Offices, York

Present

David Booker (DB) (Chair)	Lay Member and Finance and Performance Committee Chair
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Andrew Phillips (AP)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer
Keith Ramsay (KR)	Lay Member and Chair of Primary Care Commissioning Committee, Remuneration Committee and Quality and Patient Experience Committee
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health

In attendance

Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Michele Saidman (MS)	Executive Assistant
Dr Nigel Wells (NW)	Clinical Chair

Apologies

Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)

In welcoming everyone to the meeting DB wished to record appreciation for the work that had taken place to produce the papers.

1. Apologies

As noted above.

2. Declarations of Interest in Relation to the Business of the Meeting

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

3. Minutes of the meeting held on 22 March 2018

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 22 March 2018.

4. Matters Arising

F&P51 "Good News": MC confirmed that the Haxby Group Practice Nurses had been congratulated on their success at the Yorkshire and Humber General Practice Nursing Awards and the Humber, Coast and Vale Sustainability and Transformation Partnership Awards

"Good News"

KR commended the 2017/18 end of year financial position, particularly in the context of the challenge at the start of the year.

5. Risk Update Report

In presenting the report which provided details of current events and risks for review by the Finance and Performance Committee, confirmed the cohort of corporate risks for escalation to the Governing Body and gave an overview of programme risk registers, PM highlighted that Child and Adolescent Mental Health Services was the main area of concern. He noted that at agenda item 7 below TP would explain the overall contract position in respect of Tees, Esk and Wear Valleys NHS Foundation Trust and the planned resources including for Child and Adolescent Mental Health Services.

PM also reported that he and DN had met with the Tees, Esk and Wear Valleys NHS Foundation Trust Chief Executive and Director of Operations for York and Selby to review progress and plan for the next two years of the contract. Work was also taking place with City of York Council in the form of reviewing case studies on children, adults and the transition, and with North Yorkshire County Council. PM proposed that a report on both Child and Adolescent Mental Health Services and overall Mental Health Services be presented to the May or June meeting of the Committee.

DN joined the meeting

PM, MC, DN, TP, KS and CA reported on the 2017/18 end of year Improvement and Assessment Framework meeting with NHS England on 23 April highlighting that there had been more positive aspects than at previous such meetings. There had been recognition that, despite continuing challenges, the CCG was making progress in terms of the financial position, quality and the fact that delivery required support from partner organisations and collaboration by providers. PM noted that NHS England was supportive of the CCG's plans to develop Mental Health Services, work with Local Authorities, development of GPs as providers and the locality approach. He advised that NHS England understood the CCG's request for expertise to support delivery of the digital agenda. The CCG would receive a formal letter from NHS England following the meeting; this would be presented to the Committee.

In response to KR requesting an update to the Primary Care Commissioning Committee on the risk relating to the Estates and Technology Transformation Fund Strategy KS explained that detailed analysis was taking place on each of the bids which would be reported to that Committee. KS added that Sustainability and Transformation Partnership capital and estates work was taking place in parallel and expressed concern about the expectations of this funding to support the digital agenda and

workforce as well as estates development. He noted that without the Estates and Technology Transformation Fund there would be financial risk to estates development in terms of any new builds. KS also explained that separate work was taking place to identify primary care needs and lessons were being learnt from Hull which was considered a "trailblazer" in respect of investment. MA-M additionally reported on risk associated with management of Mental Health estate but noted this was also an opportunity to work with Tees, Esk and Wear Valleys NHS Foundation Trust to support additional funding for clinical services in mental health.

In response to DB requesting a report on Child and Adolescent Mental Health Services and the clinical issues, DN reported on discussions Tees, Esk and Wear Valleys NHS Foundation Trust Contract Management Board which aimed to establish an Aligned Incentive approach to working; this would enable granular information to be provided She explained that currently the Child and Adolescent Mental Health Service included diagnosis of autism and attention deficit hyperactivity disorder and waiting times for emotionally unwell children and these were not routinely reported separately. DN also explained associated risks: potential delays in obtaining support at school and potential greater risk of mental health crisis if waiting was extensive for those with emotional health concerns. DN noted that these issues required investment both financially and in workforce and in this regard referred to the Operational Plan and Aligned Incentives approach. MC added that discussion was also taking place with City of York Council regarding Looked After Children responsibilities and she would report back to the Committee.

The Committee:

1. Reviewed all risks and risk mitigation plans for the cohort of risk under the management of the Committee.
2. Agreed risks that required Governing Body scrutiny
3. Requested a report on Child and Adolescent Mental Health Services for the May or June meeting.

6. Financial Performance Report Month 12

TP reported that the actual outturn position was a £20.1m deficit. This improvement from £22.5m deficit was due to release of the 0.5% national risk reserve, £2.0m and the £443k Category M prescribing benefit. In respect of prescribing TP also commended Practices' achievements through Prescribing Indicative Budgets noting that the savings had now been released in accordance with the agreement. She reported that the concerns raised at the Governing Body meeting by two of the new GP members had been addressed through separate discussion with them. KS clarified that an initial release had been made and the latest release was in response to receipt of the full information.

TP highlighted the £1.9m impact of the No Cheaper Stock Obtainable issue on the year-end position. Had this exceptional national issue not occurred the CCG's outturn would have been c£18m deficit, which was effectively the same as the in-year position from 2016/17 further adding to the stabilisation message.

TP also noted that the delivery of £7.9m QIPP (Quality, Innovation, Productivity and Prevention) equated to 55% of the CCG's target, which was rated as 'amber' in terms of benchmarking; QIPP delivery across the region was variable.

With regard to risks TP reported that a number of year-end agreements had been reached, including with York Teaching Hospital NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust. The estimates relating to other contracts were expected to have minimal impact into 2018/19. The risk relating to NHS Property Services for the 2017/18 position was due to a national issue in terms of availability of information and would change as the current work progressed. TP additionally noted that NHS Clinical Commissioners were now lobbying for improved information.

In respect of risk relating to continuing healthcare TP referred to the fact that this had been within the Partnership Commissioning Unit for 10 months of the year and in-house for the final two months. TP noted that a specialist interim agency staff member was supporting establishment in-house of the QA system and the data validation work was ongoing. Whilst there was likely to be an impact on the CCG's position and remained a financial risk, this was not expected to be material to the annual accounts. TP noted that discussions were continuing between the North Yorkshire Chief Finance Officers.

TP reported that the draft annual accounts had been submitted to NHS England a day earlier than the national deadline and commended the Finance Team for their work.

The Committee:

1. Received the month 12 financial performance report.
2. Commended the Finance Team on the work associated with submission of the draft annual accounts.

7. Draft Financial Recovery Plan 2018/19 - Financial Plan 2018/19: Priorities for Financial Efficiency

In recommending the draft Financial Recovery Plan to the Committee for approval for submission to NHS England on 30 April TP explained that the Operational Plan was completely framed by this but with incorporation of quality. She highlighted NW's assurance to the Council of Representatives that this was a plan not a promise and recognised that, whilst it was the best possible plan at the present time, there was risk to delivery.

TP reported that the Plan, previously presented based on month 10 outturn, had been amended in accordance with the national requirement for plans to be based on month 12 outturn but noted that this had not resulted in significant changes and the headlines remained as before. TP advised that the final Plan would be incorporated in the Operational Plan.

TP highlighted that, subject to approval by the Committee as delegated from the Governing Body, the Plan met the key metrics: credible QIPP target, credible QIPP plans, £14m deficit control total, Mental Health Investment Standard, no unmitigated risk and all contracts signed. TP noted that the aim of creating resource to invest in the mental health services contract with Tees, Esk and Wear Valleys NHS Foundation

Trust was demonstrated and that the Plan aligned with the CCG's Commissioning Intentions. She also confirmed that the slides on Investments and Pressures captured decisions taken in such forums as the Executive Committee and Primary Care Commissioning Committee.

In response to KR referring to the Patient Story at the April Quality and Patient Experience Committee and expressing concern about continuing healthcare pressures, DN explained that this was a whole system issue and also referred to market related concerns.

TP explained that the key risks to the Plan related to slippage in delivery of QIPP, in particular the Out of Hospital Programme and Continuing Care, although this was off-set by 0.9m of additional QIPP schemes. The key mitigations included the release of the contingency of £2.3m. The respective totals were therefore £2.5m risk off-set by £2.5m mitigation. However, TP noted that there also remained a £4.6m system risk of contract alignment with York Teaching Hospital NHS Foundation Trust which included £1.5m of winter monies (£1m for NHS Vale of York CCG and £0.5m for NHS Scarborough and Ryedale CCG) and under Payment by Results £1.5m financial impact of prior year challenges which would need further review and / or challenge, mainly relating to rehabilitation bed days and £2.1m of differently valued baseline activity. As this was a system risk TP highlighted that it should not be acknowledged in total in the CCG's plan. The joint objective was to agree an Aligned Incentives Contract that would identify how costs would be reduced to manage this.

TP advised that the Plan was profiled to align with the Commissioner Sustainability Fund which was phased: 10% in quarter 1, 25% in quarter 2, 30% in quarter 3 and 35% in quarter 4. PM emphasised that the Committee must be assured that the Plan would deliver at each gateway point. CA added that narrative would be added prior to submission to explain how the money would be released for system benefit.

Members sought and received clarification on a number of aspects of the Plan including the context of pressures previously associated with winter now being experienced all year round, investment in primary care and differentiation of demographic and non demographic growth.

PM reported on a meeting on 23 April with NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust to progress the move from Payment by Results to an Aligned Incentives Contract. He was seeking members' views in preparation for final discussion on 2 May noting that work was taking place at programme level but that agreement was still required on the contractual and financial framework both in terms of the CCG exiting legal Directions and system working towards joint objectives. A culture change from Payment by Results to agreed principles as a system was crucial.

TP referred to a presentation which explained options under an Aligned Incentive (Block and Risk Share) approach, the system gap under Payment by Results and under an Aligned Incentive Contract assuming all savings delivered at 100%, impact of system risks both on the organisational and system positions under Payment by Results and under an Aligned Incentive Contract, risk share approaches, and benefits and disadvantages of Payment by Results and Aligned Incentive Contract in relation to a

joint cost reduction programme. TP highlighted the need to incentivise different behaviours in order to achieve different outcomes and that triggering a risk share would mean failure for all the organisations and therefore all parties were incentivized to ensure delivery that would not require this to be actioned.

KS outlined the ambition of achieving a common view about provision in the community across the three Local Authorities, York Teaching Hospital NHS Foundation Trust and GPs in terms of understanding population needs on the basis of 'place' to inform appropriate service developments. He emphasised the need for innovation to maximise value for money and also referred to primary care based provision and work with Tees, Esk and Wear Valleys NHS Foundation Trust on an Aligned Incentives approach to include services in the community. KS also noted that consideration may be required of allocation being made available differentially to the localities based on need.

TP described experiences of an Aligned Incentives Contract in Hull highlighting the level of trust needed across the system.

Detailed discussion ensued on concerns, potential options and associated implications. The context of the CCG's restructure and clinical focus of the Governing Body was noted and MA-M additionally reported that a number of clinicians at York Teaching Hospital NHS Foundation Trust had expressed a willingness to consider a whole pathway approach in their specialties but not under Payment by Results.

PM proposed that the Committee approve the Plan in the context of achieving the Commissioner Sustainability Fund and authorise the team to negotiate the best possible agreement for its delivery under an alternative to Payment by Results taking account of concerns raised. The need for clinical discussion, continuation of system transformation and increasing trust between organisations were emphasised.

The Committee:

1. Approved the Financial Recovery Plan 2018/19.
2. Requested that delivery of the Plan be negotiated in the context of a move from Payment by Results to an Aligned Incentive Contract of a Block and Risk Share as quickly as possible within the associated challenges.

13. Draft Operational Plan 2018/19

CA introduced the draft Operational Plan as a CCG plan for delivering both the CCG's Commissioning Intentions and the medium-term system financial recovery plan. She noted that it also incorporated the draft system Winter Plan and the CCG's response to the NHS England national guidance and 'asks', including the draft Quality Premium indicators. Following approval by the Committee on behalf of the Governing Body the Plan would not be published until approved by NHS England but would be presented to the Governing Body at a Part II meeting on 3 May.

CA explained that the Plan was structured around firstly 'place' with a focus on delivery of the CCG's Commissioning Intentions and then built delivery around the financial context of the CCG and the system partners. CA noted that the Executive Directors had approved their slides as appropriate.

The Plan included: Activity Plans for 2018/19 with profiles of both Planned and Unplanned Care; Acute Transformation Programme - Closing the System Financial Gap; Defining the Future Operating Model – Emerging Integrated Care Model; Governance – Organisation and System; Engagement – Supporting System Transformation; Risks and Mitigation – Organisation and System; Delivery and Recovery Plans for 2018/19 – Delivering our Commissioning Intentions and System Priorities; Primary Care; Urgent and Emergency Care; Out of Hospital Care; Elective (Planned) Care – Priorities for elective care transformation: core to the Acute Transformation and Financial Recovery Plan; Mental Health, Learning Disability Services and Continuing Healthcare; Cancer Care; Maternity Care; End of Life Care; Humber Coast and Vale Sustainability and Transformation Partnership Collaborative Programmes – Priorities for joint working; and an Annex comprising the draft Winter Plan 2018/19 and draft performance trajectories which required further development. CA noted that NHS England's 13 Key Questions, relating to assurance around delivery of guidance, and the CCG's responses to each, agreed by NHS England, were included as a checklist. CCG delivery of the finance, activity and performance trajectories and would be monitored against these during 2018/19.

CA noted that, following submission on 30 April, the Quality Premium, once approved, would be subject to a quality and safety gateway, a financial gateway and an end of year performance gateway.

In response to CA seeking their views members made a number of suggestions to enhance aspects of the Plan. CA noted that she would discuss with NHS England the expectations of the Winter Plan in view of concerns raised in this regard about potential cost implications.

With regard to planned failure of some Constitutional performance targets, such as Improving Access to Psychological Therapies, CA assured members that there would be clear narrative about intentions to progress performance in these areas. She highlighted that work was taking place with teams to develop innovative approaches to delivery of the Plan, including emerging aligned incentives working with provider partners, and that assurance would be via the monthly meetings of the Financial Recovery Board.

CA would finalise the Plan in terms of content and formatting prior to submission on Monday 30 April and any further comments or amendments would be welcomed before submission.

The Committee commended the Plan and expressed appreciation for the work involved in its development.

The Committee:

Approved the Operational Plan 2018/19 noting that amendments would be incorporated as per the discussion.

The following items were noted as received due to the focus on the above items.

8. Update on Better Care Fund
9. Contract Trading Report Month 11
13. Integrated Performance Report Month 11
14. Winter Update
15. Draft Winter Plan 2018/19

15. Key Messages to the Governing Body

- The Committee recorded appreciation of the achievement of the stabilised financial position at year-end and wished to thank all members of staff, the Governing Body and associated committees for their exceptional contribution in the past year. However, the Committee also noted the continuing challenges for the new financial year.
- The Committee approved the Financial Recovery Plan 2018/19 emphasising that the CCG was intent on moving from Payment by Results to create an Aligned Incentive Contract / Block and Risk Share with York Teaching Hospital NHS Foundation Trust as a matter of priority.
- The Committee approved the Operational Plan 2018/19 for submission to NHS England on 30 April 2018.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

16. Next Meeting and Forward Plan

The next meeting would be 9am to 1pm on 24 May 2018.

NHS
Vale of York
Clinical Commissioning Group

Minutes of the Finance and Performance Committee Meeting held on 24 May 2018 at West Offices, York

Present

David Booker (DB) (Chair)	Lay Member and Finance and Performance Committee Chair
Michael Ash-McMahon (MA-M)	Acting Chief Finance Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Keith Ramsay (KR)	Lay Member and Chair of Primary Care Commissioning Committee, Quality and Patient Experience Committee and Remuneration Committee
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health

In attendance

Caroline Alexander (CA) – items 16 and 17	Assistant Director of Delivery and Performance
Anna Bourne (AB) – items 11 and 12	Senior Procurement Lead
Abigail Combes (AC) – items 1 to 6	Head of Legal and Governance
Becky Case (BC) – item 13	Head of Transformation and Delivery
Louise Horsfield (LH) – item 12	Commissioning and Transformation Manager
Shaun Macey (SM) – item 11	Head of Transformation and Delivery
Michele Saidman (MS)	Executive Assistant
Jon Swift (JS) – items 1 to 8	Director of Finance, NHS England North (Yorkshire and the Humber)

In welcoming everyone to the meeting DB reiterated members' previously expressed appreciation of JS's support and outlined the challenges facing the CCG to be addressed in the meeting:

- The need to create an Aligned Incentives Contract, across the system, to control costs
- The imperative to take an early, measured and confirmed overview of QIPP which is critical to financial stability
- The growing concerns regarding Continuing Healthcare and potential cost implications

The agenda was discussed in the following order.

1. Apologies

There were no apologies.

2. Declarations of Interest in Relation to the Business of the Meeting

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

3. Minutes of the meeting held on 26 April 2018

The minutes of the previous meeting were agreed subject to amendment of KR's title to read 'Lay Member and Chair of Primary Care Commissioning Committee, Remuneration Committee and Quality and Patient Experience Committee'.

The Committee:

Approved the minutes of the meeting held on 26 April 2018 subject to the above amendment.

4. Matters Arising

F&P45 Format of the Financial Performance Report to be aligned with that of the Integrated Performance Report: MA-M advised that this would be implemented from Month 2 as full month end reporting did not take place for April due to lack of availability of activity based information.

The other matter arising was on the agenda at items 14 and 15.

5. Risk Update Report

AC presented the report which provided details of current events and risks managed by the Finance and Performance Committee for consideration regarding effectiveness of risk management approach and application of corporate risk appetite approach; confirmed the cohort of corporate risks for escalation to the Governing Body; and gave an overview of programme risk registers. With regard to the latter AC explained that programmes were currently being aligned with strategy areas and escalation thresholds were being established. AC also noted that a full update of the CCG's Board Assurance Framework was taking place; associated risks, and risks arising from the latest NHS England CCG Improvement and Assessment Framework, were being compiled.

AC proposed, and members agreed, that she should review the risks with operational leads to ensure only those appropriate for management by the Committee were reported as had been agreed with the Governing Body and Quality and Patient Experience Committee.

KR sought clarification about incentivising providers to meet targets in the absence of such as the proposed Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust. MA-M responded that DN was discussing an aligned incentives

type approach with Tees, Esk and Wear Valleys NHS Foundation Trust and gave the example of the CCG's offer to reinvest in the contract envelope for clinical services the significant funding released from their market rent adjustment and estate rationalisation. He noted that this aligned with mental health services being a priority for the CCG and the potential for additional investment in Child and Adolescent Mental Health Services which members emphasised was a reputational as well as a financial and quality risk. AC referred to this risk in the context of patient safety and quality noting the training provided to staff in the CCG in line with the risk strategy which included an expectation that where these risks related to another provider, committee Chairs would be asked to support the seeking of assurance from providers to address concerns. In this context it may be that there was an expectation that, as Chair of the Quality and Patient Experience Committee, KR would seek information about actions being taken to address concerns.

The Committee:

1. Received the Risk Update report.
2. Agreed that AC should review the risks with operational leads to ensure only those appropriate for management by the Committee were reported.

6. Finance and Performance Committee Terms of Reference

In presenting the revised terms of reference AC highlighted the additions relating to the Quality and Patient Experience Committee being informed of any concerns, the inclusion of oversight of Emergency Preparedness, Resilience and Response, and the updated Committee membership. Members sought and received clarification on a number of aspects noting in particular with regard to primary care that the Committee's role in such as item 11 was to provide assurance to the Governing Body about the procurement process. KS added that the Primary Care Commissioning Committee was the forum where the related expenditure recommendations would be made and noted that the Finance and Performance Committee would receive all CCG procurements to provide assurance for decision making process.

AC confirmed that the report to the Governing Body on the committee structure would formally state each committee's areas of decision making to ensure clarity.

The Committee:

1. Approved the revised terms of reference.
2. Noted that Emergency Preparedness, Resilience and Response would be added to the work plan.

"Good News"

MA-M referred to the CCG's Chronic Fatigue Service contract and described the changes accessing this service had made for a friend who had been extremely appreciative of the positive impact on her life. He noted that the CCG had recently recommissioned this comparatively small contract.

AC left the meeting

PM and DN joined the meeting during item 7

7. Financial Performance Report Month 1

MA-M reiterated that this report was in the context of there not being availability of activity based information for April. The report demonstrated how the draft financial plan submitted to NHS England would be reported against throughout the year and provided details and assurance around the actions being taken for the year to date.
MA-M referred to the £14.0m Commissioner Sustainability Fund noting that the financial plan did not assume access to this. He explained that the CCG was currently working to the draft financial plan submitted to NHS England on 30 April 2018 which was based on a brought forward deficit of £43.8m and a planned for in-year deficit of £14.0m in 2018/19, resulting in a cumulative deficit of £57.8m at the end of the financial year. Feedback from NHS England had been incorporated in the draft Financial Recovery Plan at the following agenda item. MA-M also noted that the in-year position for Commissioned Services and Running Costs were respectively a deficit of £14.726m and an underspend of £726k. The latter was due to vacancies and savings on the eMBED contract which was part of QIPP (Quality, Innovation, Productivity and Prevention).

MA-M noted that the current financial plan required delivery of a £14.5m QIPP and that 2017/18 year-end positions for four contracts – Ramsay and Nuffield Hospitals, Harrogate District NHS Foundation Trust and Leeds Teaching Hospitals NHS Foundation Trust – would be based on actual activity, which was still to be finalised.

With regard to the Aligned Incentives Contract MA-M reported that a formal offer, based on a number of key principles, had been made to York Teaching Hospital NHS Foundation Trust by NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs but noted there would be no formal commitment until after their Board meeting on 30 May. MA-M explained that the offer was for a revised contract value post QIPP of £339.794m across the three CCGs and commitment to work to deliver services within the commissioners' affordability envelope of £330.079m. This was against the York Teaching Hospital NHS Foundation Trust's assumed income of £351m. There was therefore a c£21m alignment gap.

In response to clarification sought by members MA-M explained that NHS Vale of York CCG's share of the Aligned Incentives Contract offer was £219.316m against the planned £212.932m and the 2017/18 outturn of £217.616m but noted with regard to the latter that c£1.0m had transferred to Humber Teaching NHS Foundation Trust relating to the community beds at Malton Hospital in 2018/19.

MA-M reported on discussion at a meeting he, PM and KS had attended between the three CCGs and York Teaching Hospital NHS Foundation Trust to discuss the principles of the Aligned Incentives Contract offer. He advised that it had not formally been submitted to NHS England or NHS Improvement as it first required approval of the respective organisations' governance processes therefore there was the potential for caveats to be added.

Discussion ensued in the context of York Teaching Hospital NHS Foundation Trust's financial position, their breach of licence, the ongoing discussions between commissioners and the provider and the key requirement for culture change.

The Committee:

1. Received the month 1 financial performance report.
2. Noted the ongoing work to agree an Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust.

8. Draft Financial Recovery Plan

MA-M described the development of the Financial Recovery Plan noting that this updated draft also incorporated amendments to address areas highlighted in JS's letter, included as an appendix to the report.

MA-M referred to the CCG's £14.0m control total for eligibility for the Commissioner Sustainability Fund and explained that there were three conditions/measurements to access this: deliver a financial plan consistent with the financial control total for 2018/19; agreement of a milestone-based recovery plan with NHS England by the end of quarter 1 if not already in place; and hit the year to date financial control total for each quarter across 2018/19 and provide a credible and well-evidenced forecast in line with the plan at the end of quarters 1, 2 and 3. MA-M explained the phasing of the Commissioner Sustainability Fund and noted that if a quarterly payment was missed the next payment would not be lost and that a lost quarterly payment could be earned back if the cumulative total was met the following quarter.

Discussion ensued with regard to QIPP delivery to ensure access to the Commissioner Sustainability Fund. MA-M explained that some schemes were profiled to deliver in quarters 2 and 3 but noted such as Prescribing Indicative Budgets and the £1m acute QIPP agreed with Ramsay Hospital for health optimisation were in place from the start of the year.

DN described issues contributing to the continuing healthcare financial pressures, including market management and issues from the incompatibility of SystmOne and QA system which meant manual tracking of individual cases. She noted that c£250k savings identified to date required validation through finance.

In response to JS advising of the opportunity to increase the number of days of QIPP support, DN explained the need for system change, new processes and project management to address the current situation with continuing healthcare. DN added that, as well as the nurse resource, the market and overall transformation and management required attention. JS reiterated the opportunity for further support; DN thanked him for this.

MA-M explained that under an Aligned Incentives Contract if the cost reduction was not achieved in quarter 1 discussion would be required with system partners to ascertain the reasons and address the fact that management had not been within the resource envelope. He noted that if the system remained under Payment by Results contingency plans were being developed but further potential options were required.

MA-M advised that an Aligned Incentives Contract was more cost effective and that the biggest risk to not delivering QIPP in quarters 1 and 2 related to the CCG being able to exit legal Directions.

PM referred to PwC's recent system work advising that their report would be issued to the three CCGs and York Teaching Hospital NHS Foundation Trust on 29 May which would be key for determining action required. He emphasised that there was no alternative to an Aligned Incentives Contract to deliver the system transformation required. DN added that there was a need to recognise the potential requirement for areas of investment to maintain safety and sustainability.

DB reiterated the Committee's previous mandate to proceed to achieve an Aligned Incentives Contract and requested an assurance update with regard to management of orthopaedics in view of it being so crucial to delivery of the Financial Recovery Plan.

MA-M reported that NHS England had requested further consideration of proposed spend on mental health services particularly with regard to services for children and young people where the plan was £116k short, although the overall Mental Health Investment Standard was being met. He explained that because of the way the CCG's budgets were set the £3 per head for primary care was in effect double funded and therefore provision had already been made for c£0.25m. MA-M proposed that £120k be moved recurrently to services for children and young people and that the residual amount be moved into reserve to maintain the bottom line. KS additionally noted that the Executive Committee had approved GP cover for the Minor Injuries Unit for it to become an urgent care centre in Selby.

MA-M confirmed that the £120k would be recurrent and also referred to the potential for £47k relating to CQUIN (Commissioning for Quality and Innovation) to address historic debt. Members supported this additional amendment to the Financial Recovery Plan, which would be submitted to NHS England the following day.

Further discussion took place in the context of the Financial Recovery Plan being both realistic and in line with the CCG's commitment to invest in primary care and mental health services. There was also recognition that investment would be required in constitutional target areas and associated reduction in availability for investment in acute services.

In terms of beyond 2018/19 MA-M referred to the CCG's plan to return to an in-year 1% surplus without the Commissioner Sustainability Fund by 2021/22 and a c£10m surplus by 2022/23. He explained that if this trend continued profiling from high level modelling indicated potential 1% cumulative surplus from 2026/27; this trajectory would improve if the Commissioner Sustainability Fund continued.

The Committee:

1. Approved the updated Financial Recovery Plan and the associated multi-year recovery.
2. Requested an update at the next meeting to provide assurance in respect of orthopaedics.

9. Better Care Fund Update

In addition to the update relating to City of York Council Better Care Fund PM reported on a number of issues in this regard in terms of assessment of the schemes. He advised that this was now being monitored by the CCG's Executive. PM also noted that Pippa Corner, Head of Joint Commissioning Programme (City of York Council / NHS Vale of York CCG) had written to him proposing appointment of a Joint Programme Performance Manager to manage the Better Care Fund.

Discussion ensued in the context of performance issues and the historic relationship and cultural issues which had also been identified in the Care Quality Commission York Local System Review in 2017. DN additionally explained that mental health delayed transfers of care in mental health services had not previously been reported but Tees, Esk and Wear Valleys NHS Foundation Trust was now reporting them which had resulted in City of York Council being flagged for its delayed transfer of care levels. DN also referred to the fact that based on November information conditions had been placed on the City of York Council Improved Better Care Fund and noted that they had expressed concern in terms of equity as not all areas reported mental health delayed transfers of care.

DN reported that City of York Council had proposed changes in criteria for attributing responsibility to health and social care for joint funded delayed transfers of care which were possibly not acceptable as the CCG neither had responsibility for sourcing placements nor held any such contracts. This change would affect the CCG baseline and as such was being discussed at the Finance and Performance Committee for advice and steer. DN also highlighted that Tees, Esk and Wear Valleys NHS Foundation Trust had invested in a nurse to plan discharges early but that placements in York were limited.

PM added that delayed transfers of care was a specific issue within the City of York Better Care Fund. He reported that, following discussion, the Executive Team had supported the previous reporting methodology and did not agree to a change. DB and KR agreed with this stance and noted that NHS England advice was being sought for this with awareness of potential impact on the wider relationship.

With regard to the request in the report for the Committee to receive quarterly rather than monthly reports with exception reporting as appropriate, members agreed that updates should include the three Better Care Funds. It was agreed that this approach would be progressed when the new Chief Finance Officer took up post.

The Committee:

1. Received the update report.
2. Agreed that the statutory position be maintained in respect of delayed transfers of care.
3. Noted that updates on the three Better Care Funds would be progressed when the new Chief Finance Officer took up post.

PM and JS left the meeting; AB and SM joined the meeting

11. Improving Access to GP Services

Further to approval by the Executive Committee SM presented the report which included the draft service specification, budget information and procurement process to meet the NHS England mandated deadline of a 1 October 2018 start date for the Improving Access to GP Services contract; the intention was that an Invitation to Tender (ITT) advert would be published on 29 May 2018.

SM explained that the service would be procured in three 'lots' with services being commissioned to meet patient needs based on the three established localities – North, Central and South – across the CCG's footprint. The contract would be awarded for three years and be flexible in the context of future developments; bidders could bid for more than one 'lot'. Engagement events were being arranged for potential bidders who were expected to include General Practice working in collaboration with partner providers.

AB advised that, subject to expressions of interest, an event was being planned for 5 June. She noted that General Practice was being encouraged to seek professional support in development of their bids and to network with potential partners in order to encourage bids from our GPs. The event was published on Contracts Finder.

AB explained that the questions to potential bidders would include the need for premises and associated arrangements. She assured members that although scoring would be 100% quality, a due diligence check would also be undertaken on the commercial envelope to ensure viability of their offering in terms of costs associated with delivering the service, such as staff and premises.

In terms of funding SM reported that NHS England would be passing the funding for Improving Access to General Practice services at evenings and weekends to the CCG on an annual basis. The full value would be passed on to the successful Provider(s) via the block contract. SM advised that NHS Planning Guidance confirmed 2018/19 funding of £3.34 per weighted head and £6.00 per weighted head from April 2019 but noted that bidders needed to be made aware that list sizes and hence funding to the CCG may change over the duration of the contract.

Members sought and received clarification on aspects of the additional capacity noting that the new service would be open at Bank Holidays and the specification was for additional evening and weekend appointments to those offered in the current core hours. SM additionally explained that Practices in each locality would need to work together to book appointments through the hub and therefore provide patient choice.

With regard to Information Management and Technology support for the new hours SM advised that the successful provider would be required to make all reasonable efforts to secure effective IT support within the constraints of the current EMIS and SystmOne support services not being available at evenings and weekends. AB added that this would be included in the procurement questions.

AB highlighted the timelines for the approval process and sought and received agreement for the anonymous award report to be circulated prior to the 26 July meeting of the Committee on either 24 or 25 July, dependent on completion. She also noted the potential for delegated authority to be sought from the Governing Body if there was no meeting on 2 August 2018.

The Committee:

1. Approved the Improving Access to GP Services Procurement as detailed.
2. Noted that delegated authority for award approval may be sought from the Governing Body due to the timescale.

SM left the meeting; LH joined the meeting.

12. Procurement of a Single Provider Model Minor Eye Conditions Service

Further to approval by the Executive Committee LH presented the report which included the draft service specification, budget information and procurement process for a single provider model Minor Eye Conditions Service noting the intention to publish the Invitation to Tender on 21 June 2018.

LH explained that the current Local Enhanced Service for minor eye conditions was no longer sustainable therefore the proposal was to procure a similar replacement service with improved governance arrangements and managed by a single company. The current timescale of patients being seen within a week would be reduced to 48 hours.

The service specification was in near final version, and was subject only to minor changes at this stage. The financial information provided was currently high level because this was the final meeting of the Committee prior to the Invitation to Tender being published on 21 June 2018 (with the next committee meeting being on 3 July 2018); ideally more developed information would have been available for the Committee's consideration. However with another month in the timeline until the advert, there was still further work to be done around the financial modelling. Greater financial detail would be distributed virtually to the Committee when it was available.

LH advised that the options for a costing model were on a cost per case basis or a 'cap and collar' contract, noting that the latter was preferable for the CCG due to potential increase in activity. The service would include two to eighteen year olds, whereas the current service was for patients aged 18 years and over only. The cost envelope was based on current activity and demand, with growth and uplift, but was not adjusted for the inclusion of children aged two to 18 years in the service as it was not possible to accurately quantify this element of the service currently; the new service was expected to be delivered within the envelope.

In response to assurance sought by members, LH wished to recognise the work of the current service but highlighted the need for this to be enhanced. The revised service specification would be more robust and provide assurance on quality and safety through monitoring; triage would be through Practices. With regard to serving notice LH explained that there was no specification of timescale in the current contract but the intention was to give six months' notice for a 1 December 2018 start date. AB reported that there was at least one provider interested in the new service. She also noted that notice to the current providers would include a caveat of a potential request to continue the service should a new provider not be successfully procured, to mitigate risk around service continuation.

Members sought and received clarification on aspects of the service including in respect of training with particular reference to children. LH advised that accreditation was through the Wales Optometry Postgraduate Education Centre (WOPEC); AB added that safeguarding training was also required.

The Committee:

Approved the procurement of a single provider model Minor Eye Conditions Services as detailed.

DB reported that his 93 year old mother had had a recent experience relevant to this agenda item. As the result of a visit to an optician she had the following day attended a fast track appointment with an ophthalmologist and on the same afternoon seen a Registrar and a Consultant who had diagnosed a minor stroke. This demonstrated that empowering specialist health workers, in both public and private settings, can improve patient experience and reduce costs

AB and LH left the meeting

10. Contract Trading Report Month 12

In presenting this report MA-M additionally referred to the update at item 7 regarding the Aligned Incentives Contract noting that the formal offer letter to York Teaching Hospital NHS Foundation Trust was included as an appendix. He highlighted that the Leeds Teaching Hospitals NHS Trust forecast outturn had, subject to confirmation, improved by £46k and that confirmation had been received that Tees, Esk and Wear Valleys NHS Foundation Trust did not achieve the CQUIN in full resulting in a reduction of £47k which would be reinvested, non recurrently, in children's services in 2018/19 (not in Improving Access to Psychological Therapies as in the report). MA-M also reported that the Ramsay Hospital's forecast outturn position had deteriorated by £52k and that there was a £41k deterioration in the forecast outturn with Harrogate and District NHS Foundation Trust due to continuing coding and counting issues. He noted however, in respect of the latter, that this was considerably less than the £900k carried forward from 2016/17 into 2017/18.

In response to MC referring to the fact that York Teaching Hospital NHS Foundation Trust had not fully achieved the quarter 4 Sepsis CQUIN, MA-M explained that this was encompassed within the agreed year-end position. Further discussion ensued regarding the process for decision making about CQUIN and potential opportunities, including the context of the requirement to continue to offer CQUIN under an Aligned Incentives Contract; this would be followed up outside the meeting.

BC and PM joined the meeting

The Committee:

Received the Month 12 Contract Trading Report.

13. Winter 2017/18 and 2018/19 Update with Urgent and Emergency Care Network news

BC referred to the report which provided an overview of the whole year comparison between urgent care standards in 2016/17 and 2017/18. This included a summary of the work currently ongoing in the regional Urgent and Emergency Care Network and also the recent request for a revised trajectory for the 50% Clinical Advice via NHS111 project.

With regard to admissions BC explained that the higher than expected respiratory admissions in November and December were being reviewed following identification of coding issues. She also noted that there had been additional support for weekend discharges during winter but this needed to be long term and with the associated culture change. Focus was required on discharges and delayed transfers of care.

BC reported that discussions had begun at regional level for 2018/19 winter planning noting inclusion of mental health discharges including care homes. She advised that the Complex Care Discharge Group, which met monthly, had a number of workstreams mostly led by York Teaching Hospital NHS Foundation Trust. Additionally, information was awaited, as identified by Ernst and Young, for system improvements.

DN had discussed concerns with York Teaching Hospital NHS Foundation Trust around discharge processes and criteria which led to discharges to care homes. She noted that the CCG invested considerably in community beds but had little control over the admissions and also emphasised that discharges should take account of recuperation or rehabilitation potential. DN added that work was currently taking place in the context of consideration of a community bed rather than on the basis of three separate organisations. MC added that she had requested detailed analysis about nursing and medical staff who were key to addressing the issues but were not included in the work at this time.

BC reported that the Local Authorities were being proactive in requesting CCG involvement and were working with York Teaching Hospital NHS Foundation Trust. She noted, however, that this was not on a clinical basis.

KS, the CCG's lead on community, emphasised that a long term system solution was required as delayed transfers of care was a community issue. The people affected needed community, not hospital, support.

PM noted the current review of the A and E Delivery Board and the Complex Discharge Group as an opportunity for the system to be reorganised to address issues relating to delayed transfers of care.

DB requested an update for the next meeting to provide assurance on progress to resolve the issues.

BC described the ongoing work in relation to delivery of 50% clinical triage via NHS111 noting that Humber, Coast and Vale Sustainability and Transformation Partnership was currently achieving 42.6%. It should be noted that this figure does not currently include

North East Lincolnshire CCG which has a separate Single Point of Access (not NHS111) so one potential solution was the inclusion of approximately 10,000 calls per month via this SPA, potentially by routing these through NHS111. When these are included the Sustainability and Transformation Partnership figure is 60%.

The Committee:

1. Received the overview of the whole year comparison between urgent care standards in 2016/17 and 2017/18 and the summary of the work currently ongoing in the regional Urgent and Emergency Care Network including the recent request for a revised trajectory for the 50% Clinical Advice via NHS111 project.
2. Requested an update on progress towards addressing issues relating to delayed transfers of care at the next meeting.

BC left the meeting

14. Children and Young People's Mental Health: Local Transformation Plan 2017/2018 Quarter 4 Update

In presenting this report DN referred to discussion both at the previous Committee and at the Governing Body.

DN referred to the 2015 *Future in Mind* framework and associated funding to support transformation over five years from 2015/16 noting that the CCG had received £579,890 of which at least £166k was spent on establishing a community eating disorder service and a further £233k for the school wellbeing services. However, from 2016 onwards the remaining monies had been included in the CCG's baseline.

DN explained that the CCG funded three significant schemes through *Future in Mind:* Community eating disorders, in partnership with the three North Yorkshire CCGs and provided by Tees, Esk and Wear Valleys NHS Foundation Trust; School well-being service in City of York, jointly funded with York City Council; and Compass Buzz in the North Yorkshire County Council area as part of a contract across North Yorkshire County Council to develop capacity in schools to respond to emotional and mental health problems.

DN reported that the school well-being service helped to reduce inappropriate referrals to Child and Adolescent Mental Health Services; the current issue regarding ongoing funding this was being addressed. DN explained that, whereas some areas had also invested in primary healthcare workers as pre-Child and Adolescent Mental Health Services support – this was not the case across the CCG where c30% of referrals to Child and Adolescent Mental Health Services were inappropriate. There was an opportunity to consider alternate delivery of the Child and Adolescent Mental Health Services pathway.

DN advised that Compass Buzz had been commended by the Care Quality Commission but noted that GPs were not sufficiently informed about this or other alternatives. There was a need across the localities for both GPs and parents to be better informed.

DN referred to the 2017/18 Quarter 4 Local Transformation Plan update included in the report noting that submissions were now being signed off by the Executive for assurance. She noted some improvements in Red Amber Green (RAG) ratings and also advised that NHS England's response to the Quarter 3 submission had recognised progress though queried whether investment was at the level required.

The Committee:

Received the Children and Young People's Mental Health: Local Transformation Plan 2017/2018 Quarter 4 Update.

15. Children and Young People's Mental Health: Community Eating Disorders

DN highlighted that in response to the Committee's request for assurance on Child and Adolescent Mental Health Services she would present a number of reports to provide clarity. In addition to this Community Eating Disorders report she would provide updates to the next meeting on Attention Deficit Hyperactivity Disorder, autism assessment and emotional health and well-being.

DN presented the report which described the *Future in Mind* requirements for a community eating disorder service, the national service requirements, service structure, performance in 2016/17 and 2017/18, Tees, Esk and Wear Valleys NHS Foundation Trust's position, and actions taken. DN explained that the community eating disorders service in the CCG was based on anticipated demand and on this basis had been planned for 30 cases. However referrals were much higher than this: 60 in 2016/17 and 77 in 2017/18. Additionally, the fact that the service was more generic not specialist impacted on monitoring performance against the tight deadlines imposed by the national standards. Investment in staffing was for 6.6 whole time equivalent across North Yorkshire and York for the enhanced service against the recommended 17 in a specialist model.

Members sought clarification of the performance reported in 2017/18 for urgent referrals, routine referrals, discharges and completed noting that referrals were from a number of sources and that further work was required to gain a better understanding of the need for this service. DN added that compliance with the national standards had not been accounted for when the service had been commissioned emphasising the need to identify unmet need. She also noted that physical healthcare checks were not commissioned under the contract.

DN reported that an action plan had been drafted to progress the issues relating to Community Eating Disorders which included agreed trajectories for 2018/19 of 25% compliance for routine cases and 75% for urgent cases. A set of trajectories for agreeing compliance with the national target beyond 2019/20 was also included.

CA joined the meeting during this discussion

With regard to potential investment MA-M referred to the earlier discussion but noted that the £120k proposed would not meet the £300k shortfall of the service model for children with eating disorders. However, following discussion members agreed to consider this service within the overall context of the Child and Adolescent Mental

Health Services concerns when DN had presented the further reports at the next meeting. A thematic report would then be presented in a number of forums, including the Quality and Patient Experience Committee with its restructured clinical focus, to inform prioritisation.

MC additionally reported that she was appointing a Head of Children's Services who would provide clinical advice support to this work.

The Committee:

1. Received the report on Community Eating Disorders relating to children and young people.
2. Noted that a thematic report would be provided to inform prioritisation of services for children and young people.
3. Noted that a Head of Children's Services was being appointed.

KR left the meeting

16. Integrated Performance Report Month 12

CA presented the report which comprised key performance headlines, performance summary against all constitutional targets, and programme overviews relating to planned care, unplanned care, mental health, learning disability and complex care, primary care and included annexes providing core supporting performance information. She noted that the information presented was the validated year-end position and included the full impact of winter on non-elective and elective care.

CA explained that future iterations of this report would be aligned with the NHS England Improvement and Assessment Framework indicators and with the key local indicators which the CCG was monitoring to report on the impact of performance and financial recovery delivery programmes. To this end she requested a dedicated session at the next Committee meeting in order to confirm all performance priorities and associated trajectories were understood and agreed by the Committee and confirmed in turn to Governing Body. She also reported that York Teaching Hospital NHS Foundation Trust was introducing a new transformation programme which would build on and refresh the recovery programmes in their existing performance improvement boards - Children, Cancer, Planned Care, Urgent Care and Carter/Estates. The ambition of the System Transformation Board was to move to joint delivery of cost reduction and transformation programmes that would align CCG QIPP work and York Teaching Hospital NHS Foundation Trust local Cost Improvement Programme schemes. This would require the establishment of joint datasets, which may include unvalidated information to enable performance recovery and financial recovery to be considered together.

CA referred to the current urgent and emergency care performance on the Scarborough Hospital site noting that both the Ernst and Young review and NHS Improvement had identified a lack of resilience.

With regard to the A and E four hour 95% target at the year-end CA highlighted that the 2017/18 performance was an improvement of 0.5% year on year from 2016/17.

She advised that the A and E Delivery Board was required to provide a winter plan submission for 2018/19 by the end of June.

CA noted that all 14 day, 31 day and 62 day cancer performance targets had all been met in month. She would clarify the figure of 70,000 patients being included in the ongoing colorectal two week wait improvement work focused on FIT (Faecal immunochemical test) with SHIELD Practices, noting the hope that this pilot would be continued but that this figure was undoubtedly incorrect. CA also highlighted that NHS Improvement Health Economics team had identified that delivery of two week waits and the move towards reducing this to seven days was a key improvement priority area to support delivery of the 62 day performance target in turn.

In relation to recent correspondence from NHS England regarding breast screening KS explained that screening revisits were a separate pathway and NHS England was commissioning additional capacity to deliver this.

CA advised that she was seeking detailed analysis of the significant deterioration in diagnostics. With regard to MRI breaches at York Teaching Hospital NHS Foundation Trust CA explained that there was a cohort of 25 children who required an MRI under general anaesthetic. She was awaiting information as to how many of the 25 had taken up the offer of being transferred to Sheffield. Those who remained on the waiting list in York would be managed by a paediatrician and the CCG's Deputy Chief Nurse was awaiting clarification from York Teaching Hospital NHS Foundation Trust on the approach being taken to manage any clinical risk in relation to these children while they wait. This was being progressed through sub Contract Management Board for understanding and managing performance and quality risks.

CA reported that the 42 breaches in relation to CT scanning at Hull and East Yorkshire Hospitals NHS Trust were due to both equipment and workforce capacity issues which the Cancer Alliance was working to address.

CA noted that consideration was being given to utilising the Referral Support Service to help to address the deteriorating diagnostics performance and this would be discussed further through the expert consulting programme of work under the Planned Car Steering Group.

CA highlighted an improvement in delivery against prevalence and access targets for Improving Access to Psychological Therapies.

The Committee:

Received the month 12 Integrated Performance Report.

17. Performance Priorities for 2018/19

CA referred to the fact that the CCG had been assessed as Inadequate against the 2016/17 Improvement and Assessment Framework and that the 2017/18 outcome was not yet known. This would be assessed and reported by July 2018. She explained that the NHS England weightings for 2016/17 had been 50% for the 49 performance and outcomes measures, 25% for quality of leadership and 25% for finance management

indicator, noting that, although the weightings for 2017/18 were not known the CCG performance had improved across the majority of the indicators.

CA noted that she would present at the next Committee the priority indicators which the CCG could progress to move towards an assessment of 'Good', or at least 'Requires Improvement' overall for 2018/19 when assessed in June/July 2019/20, although the Improvement and Assessment Framework assessment would not be available until July.

Members emphasised the need to both focus on the CCG's performance but to also maintain the momentum of the system financial recovery work.

The Committee:

Noted the update.

18. Key Messages to the Governing Body

- The Committee noted and welcomed the beginning of the process to move to an Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust and requested additional information at the next meeting on areas, including orthopaedics and delayed transfer of care, that were affecting progress across the system.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

19. Next Meeting and Forward Plan

The next meeting would be 1pm to 5pm on Tuesday 3 July 2018.

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Vale of York
Clinical Commissioning Group

Item 18

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	22 May 2018
Chair	Keith Ramsay

Areas of note from the Committee Discussion

- The Committee approved revised terms of reference.
- The Committee received the updated draft 2018/19 financial plan for delegated commissioning.
- The Committee welcomed the plans from the Central and North Localities for the 2018/19 PMS premium and £3 per head transformation funding.
- The Committee noted the ongoing public concern about Unity Health's consultation prior to opening the new surgery at Kimberlow Hill, York.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

NHS
Vale of York
Clinical Commissioning Group

Minutes of the Primary Care Commissioning Committee held on 22 May 2018 at West Offices, York

Present

Keith Ramsay (KR) - Chair	Lay Member and Chair of the Quality and Patient Experience Committee and Remuneration Committee in addition to the Primary Care Commissioning Committee
Michael Ash-McMahon (MA-M)	Acting Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
David Iley (DI)	Primary Care Assistant Contracts Manager, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Dr Kevin Smith (KS)	Executive Director of Director of Primary Care and Population Health

In attendance (Non Voting)

Kathleen Briers (KB)	Healthwatch York Representative
Abigail Combes (AC)	Head of Legal and Governance
Dr Paula Evans (PE)	North Locality GP Representative
Shaun Macey (SM)	Head of Transformation and Delivery
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Apologies

Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)

Unless stated otherwise the above are from NHS Vale of York CCG

Two members of the public were in attendance.

There were no questions from members of the public.

Agenda

1. Welcome and Introductions

KR welcomed everyone to the meeting. He particularly welcomed PE to her first meeting as North Locality representative, DI on behalf of HM, and MA-M who was attending his first meeting as Interim Chief Finance Officer.

KR highlighted agenda item 6, which would form part of a report to the July Governing Body of all committee terms of reference, and noted with regard to item 11 the expectation that discussions between Healthwatch and the CCG would continue after the meeting.

2. Apologies

As noted above.

3. Declarations of Interest in Relation to the Business of the Meeting

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

4. Minutes of the meeting held on 27 March 2018

The minutes of the meeting held on 27 March were agreed.

The Committee

Approved the minutes of the meeting held on 27 March 2018.

5. Matters Arising

SM confirmed that the matter arising, which related to commissioning of Local Enhanced Services and scheduled for the July meeting, would be across all three localities.

The Committee

Noted the update.

6. Primary Care Commissioning Committee Terms of Reference

AC referred to the Committee Terms of Reference advising that they had been reviewed in the context of the re-set Governing Body and the CCG's ambition of being released from legal Directions and special measures. Account had also been taken of the Deloitte's Conflict of Interests review in terms of membership. AC additionally explained the proposal for quality issues relating to primary care to be managed through the Quality and Patient Experience Committee with reporting to the Primary Care Commissioning Committee if appropriate. This would mean that all aspects of quality from the patient experience perspective would be focused in the same forum with a consistent approach for reporting of primary and secondary care quality matters.

In response to PE enquiring about involvement of primary and secondary care clinicians, KS and MC referred to the fact that the Care Quality Commission was the body which scrutinised primary care and that there was a gap in triangulation of information with the current arrangements of primary care quality not being reported at the Quality and Patient Experience Committee. The proposed change would provide assurance that quality was being reviewed through an appropriate structure

and with potential exception or summary reporting to the Primary Care Commissioning Committee. Additionally triangulation of the agendas of these two committees was provided through the fact that KR was chair of both and therefore provided assurance in this regard.

KR referred to the 'in attendance' membership of the Primary Care Commissioning Committee highlighting the need to recruit a Practice Manager and Health and Wellbeing Board representative.

SS additionally highlighted that from a Local Authority perspective issues relating to Public Health commissioned services were considered on a case by case basis and suggested potential for this to be included in the remit of the Quality and Patient Experience Committee, which had to date received a number of specific reports. KR requested that a proposal be developed for consideration at a future meeting noting that, as principal commissioner, the CCG received patient feedback from many sources.

The Committee

1. Approved the revised terms of reference.
2. Requested that a proposal be developed for Public Health commissioned services to be incorporated in the remit of the Quality and Patient Experience Committee.

7. Primary Care Commissioning Financial Report

MA-M presented the report which detailed the financial outturn of the CCG's primary care commissioning areas for 2017/18 and provided an update on the draft primary care delegated budgets for 2018/19 which had been revised in line with national guidance.

MA-M reported that the 2017/18 year-end position for delegated commissioning budgets was £41.9m against the £42.0m budget and noted that the variance should read as an underspend of £134k, not an overspend as per the report. Most of the movements in year had been forecast and previously reported. MA-M noted the receipt of £230k additional non recurrent allocation in Month 11 included in 'Other GP Services' which recognised previously reported one-off overspends during the year.

MA-M advised that the iteration of the draft financial plan for delegated commissioning for 2018/19 previously presented had been revised to take account of draft GP contract changes and may still be subject to change pending the finalisation of this and any associated guidance from NHS England. He explained that the revised draft plan currently described expenditure of £43.8m against the 2018/19 £43.9m delegated commissioning allocation, which represented an increase of £1.2m (2.8%) from the 2017/18 allocation. There was a 0.5%, c£0.25m, contingency against which there was no expenditure.

MA-M noted inclusion of the updated information relating to 'Other Primary Care', the areas that were not delegated, and the associated variances in terms of the draft

plans of 8 March and 30 April 2018. He highlighted the continuing improved position for prescribing noting this in the context of the issue of No Cheaper Stock Obtainable issue and commended Practices for their support in this regard.

MA-M provided clarification on a number of aspects relating to premises in the delegated commissioning areas confirming the intention to progress efforts to access estates transformation funding. He also explained that Primary Care IT as per the information under 'Other Primary Care' areas comprised both support to primary care and also the migration to the new HSCN from the N3 Network noting that the CCG had received two additional allocations in 2017/18 for these and the associated expenditure had been accrued up to these amounts. MA-M reported that 11 sites had completed the migration and that work was ongoing in terms of the public access to wifi in Practice waiting rooms with the scheduled completion date of the end of May 2018.

In response to PE seeking clarification about the reduced allocations for Quality and Outcomes Framework and Enhanced Services in the plan, MA-M explained the methodology and offered assurance that payment would be made based on the actual levels of achievement. KS added the CCG appeared to have over budgeted in 2017/18 emphasising that the reduction was in budget, not in spend.

PM referred to the ambition of discussions being in the context of the CCG's philosophy of benefitting patients and adding value to the patient experience. He requested that KS work with the Head of Communications and Media Relations to consider how this could be progressed so that the focus was on the patient, in a similar way to the work relating to the CCG's 2018/19 Commissioning Intentions. In this regard KS highlighted the focus on primary care and mental health services and noted the work ongoing to reduce bureaucracy and enhance engagement with primary care. He also noted, however, that although there had been progress there was still a need to build trust with Practices in terms of sharing information particularly with regard to lessons to be learned to address areas of variation.

KB highlighted that from a patient perspective translation of financial information to examples of service improvement would be welcome.

In conclusion KR highlighted the need to be realistic in expectations noting there were areas, such as waiting times, which were outwith the CCG's control but noted the Commissioning Intentions as a means of progressing.

The Committee:

Received the Primary Care Commissioning Financial Report.

8. General Practice Visits and Engagement Update

KS reported that CCG staff were working with Practices in a number of ways, including through the localities. This was resulting in "soft" intelligence that would not be gathered in other ways. A group had been established in response to identification of the need for a systematic approach to engage with Practices in ways that ensured equity. KS noted that General Practice visits was a statutory term but

highlighted that the visits should be in a format that was proportional and not onerous for Practices. The “soft” intelligence and dashboard approaches should also be utilised for purposes of quality.

KS referred to the NHS England risk profile noting that, while this could be utilised, the information held by Practices in this regard would be variable. In terms of reporting to the Committee there should be an approach which encompassed all aspects of information except that which would be reported to the Quality and Patient Experience Committee as discussed above. KS also noted opportunities for improved engagement with Practices as a result of the locality model and highlighted that the CCG was aware of specific times of the year when Practices had priorities such as the annual recording of Quality and Outcomes Framework requirements in February and March.

SS agreed that the “soft” intelligence was crucial noting potential for the need for assurance in the event of identification of issues that may impact on the whole system, for example relating to children, social care and adult services.

PM referred to the fact that all 26 Practices in the CCG were rated as ‘Good’ by the Care Quality Commission. He noted in the context of improving patient care, experience and outcomes through resourcing services in the community that the Committee would require assurance but there would also be the challenge as commissioners to support General Practice as providers at scale to progress opportunities for improvements in integrated care. Discussion would take place at the Governing Body about further developing primary care in this regard.

DB referred to opportunities described in the Primary Care Assurance Report at the following agenda item for such as anticoagulation to reduce atrial fibrillation. KS detailed the requirements to initially work with Practices according to their individual circumstances where a specific issue arose and to offer support according to their priorities. Engagement was more effective when it was in response to an identified issue and was part of a whole pathway approach.

Discussion included a number of aspects of the Primary Care Assurance Report. MC noted the need for further work to understand the individual issues of Practices to ensure availability of robust services. PE referred to the fact that the finances underpinned such as staffing for Practices and highlighted that Practices were now more open to constructive challenge.

KS emphasised that the Primary Care Assurance Report did not relate to the core funding noting that the CCG would continue as far as possible to pass money on to Practices and developments with a primary care focus would be progressed. MA-M reiterated that passing money on to primary care was a priority for the CCG citing examples from the £3 per head funding and noting the locality influence in this regard.

The Committee:

Noted the update.

9. Primary Care Assurance Report

KR noted the discussion at the previous item but sought clarification as to how the information was being used and, from a commissioner perspective, what improvements were being made.

KS responded that the information contributed to benchmarking Practices. He explained that the Quality and Outcomes Framework indicators were a particular way of Practices recording information that gave access to financial benefit but did not measure the quality of care provided. Additionally, the stroke data referred to in the previous discussion was not actual data but an estimate for a population of the size of the CCG. The term variation related to both recording by and prevalence in Practices but did not explain the associated reasons.

Discussion ensued in the context of sharing information with Practices to gain an understanding about areas of variation. This would also provide opportunities for triangulation and assurance, for example with regard to patients having access to such as NHS health checks and lifestyle services. A holistic understanding of Practice populations and available services would enable appropriate support to be provided.

The Committee:

Received the Primary Care Assurance update report.

10. Approved Plans from Central and North Localities for 2018/19 PMS Premium and £3 Per Head Transformation Funding

KS referred to the report which provided background information relating to the 2018/19 PMS Premium and £3 per head transformation funding and summarised Central and North Localities plans approved at a private meeting of the Committee due to commercial sensitivity. He noted that a bid from the South Locality was expected and welcomed the progress in working as localities for the benefit of the respective populations. KS highlighted the need for all bids to be considered in terms of sustainability and added that a similar approach of collaborative working between Practices and other providers was anticipated in relation to the requirement for CCGs to commission extended access to GP services at evenings and weekends from October 2018.

SM described the four projects developed by the Central Locality: Supporting complex older patients in their home (including Care Homes), Improving quality of services to patients with mental health conditions, Development of a Learning Disability Support Team (as part of Complex Care and Vulnerable Adults Programme of Care) and Complex older patients at risk of hospital admission due to falls. SM noted that he was working closely with the Practices and would provide regular updates on progress.

SM explained that the North Locality, which had fewer Practices and a smaller population, planned to further develop and expand the North Integrated Care Team working with system partners to co-ordinate care for frail and vulnerable patients.

In response to members seeking clarification about resources, with particular reference to recruitment and beyond 2019 when this funding would cease, KS emphasised that this was not additional funding but from within the CCG's allocation. Practices would need to demonstrate value for money and impact of transformation for the CCG to consider continuing the funding. MA-M added that the CCG's aim was to support Practices to deliver schemes and make resources available recurrently.

Discussion included recognition that previously the CCG had required confirmation of the return on investment upfront whereas the current approach was to enable resources to be utilised by the system. There was recognition of the complexity of demonstrating specific benefits but also the need to ensure appropriate governance arrangements.

The Committee:

1. Received and welcomed the update on the approved plans from Central and North Localities for 2018/19 PMS Premium and £3/head Transformation Funding.
2. Noted that a bid from the South Locality was expected.

11. Patient Enquiry via Healthwatch regarding Unity Health Closure of Sites

In introducing this item KR noted that Unity Health was a private business but he had requested a report in view of significant concerns raised about their decision making process to close two sites. He added that the member of the public who had raised this with Healthwatch still had concerns that the issue had not been fully addressed.

SM referred to the report which aimed to provide assurance of the process followed by Unity Health that led to Kimberlow Hill Surgery replacing the Univerity of York campus and Hull Road sites. He explained that the Practice had first approached the CCG in October 2015 with plans for a new build based on availability of a plot of land for a potential new surgery and the fact that the University did not intend to renew the lease for the campus surgery. Additionally, an extensive premises review in 2013 had highlighted that Unity Health only had 26% of the recommended floor space and was therefore a priority for development as the Practice which was most under the required physical capacity for their population within the CCG. SM also noted the context of the transition to delegated commissioning at the time but reiterated that Unity Health was an independent business.

SM highlighted that the concern expressed by the member of the public related to Unity Health's consultation with patients and referred to the report which described this process. He noted that questions raised at the time had included queries around the site being developed specifically for the student population, and the increased distance for some patients between the Hull Road Surgery and Kimberlow Hill Surgery.

SM explained that from the CCG's perspective the Practice was replacing one surgery that would be closing and another surgery with compliance issues with a new build that was equidistant between the two sites. He also noted that the Practice had committed to working with the Local Authority to look at opportunities around local transport routes, with the intention of routing buses to stop outside the new premises. The site closures were considered to not adversely affect patient services and the CCG had been assured that appropriate public consultation had been undertaken by the Practice at the outset.

KB referred to concerns that Healthwatch had reported to SM, including regarding patient mobility issues and the fact that there was a main road to cross. She recognised benefits in the new surgery but requested that a more robust consultation and clear impact assessment take place in future to provide assurance to residents who may not support a development.

Discussion included the role of Healthwatch and Patient Participation Groups to raise concerns, the fact that consultation requirements were not in terms of a percentage of Practice patient population but were required to be proportional to provide assurance to commissioners, and the context of Practices as independent businesses. SM confirmed that he would liaise with Healthwatch to manage the expectations of any future consultations.

SS reported that she had been at the York Health and Adult Social Care Policy and Scrutiny Committee when Unity Health had presented their report which had included as an annex information on the Hull Road Surgery public consultation event on 15 April 2016. She noted that a number of questions had been raised and reiterated the fact that the Practice had been asked to work with City of York Council's transport team to address the issue of access for vulnerable patients. SS agreed to follow this up and update the Committee by email.

The Committee:

1. Received the report on the patient enquiry via Healthwatch regarding Unity Health's closure of sites.
2. Noted that SS would circulate an update regarding liaison between Unity Health and the City of York Council's transport team on concerns relating to the transfer of services from the Hull Road Surgery to Kimberlow Hill Surgery, York.

12. NHS England Primary Care Update

DI presented the report which provided an update on standard items relating to the delegated commissioning agenda. These comprised contractual issues in respect of the outcome of the General Medical Services 2018/19 contract negotiations, Third Next Appointment, the annual Dispensing Services Quality Scheme, East Parade Medical Practice in York, assurance of General Practice and NHS England Directed Enhanced Services. Information was also presented on the General Practice Forward View, clarification on the GP Retention Scheme presented at the March meeting of the Committee, and publication of the 2018/2021 North Yorkshire Pharmaceutical Needs Assessment and York Pharmaceutical Needs Assessment.

In relation to the Estates and Technology Transformation Fund DI advised that a report would be presented at the next meeting regarding deliverability of programmes and, subject to the Committee's support, the funding would be released.

The Committee:

Received the updates from NHS England on items relating to the delegated commissioning agenda.

13. Key Messages to the Governing Body

- The Committee approved revised terms of reference.
- The Committee received the updated draft 2018/19 financial plan for delegated commissioning.
- The Committee welcomed the plans from the Central and North Localities for the 2018/19 PMS premium and £3 per head transformation funding.
- The Committee noted the ongoing public concern about Unity Health's consultation prior to opening the new surgery at Kimberlow Hill, York.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

14. Next meeting

2pm, 26 July 2018 at West Offices

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 contained commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.

Vale of York
Clinical Commissioning Group

Item 19

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	14 June 2018
Chair	Keith Ramsay

Areas of note from the Committee Discussion

- Specific quality risks for the Committee were highlighted, particularly with regard to mental health services.
- The Committee approved the Quality Assurance Strategy 2018-21
- The Committee renewed its terms of reference.
- The Committee emphasised that primary care engagement is essential across all commissioners and providers.
- The Committee noted the Care Home React to Red update and requested a further update at the next meeting.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

NHS
Vale of York
Clinical Commissioning Group

Minutes of the Quality and Patient Experience Committee Meeting held on 14 June 2018 at West Offices, York

Present

Keith Ramsay (KR) - Chair	Lay Member and Chair of the Primary Care Commissioning Committee and Remuneration Committee in addition to the Quality and Patient Experience Committee
Jenny Brandom (JB)	Deputy Chief Nurse
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health
Dr Nigel Wells (NW)	Clinical Chair

In attendance

Laura Angus (LA) – part	Strategic Lead Pharmacist
Barry Dane (BD)	Healthwatch, York
Sarah Fiori (SF)	Senior Quality Lead
Sarah Goode (SG)	Quality Lead for Primary Care
Karen Hedgley (KH) - part	Designated Nurse Safeguarding Children
Victoria Hirst (VH)	Head of Engagement
Helena Nowell (HN) - part	Planning and Assurance Manager
Christine Pearson (CP)	Designated Nurse Safeguarding Adults
Charlotte Porthouse (CPo)	CCG Lead Practice Nurse
Gill Rogers (GR)	Patient Experience Lead
Michèle Saidman (MS)	Executive Assistant

Apologies

Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Abigail Combes (AC)	Head of Legal and Governance
Susan De Val (SDV)	Commissioning Specialist, Children and Young People
Debbie Winder (DW)	Head of Quality Assurance and Maternity

The agenda was discussed in the following order.

1. Apologies

As noted above.

2. Declarations of Interest in Relation to the Business of the Meeting

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

3. Minutes of the meetings held on 8 February and 12 April 2018

The minutes of the 8 February meeting, not formally approved at the April meeting due to there not being a quorum, had been amended as agreed and were now approved.

The minutes of 12 April were agreed subject to amendment to KR's title to read 'Lay Member and Chair of the Primary Care Commissioning Committee and Remuneration Committee in addition to the Quality and Patient Experience Committee'.

The Committee:

Approved the minutes of the meetings held on 8 February and 12 April 2018 subject to the above amendment.

4. Matters arising from the minutes

A number of matters arising were noted as agenda items or not yet having reached the scheduled date.

5. Patient Story

SF introduced a video extract providing an overview of a recent presentation *Motivation and Inspiration in Dementia Care* given by Tommy Whitelaw who cared for his mother with dementia. He had received funding from NHS England to tour the country as part of the Valuing People workstream and tailored his presentation according to the audience.

Whilst recognising the need for strategies and policies Tommy emphasised that it was the people providing care who really count in terms of their training, knowledge, passion and kindness, whatever their role. Care should be delivered on the basis of what it feels like for, and what matters to, the person receiving it.

JB advised that the "what matters to you" approach was now being promoted with both patients and staff and would be followed up in the next regular staff briefing session.

Discussion included the need for awareness of support networks for carers, recognition that a "what matters to you" approach required a change of mindset on the part of clinicians, and emphasis on treatment of the patient as a whole.

The Committee:

Welcomed the presentation and noted the change of focus to "what matters to you".

6. Quality and Patient Experience Committee Terms of Reference

HN referred to the Committee Terms of Reference which had been reviewed in the context of the re-set Governing Body. She highlighted the recommendation that all quality matters be reported to the Quality and Patient Experience Committee with an enhanced role of challenge.

Members sought and received clarification of a number of areas including noting the expectation of annual assurance being provided in relation to embedding of quality. With regard to the Committee's Deputy Chair it was agreed that AK would remain in this role.

Following agreement of a number of further amendments KR requested that the revisions be incorporated and the terms of reference re-circulated prior to inclusion in the Committee Report to the Governing Body on 5 July 2018. *Post meeting note: the amended terms of reference were circulated on 18 June.*

The Committee:

Approved the revised terms of reference pending the additional proposed amendments.

12. Risk Update Report

HN presented the report which provided details of current events and risks managed by the Quality and Patient Experience Committee and identified those risks which needed to be escalated to the Governing Body. The Corporate Events and Corporate Risks managed by the Committee were presented at Annexes A and B respectively. There were no new risks and no merging risks to report.

Members agreed that the 'Red' risk relating to primary care services at a GP Practice should continue to be managed through the Committee. KR noted that this would also be discussed at the Primary Care Commissioning Committee.

KR requested that Denise Nightingale, Executive Director of Transformation, Complex Care and Mental Health, be asked to attend the next meeting to provide a progress report on the on-going events which all related to children and young people.

In response to KR seeking clarification about mitigation of the previously reported low risk relating to the shared Infection Control Programme and TB service, JB confirmed that this had been resolved without a break in the service.

The Committee:

Agreed that there were currently no risks identified for escalation to the next meeting of the Governing Body.

HN left the meeting

9. Safeguarding Children and Children in Care

KH presented the report which provided an update on the CCG footprint's three Local Authority Safeguarding Children Boards including in relation to Complex Case processes, Serious Case Reviews/Learning Reviews and multi agency information sharing; children in care in respect of out of area placements within North Yorkshire, timeliness of health assessments and Health Passports; statutory guidance; primary care, including Multi-Agency Risk Assessment Conferences, access to safeguarding information and training for administrators in primary care; and the Care Quality Commission Children Looked After and Safeguarding Reviews.

KH additionally reported that Maggie Atkinson had been appointed as Independent Chair of the North Yorkshire Safeguarding Children Board, a review of partnership arrangement was ongoing. Discussion took place regarding A and E attendance data in North Yorkshire. KS reflected on the challenges in consistent data collection. With regard to the latter the City of York Council Director of Public Health was working with the North Yorkshire County Council Director of Public Health.

Members sought and received clarification on a number of areas. Detailed discussion ensued regarding primary care engagement with particular reference to the Multiagency Information Sharing Agreement and Child Protection Information Sharing Project. KH explained that the former related to transition arrangements for the Healthy Child Service in City of York noting that she was leading on a project to address this; the latter related to a national system.

KH reported that she was escalating the issue of timeliness of both initial and review health assessments for children in care to the Strategic Partnership.

With regard to primary care KH advised that the communication issue relating to sharing of minutes of Multi-Agency Risk Assessment Conferences was being addressed by the Nurse Consultant. She also noted that MC and the Nurse Consultant were working together to secure administration support to allow the pilot to continue. The pilot was expected to demonstrate improved outcomes in terms of managing domestic abuse cases and a business case was being developed to secure permanent administrative support. In response to KH noting that this related to City of York and was a risk in North Yorkshire, NW emphasised the need for the staffing issue to be resolved and ensure the link with primary care.

With regard to matter arising Q&PE17 relating to the 519 young people in care in North Yorkshire, KH reported that between 70 and 80 were within the CCG population.

The Committee:

1. Noted the detailed reports regarding the timeliness of health assessments for looked after children and agreed to receive further updates at the next meeting.
2. Noted the progress made against the North Yorkshire Care Quality Commission Children Looked After and Safeguarding Review action plan and agreed to receive an update against the York action plan at the next meeting.
3. Noted the issues in relation to Multi-Agency Risk Assessment Conferences information sharing with primary care and agreed to receive an update at the next meeting.

KH left the meeting

7. Quality Assurance Strategy 2018-2021

JB presented the Quality Assurance Strategy which outlined the actions required to identify and measure the quality of services commissioned in line with the CCG's values and the NHS Constitution. It also set out the associated governance arrangements, assurance methods used, and processes for escalation and additional support for

quality and safety concerns. JB advised that the Strategy had been shared with partners and stakeholders and any further feedback would be incorporated into subsequent versions unless materially important to make the changes before presentation to the Governing Body on 5 July 2018. JB noted that there was an associated agile work-plan, held in the Quality and Nursing Team, to deliver any actions and improvements related to the application of the Strategy. She also noted that plans to develop one Strategy across the Sustainability and Transformation Partnership had not come to fruition as had been intended when the original draft Strategy had been previously presented for the Committee's approval.

Members discussed the link between the Strategy, the Risk Register and monitoring of performance for purposes of assurance that any quality issues were being appropriately managed. In the context of seeking assurance from providers JB referred to the single item Quality and Patient Experience Committee with representatives from Tees, Esk and Wear Valleys NHS Foundation Trust in August 2017 in respect of Child and Adolescent Mental Health Services.

The Committee:

Endorsed the Quality Assurance Strategy 2018-21.

8. Quality and Patient Experience Report

JB introduced the report which provided an overview of the quality of services across the CCG's main providers and an update on the quality improvement work of the CCG's Quality Team relating to quality improvements affecting the wider health and care economy. Key pieces of improvement work included: Special School Nursing Review as part of review of the 0 – 19 pathway, Care Home Strategy development, maternity services transformation and workforce transformation. Members of the team highlighted aspects of the report.

With regard to primary care complaints and feedback SG noted the CCG's culture of encouraging sharing of such information. She highlighted that currently NHS England did not inform the CCG about complaints relating to GP Practices but noted that this was expected to change. SG also referred to the YOR-Insight soft intelligence tool on the CCG website from which feedback about perceived gaps, issues or good practice provided an opportunity for the CCG to facilitate anonymous sharing of best practice and lessons learned. She also noted that annual requirements for Practices to provide information were being introduced. KS added that building a culture of sharing information and utilising "soft" intelligence would enable the CCG to identify opportunities to offer support to Practices and to address variation. The Committee would then receive exception reporting.

In respect of the Care Quality Commission SG noted that CCG staff continued to meet regularly with the local inspectors. This also provided opportunities for information sharing and support to General Practice.

JB reported that work was ongoing to address communication issues between District Nurses and GPs relating to the inoperability between SystmOne and EMIS IT systems and sharing permissions. She additionally noted that launch of the District Nurse Transformation Plan was imminent.

JB referred to local and national workforce issues advising that opportunities were being sought to progress new and sustainable models and also to support current staff. In response to NW referring to potential opportunities, such as the Hull York Medical School and training in the community, and highlighting the need for generalist training to ensure sustainability, JB confirmed that the CCG had links to local organisations. However, there was a need to develop further understanding both of the workforce challenges in primary care and General Practices and also in terms of such as learning taking place, mentoring for sustainability and research to lead change. SG added that there was potential access to workforce resilience funding.

With regard to infection prevention and control JB highlighted changes from April 2018 in categorisation of methicillin-resistant staphylococcus aureus blood stream infections. Cases would now be reported by time of infection onset instead of patient admission. Cases where the infection onset was greater than two days after admission would be considered hospital-onset cases; all other cases would be considered to be community-onset. Collaborative work was taking place to build on associated learning opportunities.

JB reported that the clostridium difficile threshold remained at 48 for 2018/19 and that there had continued to be a rise in cases. She advised that DW was leading the collaborative work relating to infection prevention and control and noted the new leadership in this regard at York Teaching Hospital NHS Foundation Trust.

JB advised that work was continuing with York Teaching Hospital NHS Foundation Trust to agree a manageable robust process for assurance in respect of Serious Incidents and Never Events. She noted that no further Never Events had taken place but there was still a need for the CCG to be informed of specific actions that had been implemented. JB additionally noted that the newly appointed Head of Patient Safety would be working to the Chief Nurse from July which it was hoped would influence alignment of processes and provide assurance.

JB explained that the children waiting for MRI scans at York Teaching Hospital NHS Foundation Trust were predominantly on the epilepsy diagnostic pathway and most required anaesthesia. The issue was capacity in radiology and anaesthetics. JB reported that the CCG had sought assurance and been advised that parents of more than half the 27 children waiting had agreed to scans at Sheffield Teaching Hospitals NHS Foundation Trust week commencing 18 June. Assurance had also been received that the children were receiving regular reviews by their paediatricians during the waiting time and part of this included consideration as to whether the investigation was still appropriate.

JB advised that York Teaching Hospital NHS Foundation Trust continued to report serious incidents in accordance with the Serious Incident Framework and that the CCG continued to attend and participate in the falls and pressure ulcers multi-disciplinary reviews. JB also commended progress with their embedding of compliance with the duty of candour standards.

JB reported that Tees, Esk and Wear Valleys NHS Foundation Trust remained committed to improving processes and assurance relating to serious incidents and that the CCG was continuing the clinical quality visits to their services. These provided an

opportunity to discuss risks with clinicians and gain an understanding about the issues and mitigating actions particularly in relation to Child and Adolescent Mental Health Services.

With regard to CCG incidents JB noted that the Referral Support Service had reported a number of cases relating to two week wait referrals which had not been received by them within an appropriate timescale. Enquiries into reasons for this had identified administrative issues. Discussions were taking place to support Practices.

JB highlighted that the increased capacity in the Quality and Nursing Team would enable a Quality representative to attend the Contract Management Boards or Quality meetings of all the main providers. This, combined with the assurance framework identified in the Quality Assurance Strategy, would increase assurance and identification of risks to both quality of care and patient experience.

JB noted that the CCG had been alerted to incidents when a GP Practice had not been informed of their patients being assessed by but not conveyed to hospital by Yorkshire Ambulance Service staff. The new Lead Nurse at Yorkshire Ambulance Service had carried out an investigation and shared the outcome with the GP Practice. A further meeting was planned to consider how short term improvements could be made and learning shared. NW added that this was an issue for primary care noting that the NHS 111 system could be utilised to pass on such information.

LA left the meeting

JB referred to the proposed service changes at The Retreat, mainly relating to reducing their bed base and developing a model for increased residential and community care. She highlighted the need for the CCG to be aware of potential impact, particularly for eating disorder services. KR additionally noted the timescale for the new mental health hospital which was not scheduled to open until early 2020.

With regard to the updates on screening and immunisation JB highlighted 2018/19 'flu planning, assurance being sought due to reduced performance in the breast screening programme and wastage due to cold chain incidents. Members sought and received clarification regarding the latter, including the need for investment in fridges of a slightly higher standard.

GR referred to the patient experience update. She reported that continuing healthcare complaints remained the main issue but noted that delays should be reduced as the team had been enhanced. The other main concern from the patient experience perspective related to prescribing of gluten free foods. In this regard Louise Horsfield, Commissioning and Transformation Manager, was commended for providing detailed communication.

In respect of the patient engagement update VH highlighted that the internal stakeholder audit had received Significant Assurance. An action plan had been developed in response to the audit recommendations which focused on how the results of stakeholder engagement were reported and published, and clearer articulation of the link between the stakeholder engagement programme and the impact on health inequalities.

VH referred to the NHS 70 celebrations reporting on collaborative working with partner organisations, including YorWellbeing, and noting that Rachael Maskell MP had invited employers had been invited to a meeting in this regard.

VH advised that the patient stories would be posted on the 'Get Involved' section of the CCG's website in the near future and sought further suggestions for this agenda item. She also noted work taking place with clinicians and carers to develop an End of Life Strategy.

CP noted that there were no new issues in respect of the care homes and adult safeguarding update. She reported on attendance at meetings and progress and, in response to clarification sought by members, explained that the Care Quality Commission was the overarching regulator but local authorities held the contract with providers. CP highlighted positive comments from the Care Quality Commission Safeguarding Officer relating to Amelia House, York, but advised that a number of further safeguarding referrals had since been made; the suspension currently remained in place.

SF highlighted the launch in April of the Humber, Coast and Vale Excellence Centre in partnership with the National Skills Academy. She reported on the success of the React to Red and Safety Huddles noting presentation of a poster at the Tissue Viability Society Conference in Newcastle in April and subsequent acceptance by the Patient Safety Congress in London in July 2018.

SF reported on the success of a conference in May entitled *Recognising and Responding to Deterioration in Care Home Residents* (RAPID). She noted that a bid for funding via the Q community had the potential for up to £30k from the Health Foundation. The bid, which hoped to achieve support for extending scope of the RAPID work into the domiciliary care setting, had already generated interest from across the Q Community.

SF also noted her work with the Carers Centre, attendance at the Partners in Care Forum and advised that the report of a mattress trial audit in a nursing home was being written up.

In presenting the mental health information JB referred in particular to Child and Adolescent Mental Health Services and the Community Eating Disorder Service. There was continuing concern regarding waiting lists for treatment once assessments had been completed. JB noted the measures being taken to address this, which included investment of £50,000 each by the CCG and Tees, Esk and Wear Valleys NHS Foundation Trust in the emotional pathway (including depression, anxiety, self-harm) in 2018/19. Additionally a review, led by the CCG, aimed to evaluate and make recommendations around psychology liaison at York Hospital. JB also noted workshops were planned relating to eating disorders and transition between childhood and adulthood for people receiving services. With regard to the latter JB referred to a previous patient story. She also highlighted that the CCG was currently recruiting a Senior Quality Lead – Children and Young People who would work with partners to develop a Children's Strategy.

Members discussed in detail the React to Red programme in care homes. SF highlighted that the training promoted an understanding of the importance of 'red' in terms of prevention and escalation in accordance with the local pathways and protocols. She advised that qualitative improvements had been demonstrated but it was not possible to evidence reduction in associated referrals. SF emphasised the need for care homes to establish leads to embed React to Red and so ensure sustainability, also noting a proposal that React to Red be incorporated in care homes induction and annual refresher programmes. NW highlighted the need for a culture change in the care sector and for primary care to have a greater understanding of the React to Red pathway. Further discussion included the context of care homes being independent businesses and opportunities for District Nurses and domiciliary workers to identify issues on home visits.

The Committee:

Received the Quality and Patient Experience Report.

10. Safeguarding Adults

In presenting this report CP highlighted in respect of the Learning Disability Mortality Review programme that the annual report had been published alongside a stakeholder briefing paper which were included as appendices for the Committee. She noted among the successes of the programme the fact that it was a world first and local work in this regard. CP added that since the report had been written notification had been received of two further adult deaths therefore there were now four awaiting review.

CP's report also provided updates on Sexual Assault and Abuse Services, Prevent, City of York and North Yorkshire Safeguarding Adults Boards, and the current safeguarding reviews with City of York Council Safeguarding Adults Board and North Yorkshire Community Safety Partnership. CP provided clarification on a number of aspects of the report.

The Committee:

Received the Safeguarding Adults report.

11. Draft Patient and Public Participation Annual Report 2017-18

In presenting the draft Annual Report VH confirmed that amendments discussed at the last meeting of the Committee had been incorporated along with further additional information. The final design work would now be completed and the report presented for ratification by the Governing Body on 5 July 2018.

The Committee:

Approved the Patient and Public Participation Annual Report 2017-18.

13. Key Messages to the Governing Body

- Specific quality risks for the Committee were highlighted, particularly with regard to mental health services.
- The Committee approved the Quality Assurance Strategy 2018-21
- The Committee renewed its terms of reference.
- The Committee emphasised that primary care engagement is essential across all commissioners and providers.
- The Committee noted the Care Home React to Red update and requested a further update at the next meeting.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

14. Next meeting

9am, 9 August 2018.

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Item Number: 20

Name of Presenter: Dr Kevin Smith

Meeting of the Governing Body

Date of meeting: 5 July 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Commissioning Committee Recommendations

Purpose of Report
For Information

Reason for Report

These are the latest recommendations from the Medicines Commissioning Committee – April and May 2018.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks (not yet on Covalent)

Recommendations

For information only

CCG Executive Committee have approved these recommendations

Responsible Executive Director and Title	Report Author and Title
Dr Kevin Smith Director of Primary Care and Population Health	Laura Angus Strategic Lead Pharmacist

Recommendations from York and Scarborough Medicines Commissioning Committee April 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA511: Brodalumab for treating moderate to severe plaque psoriasis		Brodalumab 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 therapies, including ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet A radiation), or these options are contraindicated or not tolerated and • the company provides the drug with the discount agreed in the patient access scheme. Stop brodalumab at 12 weeks if the psoriasis has not responded adequately, defined as: • a 75% reduction in the PASI score (PASI 75) from when treatment started or • a 50% reduction in the PASI score (PASI 50) and a 5‑point reduction in DLQI from when treatment started.	Red	Do not expect this guidance to have a significant impact on resources; that is, it will be less than £5 million per year in England (or £9,100 per 100,000 population). This is because the technology is an option alongside current standard treatment options and we do not think practice will change substantially as a result of this guidance. Expect approx. 5 patients across VoY and S&R CCGs.
NHSE commissioned Technology Appraisals – for noting					
2.	TA508: Autologous chondrocyte implantation using chondrosphere for treating symptomatic articular cartilage defects of the knee		Autologous chondrocyte implantation (ACI) using chondrosphere is recommended as an option for treating symptomatic articular cartilage defects of the femoral condyle and patella of the knee (International Cartilage Repair Society grade III or IV) in adults, only if: • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as assessed by clinicians	Red	No cost impact to CCGs as NHS England commissioned.

		experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) and • the defect is over 2 cm^2.		
3.	TA509: Pertuzumab with trastuzumab and docetaxel for treating HER2-positive breast cancer	Pertuzumab, in combination with trastuzumab and docetaxel, is recommended, within its marketing authorisation, for treating HER2-positive metastatic or locally recurrent unresectable breast cancer, in adults who have not had previous anti-HER2 therapy or chemotherapy for their metastatic disease, only if the company provides pertuzumab within the agreed commercial access arrangement.	Red	No cost impact to CCGs as NHS England commissioned.
4.	TA510: Daratumumab monotherapy for treating relapsed and refractory multiple myeloma	Daratumumab monotherapy is recommended for use within the Cancer Drugs Fund as an option for treating relapsed and refractory multiple myeloma in adults whose previous therapy included a proteasome inhibitor and an immunomodulator, and whose disease progressed on the last therapy, only if: • they have daratumumab after 3 previous therapies and • the conditions in the managed access agreement are followed.	Red	No cost impact to CCGs as NHS England commissioned.
5.	TA512: Tivozanib for treating advanced renal cell carcinoma	Tivozanib is recommended as an option for treating advanced renal cell carcinoma in adults, only if: • they have had no previous treatment **and** • the company provides tivozanib with the discount agreed in the patient access scheme.	Red	No cost impact to CCGs as NHS England commissioned.
6.	TA513: Obinutuzumab for untreated advanced follicular lymphoma	Obinutuzumab is recommended as an option for untreated advanced follicular lymphoma in adults (that is, first as induction treatment with chemotherapy, then alone as maintenance therapy), only if: • the person has a Follicular Lymphoma International Prognostic Index (FLIPI) score of 2 or more • the company provides obinutuzumab	Red	No cost impact to CCGs as NHS England commissioned.

		with the discount agreed in the patient access scheme.		
7.	TA514: Regorafenib for previously treated advanced hepatocellular carcinoma	Regorafenib is not recommended for treating advanced unresectable hepatocellular carcinoma in adults who have had sorafenib.	Black for this indication	No cost impact as not recommended.
8.	TA515: Eribulin for treating locally advanced or metastatic breast cancer after 1 chemotherapy regimen	Eribulin is not recommended for treating locally advanced or metastatic breast cancer in adults who have had only 1 chemotherapy regimen.	Black for this indication	No cost impact as not recommended.
9.	TA516: Cabozantinib for treating medullary thyroid cancer	Cabozantinib is recommended, within its marketing authorisation, as an option for treating progressive medullary thyroid cancer in adults with unresectable, locally advanced or metastatic disease, only if the company provides cabozantinib with the discount agreed in the patient access scheme.	Red	No cost impact to CCGs as NHS England commissioned.
Formulary applications or amendments/pathways/guidelines				
10.	Budesonide rectal foam	Approved removal of prednisolone foam enema which has the potential for significant cost savings. Replaced by a second line alternative, budesonide foam, which is more costly than the proposed first line options, Colifoam and prednisolone liquid enema, but cheaper than prednisolone foam.	Green	Potential cost saving Budensonide rectal foam = £57.11 for 14 days treatment Vs Prednisolone rectal foam = £187 for 14 days treatment
11.	Salofalk foam	Inflammatory Bowel disease section of formulary reviewed and MCC approved addition of Salofalk foam as replacement for Asacol foam which has been discontinued.	Green	No significant cost impact expected. Salofalk foam = £30.17 for 7 days treatment (2g OD) Vs Asacol foam £26.72 for 7 days treatment (2g OD)
12.	Asacol foam	MCC approved removal from formulary as product discontinued.	N/A	
13.	Prednisolone foam enema	MCC approved removal from formulary as the most expensive of the three marketed rectal steroid foams. To be replaced by budesonide foam.	N/A	Potential cost saving – see Budesonide rectal foam.

14.	Glucodrate withdrawal and replacement with St Mark's solution	In Sept 2017 the committee approved Glucodrate – an oral rehydration solution which has now been discontinued. It was comparable to St Marks powder which the Trust used at the time as an option for the treatment of high output stoma /short bowel (instead of double strength Diorylate) when potassium levels are high and the patient is unable or unwilling to make their own rehydration solution). It also had the advantage of being more palatable as contains sodium citrate not sodium chloride. St Mark's Solution approved in those unable to make up the solution themselves and in whom dioralyte is not suitable.	Amber Specialist Recommendation	Cost increase as Glucodrate = £2.61 per day compared to St Marks = £12.24 Have issued Glucodrate to 3 patients (11 x 30 boxes = 333 doses) in York since Nov 2017 No significant cost impact expected.
15.	Estriol 0.1% cream (Ovestin®)	Current formulary choice of oestrogen cream is Estriol cream 0.01%. The applicator size is such that the dose of oestrogen is the same irrespective of whether the 0.1% or 0.01% cream is used. 0.1% has the advantage of being cheaper and contains no arachis oil so is suitable for use in those with peanut allergy. MCC approved addition of Estriol 0.1% cream to formulary as replacement for Estriol cream 0.01%. which will be made RED.	Green	Potential cost saving Estriol 0.01% Cream 80g (with applicator) = £24.98 [MIMS} Estriol 0.1% Cream 15g (with applicator) = £4.45 [MIMS] Issues of Estriol 0.01% from YH = 113 in last 12 months (+ 13 additional via Lloyds for out pts) Issues of Estriol 0.01% from Scarborough = 67 in last 12 months In Jan-Dec 2017: <u>Scarborough and Ryedale</u> Estriol 0.1% = £5430 = 1098 issues Estriol 0.01% = £36,578 = 1487 issues <u>Vale of York</u> Estriol 0.1% = £7564 = 1342 issues Estriol 0.01% = £79,706 = 3144 issues
16.	Tadalafil Once Daily – review of RAG status	Current listed as BLACK on formulary and no change approved as not recommended by NHSE Items of Low Clinical Value Guidance.	Black	No cost impact is expected as use of tadalafil once daily not recommended by NHSE items of local clinical value guidance.

17.	Overactive bladder in women pathway	Approved.	N/A	No significant cost impact expected.
18.	Anticoagulant choices in non-valvular AF - updated	Approved updated document with change from NOAC to DOAC. Has been 2 years since last review. No other changes made.	N/A	No significant cost impact expected.
19.	Erectile dysfunction medal ranking	The current erectile dysfunction medal ranking formulary has been updated; the main changes to this version are the prices of the medicines. Generic Sildenafil still remains the most cost effective preparation.	N/A	No significant cost impact expected. Generic Sildenafil still remains the most cost effective preparation.
20.	Emollients – Guideline & Medal ranking	Approved updated medal ranking for emollients due to fire risk highlighted in recent media coverage, table added to show paraffin free emollients for high risk patiens.	N/A	No significant cost impact expected.
21.	NHSE Guidance: Conditions for which over the counter items should not be prescribed in primary care – guidance for CCGs	The MCC noted this guidance published in March 2018 and agreed to highlight to all stakeholder prescribers. It noted the CCG already has polices that are consistent with this guidance. The MCC currently exploring annotate OTC drugs that are on the formulary as prompt to ensure they are not prescribed acutely.	N/A	Potential cost saving if patients encourage to buy this medicines OTC for acute management of their condition.

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee May 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA518: Tocilizumab for treating giant cell arteritis		Tocilizumab, when used with a tapering course of glucocorticoids (and when used alone after glucocorticoids), is recommended as an option for treating giant cell arteritis in adults, only if: • they have relapsing or refractory disease • they have not already had tocilizumab • tocilizumab is stopped after 1 year of uninterrupted treatment at most and • the company provides it with the discount agreed in the patient access scheme	Red	Except 1-2 patients per year. It is expected that patients will received a max of 1 year of treatment with tocilizumab of 162mg every week. NHS List price is £913.12 for 4 x 162mg syringes. Cost per patient is £11,871 per year based on NHS List price.
NHSE commissioned Technology Appraisals – for noting					
2.	TA517: Avelumab for treating metastatic Merkel cell carcinoma		Avelumab is recommended as an option for treating metastatic Merkel cell carcinoma in adults, only if they have had 1 or more lines of chemotherapy for metastatic disease. Avelumab is recommended for use within the Cancer Drugs Fund as an option for treating metastatic Merkel cell carcinoma in adults, only if: • they have not had chemotherapy for metastatic disease and • the conditions in the managed access agreement for avelumab are followed	Red	No cost impact to CCGs as NHS England commissioned.
3.	TA519: Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy		Pembrolizumab is recommended for use within the Cancer Drugs Fund as an option for treating locally advanced or metastatic urothelial carcinoma in adults who have had platinum-containing chemotherapy, only if: • pembrolizumab is stopped at 2 years of uninterrupted treatment or earlier in the event of disease progression and	Red	No cost impact to CCGs as NHS England commissioned.

		• the conditions in the managed access agreement for pembrolizumab are followed.		
Formulary applications or amendments/pathways/guidelines				
4.	Standardising strengths of high risk unlicensed anti-TB medicines	Ethambutol 400mg in 5ml, Pyrazinamide 500mg in 5ml, Isoniazid 50mg in 5ml approved to be added to the formulary.	Red	No significant cost to CCGs expected.
5.	Bisphosphonates in breast cancer – updated pathway	Approved.	N/A	No significant cost impact expected.
6.	Bisphosphonates medal ranking	The current medal ranking document has been updated; the main changes to this version are : • the updated prices of the medicines (all have reduced in price except risedronate 5mg tablets which have increased) • Alendronic acid 70mg tablets are still 1st gold choice – price reduced from £14.69 to £4.92 per year • Strontium removed from secondary care options – Discontinued by manufacturer • Rationale reviewed and updated • Propose to change Zoledronic acid IV to amber specialist recommendation from red, for administration in primary care approved	N/A	No significant cost impact expected.
7.	Calcium and Vitamin D medal ranking	The current Calcium and Vitamin D Supplements medal ranking document has been updated; the main changes to this version are : • the updated prices of the medicines • Addition of Evacal D3 chewable tab (new 1st gold option) and Accrete D3 One a Day chewable tablets. • Calceos price has increased from £3.58 to £4.32 • Updated rationale	N/A	No significant cost impact expected.