Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

1 March 2018, 9.15am to 12 noon

Please note start time

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 9.15am.

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

AGENDA

STANDING ITEMS – 9.35am				
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 24	Minutes of the meeting held on 4 January 2018	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 25 to 32	Accountable Officer's Report	To Receive	Phil Mettam – Accountable Officer
6.	Pages 33 to 45	Risk Update Report	To Receive	Phil Mettam – Accountable Officer
STRATEGIC – 10.00am				
7.	Pages 47 to 66	Commissioning Intentions 2018/19	To Ratify	Phil Mettam – Accountable Officer
8.	Verbal	Joint Committee for Acute Commissioning	To Note	Phil Mettam – Accountable Officer

FINANCE AND PERFORMANCE – 10.15am				
9.	Pages 67 to 81	Financial Performance Report Month 10	To Receive	Tracey Preece – Chief Finance Officer
10.	Pages 83 to 125	Integrated Performance Report Month 9	To Receive	Phil Mettam – Accountable Officer
ASSURANCE – 11.00am				
11.	Pages 127 to 130	Standard Operating Procedure for the Approval of Commissioning Thresholds	To Ratify	Dr Shaun O'Connell – Joint Medical Director
12.	Pages 131 to 168	Quality and Patient Experience Report	To Receive	Michelle Carrington – Executive Director of Quality and Nursing
13.	Pages 169 to 195	NHS Vale of York CCG Personal Health Budgets Policy	To Approve	Denise Nightingale – Executive Director of Transformation
14.	Pages 197 to 252	North Yorkshire Safeguarding Adults Board - Annual Report 2016/17	To Receive	Michelle Carrington – Executive Director of Quality and Nursing
RECEIVED ITEMS – 11.45am				
15.	Pages 253 to 270	Executive Committee Minutes: 6 and 20 December 2017		
16.	Pages 271 to 294	Finance and Performance Committee Minutes: 21 December 2017 and 25 January 2018		
17.	Pages 295 to 304	Primary Care Commissioning Committee: 24 January 2018		
18.	Pages 305 to 321	Quality and Patient Experience Committee Minutes: 14 December 2017 and 8 February 2018		

19.	Pages 323 to 334	Medicines Commissioning Committee Recommendations: 13 December 2017 and 10 January 2018		
NEXT MEETING				
20.	Verbal	9.30am on 5 April 2018 at West Offices, Station Rise, York YO1 6GA	To Note	All
CLOSE – 12 noon				
EXCLUSION OF PRESS AND PUBLIC				
In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it is considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be transacted as it contains commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.				

A glossary of commonly used terms is available at

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

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Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body held 4 January 2018 at Pocklington Arts Centre

Present

Keith Ramsay (KR)	Chairman
David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Dr Emma Broughton (EB)	Clinical Director
Dr Stuart Calder (SC)	GP, Council of Representatives Member
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Dr Paula Evans (PE)	GP, Council of Representatives Member
Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Joint Medical Director
Dr Kevin Smith (KS)	Executive Director of Primary Care and Population Health
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Tracey Preece (TP)	Chief Finance Officer

In Attendance (Non Voting)

Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Abigail Combes (AC)	Head of Legal and Governance
Paul Howatson (PH) on behalf of Denise Nightingale	Head of Joint Commissioning
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Apologies

Dr Louise Barker (LB)	Clinical Director
Denise Nightingale (DN)	Executive Director of Transformation
Dr Shaun O'Connell (SOC)	Joint Medical Director
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member

One member of the public attended for part of the meeting.

KR welcomed everyone to the meeting and advised that no questions had been submitted by members of the public.

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

As noted above.

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

EB, AB, PE and AP declared an interest in item 9 *Personal Medical Services Premium and £3 Per Head – Proposal from Council of Representatives*. KR advised that they would remain at the meeting but would not contribute in any way to the item. He noted that SC was not a practising GP so did not have a conflict of interest and could take part fully in the discussion.

All other interests were as per the Register of Interests.

3. Minutes of the Meeting held on 2 November 2017

The minutes of the meeting held on 2 November were agreed.

The Governing Body:

Approved the minutes of the meeting held on 2 November 2017.

4. Matters Arising from the Minutes

Safeguarding Children Annual Report 2015/16: MC referred to the 2016/17 Designated Professionals for Safeguarding Children Annual Report at agenda item 13 and advised that a review of the capacity requirements for commissioning the children's agenda would now be informed by this.

Integrated Performance Report: AP reported that work was still ongoing to achieve the recommendations of the Utilisation Management Review and community bed review and PM advised that appropriate discussion at the Council of Representatives had taken place.

Accountable Officer's Report - Proposal for review of clinical networks and processes across the organisations within the Sustainability and Transformation Plan footprint: PM referred to the re-set of the Governing Body and advised that it would be more appropriate for the Clinical Chair to progress this action.

Risk Update Report: In respect of GP involvement in the Local Digital Roadmap, KS reported that a number of GPs had been identified and this was an agenda item for the Executive Committee on 17 January. He noted that potential support from NHS Scarborough and Ryedale CCG was being sought.

Integrated Performance Report Month 6: TP reported that the Executive Committee had in December approved c£300k for winter planning.

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; Council of Representatives meeting; the Better Care Fund; the Care Quality Commission York Local System Review; York Armed Forces Covenant; Emergency Preparedness, Resilience and Response assurance 2017-18; and national plans and strategic issues.

PM explained that legal Directions and special measures were still in place advising that NHS Vale of York and NHS Scarborough and Ryedale CCGs and York Teaching Hospital NHS Foundation Trust were in direct discussion with NHS England and NHS Improvement regarding the system financial position. A medium term plan – four to five years – to return the system to financial balance was in the early stages of development and would be the subject of ongoing discussion with the regulators. PM emphasised that the CCG was continuing all efforts to achieve the £16m deficit control total.

PM reported that the Council of Representatives had fully supported the proposal for the re-set Governing Body including a Clinical Chair and a representative from each of the North, South and Central localities representing the health needs of their population with a proposed start date for the new model of 1 April 2018. The process for recruitment of a Clinical Chair had commenced and would include candidates meeting members of the Council of Representatives followed by a formal assessment. PM noted that a full HR consultation would take place with current members of the Governing Body who were directly affected by the change.

PM was pleased to report that both the North Yorkshire County Council and City of York Council Better Care Fund plans had now been approved at national level. He expressed appreciation to everyone who had contributed to the process.

With regard to the Care Quality Commission York Local System Review PM explained that the York system was required to provide a response in the form of an action plan which was currently being developed. The report recognised historic challenges and highlighted the need for progress to be expedited for seven day working to support hospital discharges. PM noted a suggestion that the plan be presented to members of the York system for discussion.

In response to KR enquiring whether the CCG had met the target finish date of the end of December for the rollout of free wi-fi capability to GP Practices TP advised that the funding had been received and eMBED were leading this work. She would check about the December target date.

The Governing Body:

1. Received the Accountable Officer's Report.
2. Requested that TP ascertain whether the end of December 2017 target date for the rollout of free wi-fi capability to GP Practices had been achieved.

6. Board Assurance Framework Update Report

AC referred to the report which provided an update on the refresh of the Board Assurance Framework for 2017–18 and an overview of latest performance against Improvement and Assessment Framework indicators that informed both the Board Assurance Framework and risk registers. She noted that the Board Assurance Framework, which aligned with the CCG's priorities in the Operational Plan, would be presented at the March Governing Body.

The CCG's Statement of Risk Appetite was presented for approval following which the Risk Management Strategy and Policy would be updated accordingly and also presented for approval. The proposed Statement of Risk Appetite was:

'The CCG has an overall open risk appetite. The CCG will act in accordance with this risk appetite statement to support its strategic objectives.

The CCG has a low appetite for risk related to safety and is clear that this ought to be the focus of the CCG Governing Body. The CCG currently has an open appetite for risk related to the financial position because the CCG is currently in deficit and in Legal Directions as a result. In relation to compliance and service delivery the CCG has an open appetite to risk.'

Details of current events and risks escalated to Governing Body by its committees were presented for consideration regarding effectiveness of risk management approach. AC highlighted a previously unidentified risk that had emerged during December relating to multi-specialty community bed provision in the Ryedale area following a recent procurement by NHS Scarborough and Ryedale CCG. York Teaching Hospital NHS Foundation Trust, who owned Malton Hospital, had served notice on their community beds there as the new provider had not specified the location of the community bed base in the procurement. NHS Vale of York and NHS Scarborough and Ryedale CCGs were working to ensure the bed base, which was slightly higher for Vale of York patients, remained for at least 12 months to ensure continuity of service. TP reported that recent correspondence indicated agreement with NHS Humber Foundation Trust for provision of the beds in Malton for the next 12 months and KS confirmed that a contract had been agreed with them with effect from 1 May 2018 noting that NHS Vale of York and NHS Scarborough and Ryedale CCGs were in discussion with the Ryedale Practices to identify bed requirements. AP emphasised the need for this to include medical, clinical and out of hours cover. PM added that there was a potential for additional financial risk to the CCG in this regard which could not yet be quantified.

DB welcomed the new approach to reporting risk which provided clarity of both the risk and the 'owner' for each identified risk. He highlighted that the Audit Committee and Finance and Performance Committee would seek assurance that 'red' risks had been appropriately assessed and that all efforts were being made to address them.

Discussion included confirmation that formal engagement would be undertaken in accordance with new NHS guidance; welcoming the addition of the column relating to potential for patient harm/impact on service delivery; agreement that the risk relating to the financial position had now materialised and would be reported as such in the next report; and noting that a number of risks required 'owners'.

In response to PE highlighting the risk relating to General Practice capacity and impact on patients, KS commended the recent work with the Council of Representatives including in respect of localities and clinical leadership in the context of the redesign of the Governing Body. He emphasised that the CCG would focus on supporting General Practice, also referred to the work relating to aligned incentives and highlighted recognition of the high quality Primary Care in the CCG noting the intention of working to further strengthen this.

MC referred to discussion at the recent Finance and Performance Committee of the emerging risk relating to anticoagulation.

The Governing Body:

1. Approved the CCG's Risk Appetite Statement.
2. Reviewed risks arising and welcomed the new reporting recognising that this was a dynamic document.
3. Received the progress report regarding the refresh of the CCG's Board Assurance Framework.

STRATEGIC

7. Update on New Mental Health Hospital for the Vale of York

PH reported that City of York Council Planning Committee had unanimously granted full planning permission for the Haxby Road site for the new mental health hospital and had commended the extensive consultation that had taken place. However, as could be expected for a major building project, there were numerous conditions relating to drainage, highways and other matters, including bat boxes.

In terms of key milestones Tees, Esk and Wear Valleys NHS Foundation Trust was still working with the American owners of the Bio-Rad site with the aim of completion by the end of January 2018. Through February Waites, the appointed builders, would be working through costings to inform the full business case which would be presented at the Tees, Esk and Wear Valleys NHS Foundation Trust Board Meeting in March 2018. Subject to approval there work would commence soon after. The completion date was scheduled for December 2019 but this would become clearer when the contract had been awarded.

PH noted that NHS England was being kept up to date with progress and that Tees, Esk and Wear Valleys NHS Foundation Trust colleagues were in regular contact with the CCG.

In response to clarification sought about flexibility on the number of beds PH advised that the consultation had been on 60 but this had been increased to 72.

The Governing Body:

Noted the update.

8. Commissioning Intentions 2018/19

PM emphasised that the aim of the Commissioning Intentions was to signal change to a system approach in the Vale of York with a focus on care in the community. He noted the requirement to take account of national standards and Sustainability and Transformation Partnership priorities but in the context of focusing on the outcomes of the recent patient engagement exercise to inform plans for short and medium term financial stability.

In addition to the report circulated, which included the strategic context and specific commissioning priorities, PM gave a presentation describing: the purpose of the Commissioning Intentions; the current position; implications of implementation (the shift needed and how it would be achieved); what it would mean for people and communities, General Practice and Primary Care, care outside hospital, and hospital care; practical steps; and next steps. PM referred to the recommendation that the Governing Body support the proposal for consideration and approval of the Commissioning Intentions at the Part II meeting immediately following the meeting in public with a view for issuing week commencing 8 January 2018. He sought members' support in implementing the new system approach in a managed way to ensure there was no concern on the part of patients or provider organisations about destabilisation.

Members welcomed the system approach and detailed discussion ensued.

SS requested that consideration be given to opportunities for more active engagement both with her and Dr Lincoln Sargent, Director of Public Health, North Yorkshire County Council, particularly in relation to prevention. SS advised that Public Health England had recently confirmed that ringfenced funding would remain until April 2020 but that there would be further cuts to budgets. She noted concern had been expressed by all Directors of Public Health that the link with the Department of Health would be lost from 2020 when Public Health services would be commissioned through business rates and local taxes highlighting that joint commissioning opportunities should be maximised. SS cited the example of smoking cessation services, an area where there was currently under investment due to budgetary challenges.

SP emphasised the need to understand the challenge to achieve the proposed changes, for the Governing Body to be resolute in ensuring they were implemented and for the CCG to provide system leadership. DB noted that providers' commissioning intentions were required to align with those described and that providers should be aware of the potential for the CCG to work with alternative partners, including not for profit and voluntary sector organisations, if the current providers did not support the system approach. KR added that assurance was required in terms of capacity and capability of existing providers to change the emphasis without relationships being destabilised.

PE referred to the increased access to primary care and noted the need for assurance in this regard. She also commented on the need within General Practice for improved coordination with Public Health and highlighted concern about smoking cessation and weight management services. From the perspective of GPs as providers AB highlighted the need to ensure equity of representation in the context of the fact that General Practice was fragmented and PE noted that the system message should be one of patients feeling safe and secure.

EB highlighted availability of a number of blueprints, including the *General Practice Five Year Forward View*, and noted that aligned incentives provided the 'vehicle' for implementation.

AP referred to 24/7 integrated urgent care and noted, for example in respect of urgent care centres, the need for work to bring together primary care and what was currently in place. He also referred to potential opportunities for an increase in integrated schemes through the Better Care Fund, but highlighted the financial constraints in this regard, and sought clarification on timing of communicating the Commissioning Intentions across the system.

PM explained the intention was to signal to the system a change in a constructive, sensitive manner the following week. This would be followed by an ongoing campaign, including GPs on the radio and social media, to reinforce the impact required to achieve the aim of financial stability across the system.

TP highlighted that an Aligned Incentive Contract required a new mindset from all partners with the aim of outcomes being aligned and supported by contractual mechanisms. The Financial Strategy was based on this approach and principles had been agreed with partners.

KS emphasised the need for the Commissioning Intentions to highlight the change of focus for the CCG. Where previously much of the emphasis was on moving services out of the hospital, in future the focus would be on population needs and out of hospital provision. The purpose was to improve services in the knowledge that future services would tend to be delivered in the community. He explained the need to work with primary care at a number of levels: Practices on an individual basis, groups of Practices, localities and the CCG as a whole – with clarity as to which approach was being used. In respect of the fragmentation of General Practice KS highlighted that progress was being made within the three localities but further work was required to reach a position where each locality had a single voice, for instance one voice for the city practices in York at the Improvement Board. He noted that the Commissioning Intentions were the foundation for shifting the balance to an emphasis on developing out of hospital care.

PM welcomed members' support and referred to the proposal for private discussion later in the day on the challenge to implement system change.

The Governing Body:

Supported the proposal that the Governing Body Part II meeting consider and approved the Commissioning Intentions for issuing week commencing 8 January 2018.

9. Personal Medical Services Premium and £3 Per Head – Proposal from Council of Representatives

KR referred to the GPs' conflicts of interest declared at the start of the meeting and reiterated that they would remain in the meeting but take no part in this item.

KS presented the report which included background information pertaining to the Personal Medical Services (PMS) premium and £3 per head, a proposal from the Council

of Representatives and the context of the CCG's financial position. He explained that discussion had taken place at the December meeting of the Council of Representatives of the principles proposed by member Practices around the process for the distribution of PMS premium and General Practice Forward View £3 per head funding streams for the 2018/19 financial year. Following ratification by the Governing Body, the principles would be taken to the January meeting of the Primary Care Commissioning Committee for approval in respect of the delegated PMS premium funding and their strategic alignment within the Primary Care programme. KS commended the process by which the principles, detailed below, had been developed.

- The primary principle underpinning any proposals should be to work at scale with the aim of both releasing capacity and providing additionality. Therefore proposals should cover a locality, or an identified population health need across a geographical footprint.
- All proposed projects should collaborate across a minimum of two Practices.
- PMS will continue to include an element to fund GP time/leadership in localities.
- The funding from any Practices not yet ready to participate in collaborative projects will be made available for locality proposals.

KS highlighted the next steps noting the requirement for projects to be population centred and for the benefit of all patients in a locality and that localities would peer-review projects and submit a proposal that may consist of more than one project. He advised that, in view of the conflict of interests of Council of Representatives members, the Primary Care Commissioning Committee would be the final arbiter but requested agreement from the Governing Body for the investment change for 2018/19 which would both benefit the population and retain the non-recurrent £3 per head investment.

TP advised that the national 2018/19 financial refresh guidance had not yet been received but was expected during January. She noted that the proposed investment and other financial pressures would be incorporated to ensure that the Financial Plan for 2018/19 was an accurate reflection of the CCG's position. The Governing Body would receive the 2018/19 Financial Plan for approval and would need to consider this investment as part of the wider plan.

SC welcomed the principles but expressed concern that patients of Practices who did not choose to join collaborative working would be disadvantaged. KS explained that individual Practices would receive their fair share allocation and other Practices would need to work to attract them to join. He also noted that this was an opportunity to ignore Local Authority boundaries and work across the CCG footprint adding that the CCG's Primary Care Team would be working to encourage engagement and incentivise collaboration to maximise value.

TP explained that this investment was currently reliant on QIPP savings and would be carried forward into 2018/19. Although it was difficult to identify return on investment the projects were required to support benefit of the investment. TP advised that the refresh of the Financial Plan would include an additional £1m investment for primary care and that this would increase the overall QIPP requirement if made without a required return on investment. SP highlighted this in the context of the discussion of Commissioning Intentions noting the need for a holistic approach.

In response to SP seeking clarification about the role of the Primary Care Commissioning Committee, TP explained that the Scheme of Delegation permitted the Executive Committee to approve up to £0.5m; above this sum required Governing Body approval. The Primary Care Commissioning Committee would approve plans for deployment of the funding. TP also confirmed that lessons had been learnt from previous contracting with primary care and assured members that principles and governance arrangements, including key performance indicators, had been established to ensure robust contracting.

The Governing Body:

Ratified the proposals from the Council of Representatives and approved the release of the £3 per head funding from the CCG's NHS England 2018/19 allocation for CCG core services in accordance with the NHS Operational Planning and Contracting Guidance.

FINANCE AND PERFORMANCE

10. Financial Performance Report Month 8

In presenting this item TP noted that it had previously been discussed in detail at the December Finance and Performance Committee. She highlighted the total risk adjusted forecast had increased by £3.1m to £22.5m deficit noting that this change in reporting had taken place following discussion both within the CCG and with NHS England. The key reasons were the inclusion of the national No Cheaper Stock Obtainable prescribing issue following NHS England guidance and the formal acknowledgement of the risk of outstanding disputes with York Teaching Hospital NHS Foundation Trust, also consistent with NHS England guidance and treatment by CCGs with material challenges nationally. TP noted that the former was currently assessed as £1.6m impact but with the potential for this to reduce due to national negotiations and the latter, which related to the rehabilitation bed days challenges, had been escalated to expert determination. Work was taking place with NHS England in respect of the potential risk from the expert determination under the terms of the contract.

TP explained that the year-to-date position was behind plan by £8.3m, the plan being £4.2m deficit and actual deficit being £12.5m. This deterioration from month 7 of £2.6m was driven primarily by the deteriorating position with York Teaching Hospital NHS Foundation Trust, continuing healthcare, mental health out of contract placements, prescribing and a small element of primary care commissioning. TP advised that the System Transformation Board meeting on 8 January, attended by NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs and York Teaching Hospital NHS Foundation Trust, would focus on potential actions in quarter 4 to reduce and manage costs in the system. With regard to continuing healthcare and mental health out of contract placements validation work was taking place to ensure payments were appropriate. Financial impact from activity relating to winter would not be known until February but would to some extent be offset by the reduction in planned activity.

TP noted that the Finance and Performance Committee had welcomed a proposal for the format of the Financial Performance Report to be changed to mirror that of the Integrated Performance Report. A workshop was being planned with GPs and lay members to finalise this for future presentation.

In response to clarification sought by PE regarding the CCG's £194m contract with York Teaching Hospital NHS Foundation Trust, TP explained that the contract had been signed as, and remained, a full payment by results contract. The Heads of Terms agreement was a commitment for the two organisations to work together towards a reduced financial envelope. TP noted that discussions were taking place with both NHS England and NHS Improvement to agree a year end capped or fixed position as soon as possible. She also referred to the project initiation document for unplanned care and the restructure of the CCG's Executive Team in terms of the appointment of DN and KS. TP emphasised the statutory responsibility of managing the contract as closely as possible and noted for example ongoing challenges where concerns were identified and the modelling of referral to treatment activity.

DB reported the Finance and Performance Committee had expressed concern that the Heads of Terms agreement had not delivered as intended and emphasised the need for lessons to be learnt for any future such arrangement. TP, in response, explained that at the time of signing there appeared to be a commitment to work to a financial envelope and that subsequently the Capped Expenditure Process had been introduced. She confirmed that the Committee's concerns had been escalated to the regulators whose view was that, as they were already closely involved, no further action was required. TP noted that a national Finance Committee with both regulators had now been established.

In respect of funding for winter TP explained that the Executive Committee had committed £315k prior to notification of funding for the system from the Centre. Work was now taking place on funding from a number of sources in terms of flow and support, the majority being for the Emergency Department.

With regard to the potential outcome of the expert determination SP referred to inclusion of the full value of challenges in the CCG's risk adjusted position noting that the outcome would also take account of the trading position. TP confirmed that the outcome would be reported in terms of the contract position against the trading position.

In response to SP expressing concern that the risk adjusted position included £2.4m non recurrent measures for which there was no mitigation, with the potential for this figure to increase, TP reiterated that the System Transformation Board would be discussing how to deliver cost reductions and savings in the system on 8 January. She noted in this regard that consideration was required of impact on patients, such as waiting times. TP advised that the position presented was in agreement with NHS England and emphasised that all possible measures would continue to be pursued for the final quarter of the year.

Further discussion included the continuing healthcare position and the associated risk. TP explained that the NHS Scarborough and Ryedale CCG Finance Team had taken over financial management of continuing healthcare from the Partnership Commissioning Unit and that two months' of trials and mirroring was taking place in preparation for this being brought in house from 1 February 2018. SP had written to the Audit Committee Chairs of the other North Yorkshire CCGs and Internal Audit had been asked to undertake an investigation during January to provide assurance. KR and SP had also met with the Head of Internal Audit.

In respect of the recent joint assessment of activity in the Emergency Department to

reconcile the apparent mis-match between coded activity and observed streaming TP advised that a further joint audit was scheduled for week commencing 8 January. AP also noted that a clinical case review was scheduled for early February.

PM agreed with the concerns that the Heads of Terms had not served their intended purpose and furthermore noted concern about the potential for establishment of an Aligned Incentives Contract for 2018/19. He also referred to the earlier discussion, the recent letter from the National Director of Urgent and Emergency Care, NHS England and NHS Improvement, regarding the Winter Pressures Protocol which included direction to extend the suspension of planned activity up to the end of January, and the potential release of the Sustainability and Transformation Fund. PM explained that the current position did not provide assurance about the risk in the system or the next steps to agree a year end position for 2017/18. He also emphasised that appointments as soon as possible to the re-set Governing Body of a Clinical Chair and the three locality representatives were needed to ensure 2018/19 discussions were clinically led.

Members recognised the uncertainty of the financial position both for the CCG and for the system. KR requested the month 9 Financial Performance Report be included on the agenda for the Governing Body Workshop on 1 February.

The Governing Body:

1. Received the Financial Performance Report.
2. Requested the month 9 Financial Performance Report be presented at the Governing Body Workshop on 1 February 2018 - *Post meeting note: This was completed.*

11. Integrated Performance Report Month 8

PM referred to detailed discussion of performance in other forums and advised that he would forward a briefing to members on A & E four hour performance, 18 week referral to treatment performance, dementia diagnosis, diagnostics, cancer two week urgent referrals and cancer 62 day performance. *(Post meeting note: the information was circulated to members on 5 January).* PM noted that the deterioration in dementia diagnosis was reflected in the Risk Register and that associated actions were being followed up at the Finance and Performance Committee.

PM reported that York Teaching Hospital NHS Foundation Trust had been well placed for A and E four hour performance both regionally and nationally prior to the Christmas and New Year holiday period but had not to date released their most recent figures. Clarification of the position and impact from winter pressures would be provided at the Finance and Performance Committee.

PM advised that the CCG's committee structure was under consideration and noted a suggestion that finance and performance be separated with the former focusing on financial recovery. Discussion ensued on the committee structure with emphasis on the need for assurance that the CCG's priorities and responsibilities continued to receive appropriate consideration; the context of the re-set Governing Body was also noted. TP added that the newly established Financial Recovery Programme Board would report to the Finance and Performance Committee which may provide assurance about the detailed work.

PM also noted the context of the CCG being released from legal Directions and the 2018/19 CCG Improvement Assessment Framework. He requested that AC develop a proposed revised committee structure highlighting that the Accountable Officer should be a member of the committee which monitored performance.

The Governing Body:

1. Received the Integrated Performance Report.
2. Requested that AC develop a proposal for a revised Governing Body committee structure.

ASSURANCE

12. Quality and Patient Experience Report

MC highlighted that a film of the health and social care experiences of a patient carer of a teenage daughter with specific needs had been shown at the December meeting of the Quality and Patient Experience Committee advising that members would like to follow her in the transition to adult services. MC noted many positive aspects of the experiences and that the film would also be used for GP and nurse education purposes.

MC referred to the work being undertaken by the Quality Lead for Primary Care which included workforce development. She noted that a work plan with priorities was currently being developed.

With regard to infection prevention and control MC highlighted that clostridium difficile at York Teaching Hospital NHS Foundation Trust remained under trajectory but the zero trajectory for Methicillin-Resistant Staphylococcus Aureus Bloodstream Infections (MRSA BSI) continued to be a challenge. There had been five community cases and four York Teaching Hospital NHS Foundation Trust cases apportioned following post infection reviews. One recent case was still awaiting review. There were no systematic themes but additional training was being given on care of devices following issues identified from post infection reviews.

MC also noted that Methicillin-susceptible Staphylococcus Aureus Bloodstream Infections (MSSA BSI) cases continued to rise and were being reported to Public Health England as required and that care homes were being significantly impacted by 'flu outbreak with one being closed. MC reported that at the present time there were 20 patients in hospital with 'flu who were being cohorted by the strain.

MC referred to the Winter Pressures Protocol letter and explained with regard to mixed sex accommodation that CCGs were being asked to suspend the sanction in this regard.

In respect of 12 hour breaches MC reported that there had been 13 trolley waits across York Teaching Hospital NHS Foundation Trust of which two had been at the York Hospital site. She also noted 15 cases of norovirus.

MC reported on concerns raised at the Quality and Patient Experience Committee about serious incidents reporting noting that, although progress had been made, capacity was an issue at York Teaching Hospital NHS Foundation Trust, however an assurance framework had now been agreed. MC also referred to the Never Events at York Teaching Hospital NHS Foundation Trust highlighting that, although significant work had been undertaken in implementing the National Safety Standards for Invasive Procedures and World Health Organisation (WHO) Safer Surgery Checklist, indications were that systems and processes were not embedded.

MC noted an improvement in compliance with the duty of candour standards at York Teaching Hospital NHS Foundation Trust.

MC advised that a programme of clinical visits was taking place with Tees, Esk and Wear Valleys NHS Foundation Trust, including Huntington House, Peppermill Court and Lime Trees. A summary of the findings would be presented at the Quality and Patient Experience Committee. MC noted that the Sustainability and Transformation Partnership had established a template for a consistent approach to clinical visits.

With regard to the patient experience update MC reported that the two complaints about communication and performance of CCG staff had been made by a persistent complainant. She also highlighted the three contacts relating to Freestyle Libre noting that a number of local CCGs were now funding this following reconsideration of previous decisions.

MC explained that the methodology for the Patient and Public Engagement Improvement Assessment Framework had been based on information available on the CCG website which had resulted in an ‘amber’ rating. The CCG was going to appeal this and provide further evidence.

MC commended the ‘Good Overall’ rating by the Care Quality Commission of Yorkshire Doctors Urgent Care following an unannounced comprehensive inspection at their head office hub and at the Urgent Care Centre at York Hospital in August 2017.

In respect of quality in care homes MC noted the engagement work and close working with the Improvement Academy.

MC referred to the five two week wait breaches for suspected cancer at York Teaching Hospital NHS Foundation Trust that related to children. She advised that none of the five had been diagnosed with cancer and that both York Teaching Hospital NHS Foundation Trust and the tertiary centre were reviewing the pathway. There had been no further such breaches and referrals should now be made direct, not through dermatology.

MC noted that, although there had been significant improvement in waiting lists for child and adolescent mental health services, concerns remained particularly in relation to eating disorders.

In respect of workforce MC noted that the University of York was usually oversubscribed for student nurse applications but, in line with the national position, this was not currently the case.

MC clarified that, following £40k investment in the My RightCare IT solution for end of life care, work was taking place to seek assurance that it was compatible with the York Teaching Hospital NHS Foundation Trust system as well as that of City of York Council. NHS Scarborough and Ryedale CCG was also interested in this and potentially so was NHS East Riding of Yorkshire CCG which could therefore provide a system wide solution.

The Governing Body:

Received the Quality and Patient Experience Report

13. Designated Professionals for Safeguarding Children Annual Report 2016-17

MC referred to the annual report which described some of the key national safeguarding children issues that had arisen during the year and provided an update on progress against the Designated Professionals Strategic Plan. She noted that this had previously been presented at the Quality and Patient Experience Committee and explained the delay in its presentation to the Governing Body in the context of the number of annual reports.

MC explained that this report related to the CCG's funded Designated Professionals whose work underpinned and aided fulfilment of statutory responsibilities. She also noted assurance aspects pertaining to NHS England and Care Quality Commission reports and provided clarification sought on a number of aspects of the information

MC commended both the Children and Adult Safeguarding Teams highlighting concern about succession planning in the former. She noted the need to strengthen support to the Nurse Consultant for Safeguarding (Adults and Children) in Primary Care highlighting that for the CCG's population there should be eight members of this team and noting that NHS England had accepted the associated risk. MC advised that a business case was being developed for additional support in primary care but expressed concern about potential recruitment.

The Governing Body:

Received the Designated Professionals for Safeguarding Children Annual Report 2016-17.

16. Overview: Winter Planning Update

AP presented the report which described the lead up to winter including a recap from 2016/17, schemes highlighted for further work by different groups, local and regional proposals, the winter plan agreed by partners and the local costs, and delivery against the winter plan including escalations and key themes to date. AP explained that start dates and timings for agreed schemes varied and work was still taking place on a number of schemes.

AP reported that unvalidated reports for the previous weekend were of continued significant demand on services and noted that both York Teaching Hospital NHS Foundation Trust and Yorkshire Ambulance Service had been at high escalation levels at times.

AP explained that Yorkshire Ambulance Service, which operates regional NHS 111, had predicted a 20% increase in calls for this winter. The initial unvalidated reports indicated that at peak times there had been a significant percentage increase above this forecast. At one point NHS111 had to revert to a recorded message when call handlers had become overwhelmed. This amounted to an additional 4000 calls from NHS Vale of York CCG patients when the peak demand had occurred over the Christmas weekend. As a result the NHS111 call abandonment rate had increased during those peaks and potentially this could have resulted in an impact on A and E attendances. Yorkshire Doctors Urgent Care, the Out of Hours provider had reported at the sitreps conference calls a 60% increase in activity over the four day period. AP noted that they too had coped with the peaks in demand and were required to prioritise patients and subsequently waiting times had slipped. The 999 service had similarly been under extreme pressure at times which had impacted waiting times. There had been some diversions between the York and Scarborough Hospital sites in both directions and Harrogate and District NHS Foundation Trust had also provided support. In the community the District Nursing Team had also experienced significant pressure. It was reported that they had negotiated with Yorkshire Doctors Urgent Care for some ambulatory patients to attend primary care centres even though their staff were stretched.

AP commended the partnership working across the system for the benefit of patients. He also commended the CCG's Communication Team for providing advice and guidance to patients prior to the Christmas weekend in order to try and reduce demand from patients who could self-care or seek attention from a pharmacist. APalso reported that, in response to his request for feedback from Practices on their arrangements, initial responses had indicated that Urgent Care Centres (provided by Priory Medical Group and York Medical Group) were full throughout the run-up to Christmas. With respect to the additional GP sessions that the CCG had commissioned as part of the Winter Plan, the Practices that responded had reported the provision for additional sessions had been welcomed and fully utilised.

PM referred to additional capacity for which the CCG had agreed to contract at South Park but this had not been utilised due to an outbreak of norovirus there. He emphasised that, although this had resulted in a c£90k to £100k loss, the CCG had made an operational commitment and should attempt to identify this capacity elsewhere. TP explained that the Executive Committee had authorised £315k for winter schemes. Governing Body support for commitment above this would be required.

Discussion ensued on a number of options for potential bed availability and MC reported that the CCG had not received any requests for spot purchases.

In response to PE expressing concern at the suspension of the Unplanned Care Practitioners undertaking GP visits, AP reported that work was taking place to progress this approach in practical terms.

KR additionally referred to a national meeting he and PM had attended at which the Secretary of State had been present. Winter planning had been emphasised as a priority.

The Governing Body:

Received the winter planning update overview.

17. Equality, Diversity and Human Rights Strategy 2017-2021

In presenting this item MC noted that it was for approval, not receipt. She explained that the strategy had been refreshed to reflect changes in legislation and practice. The associated action plan was awaiting providers' sign off of their action plans to enable the CCG plan to be completed and presented at a future meeting.

SS reiterated her previous comments welcoming partnership working and noted opportunities to support the CCG in terms of working to address variation and support health equity. MC agreed to ascertain for SS whether Public Health England or the local Public Health Team were engaged in the University of York's work with the NHS to develop how to measure health inequality and how this could be supported by the indices of deprivation.

The Governing Body:

1. Approved the Equality, Diversity and Human Rights Strategy 2017-2021.
2. Requested the updated action plan at an autumn 2018 meeting.
3. Noted that MC would advise SS whether Public Health England or the local Public Health Team were engaged in the University of York's work with the NHS to develop how to measure health inequality and how this could be supported by the indices of deprivation.

RECEIVED ITEMS

The Governing Body noted the following items as received:

14. Tees, Esk and Wear Valleys NHS Foundation Trust – Two Years On
15. Audit Committee Annual Report 2016/17

18. Audit Committee Minutes of 29 November 2017

19. Executive Committee Minutes of 18 October and 15 November 2017

20. Finance and Performance Committee Minutes of 26 October and 23 November 2017

Unconfirmed Minutes

21. Primary Care Commissioning Committee of 22 November 2017

22. Medicines Commissioning Committee of 11 October and 8 November 2017

23. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 1 March 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 4 JANUARY 2018 AND CARRIED FORWARD FROM PREVIOUS MEETINGS

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

Meeting Date	***Item***	***Description***	***Director/Person Responsible***	***Action completed due to be completed (as applicable)***
13 July 2017 4 January 2018	Integrated Performance Report Month 2	• AP and colleagues work with the unplanned care programme to ensure that programme incorporated all key themes to expedite a system approach, including the Utilisation Management Review and community bed review.	AP and colleagues	Ongoing
7 September 2017 4 January 2018	Accountable Officer's Report	• A proposal to be developed for review of clinical networks and processes across the Sustainability and Transformation Plan footprint • Progress would be by the Clinical Chair when in post	PM AN Other	From April 2018

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
4 January 2018	Accountable Officer Report	• Confirmation to be provided as to whether the end of December 2017 target date for the rollout of free wi-fi capability to GP Practices had been achieved	TP	
4 January 2018	Integrated Performance Report Month 8	• Proposal for a revised Governing Body committee structure to be developed	AC	

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body **Date of meeting: 1 March 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	☐Transformed MH-LD- Complex Care
☐Reducing Demand on System	☒System transformations
☐Fully Integrated OOH Care	☒Financial Sustainability
☐Sustainable acute hospital- single acute contract	

Local Authority Area

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

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

Emerging Risks (not yet on Covalent)

Recommendations

The Governing Body is asked to note the report.

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

GOVERNING BODY MEETING: 1 MARCH 2018

Accountable Officer's Report

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

1.1 The CCG continues to work with NHS England to confirm the conditions to be applied to the CCG under special measures in 2018-19. Following a period of self-imposed turnaround, the associated achievement of financial stabilisation and delivery of a 10% net reduction in running costs, in this context the CCG is exploring the potential to move out of legal Directions. The recent audit reports of 'Significant Assurance' for financial governance, contracting and performance assurance have provided validation of the strong processes now in place.

1.2 The CCG is working to establish the joint system recovery programme with NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust and agree the priority areas to jointly address which will transform acute care in the Vale of York-Scarborough and Ryedale system. These will form a core component of the CCG's Financial and Operational Plans for 2018-19 and this joint recovery programme, it is proposed this will be supported by a new Aligned Incentives Contract framework.

1.3 In line with previous reports, the CCG continues to forecast a deficit of £22.5m at the end of 2017-18. A year-end contract agreement has now been reached with York Teaching Hospital NHS Foundation Trust to minimise risk to both organisations towards the end of the year and to allow collective focus on planning and delivery of cost reductions for 2018-19.

1.4 The underlying deficit position is showing clear signs of stabilisation with the projected closing position in line with the opening underlying deficit position. The CCG has delivered almost £8m of QIPP savings in 2017-18, three times the level delivered in 2016-17. This puts the CCG in a strong position going into 2018-19 making it possible to build on the positive progress and work closely with partners to contain and manage cost growth.

1.5 Following the publication of national guidance, planning for 2018-19 is well underway and the first cut of plans will be submitted to NHS England at the beginning of March 2018. The plan will contain primary care and mental health investment and identify clear areas for system work to maximise the use of resources and value for money.

2. Strategic issues and planning

2.1 The CCG is refreshing its financial and operational plans in line with the national planning guidance and is considering how to deliver its Commissioning Intentions within the financial and planning framework and rules. During March and April 2018 the CCG will focus on agreeing a fully aligned set of activity and contract plans with providers, which will deliver the financial and performance recovery targets required to bring the system back into balance.

2.2 The CCG, as part of the system A&E Delivery Board, will be undertaking a review of winter delivery to date in early March, assessing the impact of specific schemes and system working to meet demand on urgent and emergency care services since November 2017. The CCG has worked closely with York Teaching Hospital NHS Foundation Trust, more operationally than ever before, over this winter and this insight will provide a valuable source of recommendations for the Winter Plan for 2018-19 that require approval in April 2018.

2.3 Bids for additional NHS England elective care funding have been submitted on behalf of the local system. The bids focus on avoiding 52 week breaches in March 2018 and improving Referral to Treatment targets, cancer and diagnostics performance and mitigating the impact of winter on elective care performance.

2.4 The Governing Body is to be re-set from April 2018. This will involve the establishment of a Clinical Chair and the election of three GPs representing each of the localities within the Vale of York. This work will be captured in any necessary amendments to the CCG's Constitution and is supported by NHS England as required under legal Directions. Recommendations to the Governing Body will be available in a paper at the next meeting.

2.5 As part of this re-set I would like to publicly thank members of the Governing Body for their previous commitment to the Vale of York and, whilst they will no longer be a member of the Governing Body, we look forward to their continued contribution to our work in their various leadership roles.

3. Council of Representatives meeting

3.1 Among the agenda items at its January and February meetings, members received the Accountable Officer's briefing, a presentation on the CCG's Commissioning Intentions for 2018-19 and an update on the local system's financial position.

3.2 Members received an update on work to re-set the CCG Governing Body. They supported the recommendation and ratified the appointment of Dr Nigel Wells as Clinical Chair.

4. Better Care Fund update

4.1 The Better Care Fund plan for York was approved by government on the 20 December 2017 with the Section 75 Agreement between the CCG and City of York Council now signed to confirm the agreement to pool funds for the 2018-19 plan.

4.2 Work continues to confirm the governance arrangements of the North Yorkshire County Council and City of York Council Better Care Fund plans. In York the revised Terms of Reference have been approved by the Health and Wellbeing Board with the main change being that the Performance and Delivery Group will report through the newly established place-based improvement board for York. A performance framework is being developed which will improve the alignment of similar schemes funded by either the CCG or its partner local authorities so that a more direct comparison can be made and opportunities for integration are explored.

4.3 The Better Care Fund will be relaunched in May 2018 through a series of workshops with providers that will promote joint working and a shared evaluation of our successes.

5. Local System Review

5.1 The York Improvement Plan (Care Quality Commission Action Plan) was submitted on 31 January 2018 to Care Quality Commission (CQC) and the Department for Health and Social Care. The plan addresses each of the 13 recommendations in the report by the CQC. A number of working groups have been established to deliver the actions.

6. York Armed Forces Covenant

6.1 The CCG continues to work closely with partners and an ex-military project worker to develop work to support partners in recognising the sacrifices made by the armed forces community.

7. NHS England Commissioning Capability Programme

7.1 The CCG has been invited to participate in a new NHS England Commissioning Capability Programme that has been designed to provide additional support to build and strengthen capabilities of commissioners that work in increasingly challenging systems.

7.2 The programme, that will be delivered by an alliance of organisations including Optum, Price Waterhouse Cooper and Henley Business School, includes support provided by NHS Clinical Commissioners and will begin with a rapid local scoping phase to ensure the programme meets the needs of the CCG and those participating.

8. Humber, Coast and Vale Sustainability and Transformation Partnership

8.1 The Humber, Coast and Vale Sustainability and Transformation Partnership (HCVSTP) Board is moving its focus to three main work streams - digital, workforce, and capital/estates. In an attempt to attract significant resources to the HCVSTP area, the CCG awaits an invitation to develop and deliver work with cross sector partners towards the HCVSTP national criteria submission in July.

9. Emergency Preparedness, Resilience and Response assurance 2017-18

9.1 York Hospital experienced sustained pressure linked to the influenza strains and respiratory viruses within the local community in both December 2017 and January 2018. This affected the performance on ambulance handovers, the Emergency Care Standard and resulted in the cancellation of routine operations. Consequently, on a number of days, the Trust reported Opel 3 – Severe Pressure and daily system-wide winter calls are were held with health and social care partners across York and Scarborough throughout January 2018. To help expedite patient discharges and issue regular updates to primary care and other partners, the CCG attended operations meetings with the Trust on the days when the system was under severe pressure.

9.2 The CCG and its partners at NHS Scarborough and Ryedale CCGs are hosting a ‘lessons learnt from Winter 2017’ event on 1 March 2017 which will feed into the regional NHSE event later in the month.

9.3 Planning for the Easter Bank holiday weekend is currently underway.

9.4 The Tour de Yorkshire is being held from 3 – 7 May 2018. The routes for 2018 have now been released. The riders will pass through Pocklington and Pickering areas but the start and finish events do not impact on our local area.

10. Professor Alan Maynard

10.1 The announcement of the passing of Professor Alan Maynard, the CCG’s former Governing Body Lay Chair, was met with sadness at the CCG. Alan served as the CCG’s inaugural Governing Body Lay Chair from 2012 until 2015, helping it transition from shadow form to statutory body in 2014. As well

as his work with the CCG, Alan spent many years working as a professor of health economics at the University of York. He was also chairman of York Teaching Hospital NHS Foundation Trust between 1997 and 2010.

10.2 During his three-year term as Lay Chair he excelled at guiding the CCG as it evolved from shadow form to statutory body. The CCG benefitted greatly from his expertise during this time as he helped staff remain focused on what matters most – the best interests of the patient. The CCG was very fortunate to have such a renowned and hugely respected health economics expert work in our local health service, contributing and influencing at many levels.

11. National issues

11.1 The National Audit of Intermediate Care (NAIC) 2017 is now complete. This NHS Benchmarking audit, supported by NHS England, highlights key progress in intermediate care with more than 91% of service users maintaining or reducing their dependency across all services plus reduced average wait times. Commissioners and Providers participating in NAIC 2017 have received dashboard reports, comparing their positions to England reported positions on key metrics.

11.2 Across the country, young people and vulnerable adults are being exploited by gangs to move and sell drugs on their behalf in suburban areas, market towns and coastal regions. This criminal activity is known as ‘county lines’. The Home Office is working to safeguard vulnerable young people from this type of exploitation. To increase awareness among GPs, nursing and healthcare professionals of county lines, the Home Office has produced a guidance booklet and resources to help them understand the signs to spot potential victims and the action they should take to safeguard young people. We also encourage safeguarding leads and senior managers to promote these to their staff.

11.3 NHS England has published updated guidance for CCGs to reflect the changes to cost recovery regulations that came into effect on 23 October 2017. The guidance describes how the risk share arrangements will continue to apply for patients that require urgent or immediately necessary treatment. This version includes a new annex setting out some practical steps to support cost recovery, intended to help providers and commissioners to develop good working practices that are proportionate and flexible.

11.4 The cost of falls to the NHS is estimated to be £2.3 billion per year. With 30% of people aged 65 and over suffering a fall every year, rising to 50% of people aged 80 and over, the impact of falls on the health and care system is huge.

To support CCGs to provide cost-effective falls prevention locally, Public Health England has published Falls prevention: cost-effective commissioning. The resource includes a return on investment tool that pulls together evidence on the effectiveness and costs of interventions aimed at preventing falls in older people living in the community.

11.5 The bids have opened for wave 2 of the Perinatal Mental Health funding to develop or progress existing community Perinatal Mental Health services. The bids are for a year's funding and discussions are currently on going as CCGs need to confirm commitment to the sustainable future of the service, both within the year of development supported by an award from the Perinatal Mental Health Community Services Development Fund and maintaining a service beyond that period within the overall allocation available to the CCGs.

11.6 More women are having a positive experience of maternity care and treatment within the NHS, according to the latest Care Quality Commission survey results. The survey of more than 18,000 women in England shows improvements across most stages of maternity care.

11.7 A new guide from Shared Lives Plus explores the role that Voluntary, Community and Social Enterprise (VSCE) organisations play in helping people to benefit from personal health budgets. Through close partnership working with statutory services, voluntary and community sector partners are ideally placed to provide a range of advice, support and care services, and the report provides a timely set of recommendations for both VCSE organisations and CCGs.

11.8 NHS England and NHS Improvement are encouraging MPs to nominate individuals and teams delivering health and care in their constituencies for one-off national awards to mark the NHS's 70 birthday. This provides an excellent opportunity for NHS organisations and others to develop and maintain relationships with their local MPs, boost staff morale, and help showcase the best of the NHS to a national audience. We would therefore urge you to get involved and put your organisation forward in one or more of the ten categories. The Parliamentary Awards were launched on the 7 February 2018.

11.9 A joint working framework has been developed by the Care Quality Commission (CQC) and NHS England, with the support of NHS Clinical Commissioners. Its purpose is to help organisations work more effectively together and reduce duplication in the regulation of general practice. The framework provides an opportunity to improve joint working to reduce duplication between regulation and commissioning, and to become more streamlined and targeted in activities.

11.10 NHS Improvement has published a revised Never Events Policy and Framework and updated the Never Events list. The document aims to provide clarity for staff providing and commissioning NHS funded services who may be involved in identifying, investigating or managing Never Events, and ensures a focus on learning and improvement. The revised policy and framework became active upon initiation of the updated 2017-19 NHS Standard Contract on the 1 February 2018.

12. Recommendation

12.1 The Governing Body is asked to note the report.

Item Number: 6

Name of Presenter: Phil Mettam

Meeting of the Governing Body **Date of meeting: 1 March 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:

- an overview of latest performance against Improvement and Assessment Framework, (IAF) indicators that inform both the BAF and risk registers; and
- presents details of current events and risks escalated to Governing Body by the sub-committees of the Governing Body for consideration regarding effectiveness of risk management approach.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☒Financial ☒Legal ☒Primary Care ☒Equalities	All corporate risks escalated to the Governing Body.

Emerging Risks (not yet on Covalent)

Finance and Performance Committee – There were four main risks identified:

- Continuing Healthcare and Transforming Care/ Section 117 Vulnerable People Risks
- Multispecialty community bed provision in the Ryedale area
- Emerging contract risk from the contract with York Teaching Hospital NHS Foundation Trust
- Structure of the current anti-coagulation service

Each of the above is the subject of continued scrutiny and monitoring, with further action being taken to reduce risk.

Quality and Patient Experience Committee (QPEC) - The risk register was first sent to QPEC on 8 February 2018 where a number of risks potentially relevant for QPEC to manage were listed. The Chair of QPEC tasked the Quality Team with identifying which of these should be managed by QPEC, which were appropriate for management in other committees or through offices and which should be escalated to Governing Body. This work will be undertaken on 26 February 2018 and therefore not in time for these to be produced within this report but a verbal update can be given if required at the meeting on 1 March 2018.

Recommendations

The Governing Body is requested to:

- review risks arising and to consider risk appetite for events and high scoring risks;
- note areas of areas of concern as identified by the NHS England Integrated Assurance Framework and that risks are appropriately managed and mitigated in the CCG risk registers.

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam, Accountable Officer	Pennie Furneaux, Risk and Assurance Manager

Annexes (please list)

Annex A: Corporate Risk Register March 2018

GOVERNING BODY

RISK UPDATE REPORT

1 MARCH 2018

1. CCG IMPROVEMENT AND ASSESSMENT FRAMEWORK PERFORMANCE

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

1.2 The CCG currently has eleven national improvement and performance indicators falling into the lowest quartile as benchmarked against CCG performance nationally, as outlined below.

- Diabetes: achievement of NICE-recommended treatment targets, (Improving).
- Diabetes: attendance at structured courses, (Improving)
- Personal Health Budgets, (Improving).
- Improving Access to Psychological Therapies: Recovery rates, (Deteriorating).
- Improving Access to Psychological Therapies: Access, (Deteriorating).
- Early Intervention in Psychosis 2 week referral, (Deteriorating).
- Completeness of GP Learning Disability Register
- Diagnosis rate for people with dementia, (Improving).
- Dementia Care Planning post diagnosis, (Deteriorating)
- Population Use of Hospital Beds Following Emergency Admission, (Improving)
- Effectiveness of working relationships.

1.3 Overall, the summary report shows a stable position with no Key Lines of Enquiry specified.

1.4 Risk registers are being reviewed to ensure that risks are identified and a prioritised action plan is developed to mitigate.

2. CORPORATE RISK UPDATE REPORT

Corporate Events

2.1 The five corporate risks detailed below as events under the January Governing Body risk report have been de-escalated to managed risks:

- Failure to achieve access and recovery targets within acceptable waiting times;
- Failure to deliver the planned care 18 week RTT target;

- Increased demand on the local system resulting from an inadequate report of the Retreat. Improvements have been made as part of a plan to address issues identified;
- Failure to achieve the Dementia 67% coding target in general practice; and
- Delivery of BCF targets, (considered to have low/medium impact on the healthcare system resulting in continued pressure on the wider healthcare system).

2.2 The risk identified during December relating to Multi-Specialty Community bed provision in the Ryedale area has materialized and is being reviewed by the Finance and Performance Committee.

Corporate Risk Register

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

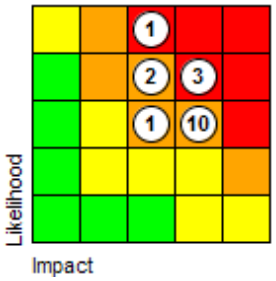
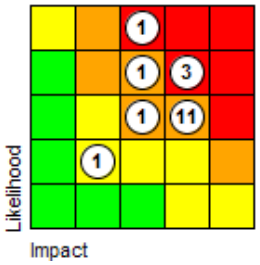
Profile of Corporate Risks Escalated to Governing Body as at 15th February 2018

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

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

Risks scores are rated as follows:

- Green – low risk
- Yellow – moderate risk
- Amber – high risk
- Red – extreme risk

Current Profile		Profile at last meeting	
	**Headline Red Risks:** • Delivery of QIPP schemes • Maintaining expenditure within allocation • Delivering the Local Digital Roadmap agenda • Failure to meet the Planned Care 18 Referral to Treat target (Full details are provided per Annex A)		**Headline Red Risks:** • Delivery of QIPP schemes • Maintaining expenditure within allocation • Failure to deliver 1% surplus • Delivering the Local Digital Roadmap agenda

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

CORPORATE RISK REGISTER 2017/18

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
ES.01 There is a potential risk that identified QIPP schemes and transformational programmes of work may fail to deliver quantified savings	The CCG QIPP plan and targets for 17/18 are complex and challenging. The national QIPP support programme report (confirmed at the Q4 16/17 assurance meeting with NHSE) as the most challenged QIPP programme in England. Unplanned care programmes particularly have a large and complex QIPP target over the next three years requiring significant partnership and transformational change. The impact for the CCG as an organisation is that it does not meet its statutory duties to meet all financial rules placed upon it and adequately commission the services the local population require, making best use of the funding it receives.	The impact for patients of not delivering QIPP and transformational programmes of work is that the CCG is unable to move the funding it receives from current contracts and services, and invest in improved service models that support the needs of people which are emerging and in different places in the Vale of York.	The established programme management arrangement and performance management framework in place within the CCG brings together all work streams and actions to drive QIPP and system transformation based around five programmes (unplanned care, planned care, primary care, MHLD & complex care and enabling & quality). All Executive leads are responsible for delivery or mitigating the risks around delivery of their QIPP plans. The Executive Team are responsible for identifying new QIPP opportunities and decision-making around financial savings where QIPP projects are not delivering at the scale or pace required to deliver the quantified savings	The CCG has now brought in a Turnaround Director to provide support in refreshing the CCG (along with S&R CCG's) QIPP programme and delivery. Monthly financial recovery boards and the recommendations and actions from this review of all current QIPP schemes and forecast position for Year-end will be reported to Finance and Performance Committee each month. There is also now a process of identifying opportunities for transformational work with partners for 18/19 underway which will support the CCG in driving financial efficiency, performance and quality improvements in services delivered for local people. There was confirmation that the CCG had delivered 58% of forecast QIPP target in 17/18 reported to Finance and Performance Committee and this was significantly higher than QIPP delivery of 16% in 16/17. There has also been considerable financial and programme delivery governance assurance reported by both the new Turnaround Director and NHSE local assurance and delivery teams. This has been support by strong audit assurance reporting across contracting, financial and performance assurance.	Caroline Alexander	Executive Director Service Transformation	16	8		15-Feb-2018
ES.20 There is a potential risk of failure to maintain expenditure within allocation	The scale of the financial challenge for the organisation is such that the CCG will not maintain expenditure within the in-year allocation.		Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	The CCG now has a forecast deficit of £22.5m, having reported all risks in the outturn position as required for Month 10 reporting. The Contracting team are in the process of trying to reach year-end agreements with all acute providers, where possible, and is in negotiation with York hospital to agree a	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		15-Feb-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
				system-wide position too. The CCG continues to work with the hospital and Scarborough and Ryedale CCG to build on the aligned incentives principles that have been agreed with a view to having a contract in place for the 1st April 2018. A high level, five-year financial plan / envelope has been agreed and recently refreshed for this place within the STP. Further detailed work to identify any alignment issues currently being undertaken. Although there has been an escalation to expert determination for Unbundled Rehabilitation, all partners continue to align 2017/18 forecast outturns with a view to reaching an agreed position before the end of the year.						
PLC.05 Constitution target – Planned Care - VoYCCG failure to meet 18 week RTT target	The % of patients on a completed admitted pathway within 18 weeks should equal or exceed 90%. This is a constitution target and failure to meet this target could result in patient safety concerns and financial penalties. The constitution splits this measure into three parts for admitted, non-admitted and incomplete pathways, this internal measure for the risk register is based on admitted adjusted pathways. Data source is the monthly RTT report produced by the CSU.	Delays in patients receiving treatment	YHFT are updating Recovery Plan and reporting actions to Unplanned Care Steering Group and CMB.	RTT performance 85.8% in December 2017 against 92% target. Patient backlog has increased due to Winter pressures when routine electives were cancelled.	Fliss Wood	Executive Director Service Transformation	16	12		14-Feb-2018
ES.04 Local Digital Roadmap: The CCG may not develop adequate enabling programmes of work to deliver the Local Digital	There is a potential risk of lack of allocated staff resource and technical expertise with the CCG to deliver the programme within required deadlines. The impact may be that progress fails to meet national requirements or attract funding. If stakeholders do not share the digital system vision and commit to delivering the local digital roadmap the CCG may be unable to access		The CCG needs to clarify STP and local level Governance arrangements, exec sponsorship, and implementation resource to ensure delivery of the Local Digital Roadmap. Steps have been taken to engage with STP digital programmes, however,	Paper to go to Exec Committee in Feb to request a joint funded LDR manager with Scarborough Ryedale CCG.	Shaun Macey; Phil Mettam	Accountable Officer	15	9		15-Feb-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
Roadmap agenda.	funding opportunities and this may result in delays in delivering the national requirements.		this needs to be formalised. An LDR Partnership Steering Group has been formed. Governance arrangements have been agreed. The CCG's Exec sponsorship is to be confirmed. Implementation of adequate resource to ensure delivery of the Local Digital Roadmap.							
ES.05 There is a risk that the CCG may failure to retain key staff to ensure continuity and system-wide stability	The CCG is in a period of transition and requires a comprehensive team to deliver on the recovery of the organisation. Following the retirement of one of the executives and two strategic programme consultants the structure is being revised to realign portfolios and develop the resource response to developing the system response to capped expenditure.	No specific clinical impact	Staff engagement group. Staff communications and engagement Whole Team sessions implemented. Learning Lunches. OD plan development Training and development opportunities. Alignment of staff to key programmes and priorities Appraisal process with focus on objectives	The structure has been implemented and reviewed against priorities. The alignment of capacity to the requirement to deliver key programmes of work requires on-going review given the changing priorities for the CCG. Options, working with partners, including NHSE are being explored with regard to ensuring capacity to deliver. The new appraisal process has focussed on delivery of objectives linked to the CCG's priorities with any training and development needs identified. The staff engagement group is being reviewed to ensure wide staff representation and a clear action plan. A range of options with regards to improved staff communication and engagement have been set up. Revised arrangements have been established. Structure being finalised in light of system strategic and operational post requirements	Michelle Carrington	Executive Director Quality and Nursing	12	2		15-Feb-2018
ES.09 Vacancies in the Executive Team may potentially impact delivery of CCG objectives	There is a lack of capacity to delivery key strategic programmes, in particular executive lead for Primary Care development and transformation. This may lead to difficulties in developing a Primary Care strategy and promoting work streams to fully develop care pathways outside hospital settings with the appropriate contractual			The turnaround proposals for the CCG are being considered by NHS England and are under ongoing review within the CCG	Phil Mettam	Accountable Officer	12	8		06-Dec-2017

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
	frame works to drive forward transformation and improve quality. A range of options have been implemented to cover these gaps.									
ES.15 There is a potential risk of inability to create sustainable financial plan	Financial modelling of allocation, demographics, tariff changes, business rules, investments, cost pressures, inflation and outturn creates an unaffordable financial challenge.		Medium Term Financial Strategy Heads of Terms Joint QIPP programme Capped Expenditure Programme	The CCG is implementing the transformational programmes identified as part of its MTFS laying the foundations for the delivery in future years with effect from 1st April 2018. This is further supported by the engagement of a Turnaround expert to review 2017/18 delivery and pursue proposals for 2018/19 onwards. The CCG continues to work with the hospital and Scarborough and Ryedale CCG to build on the aligned incentives principles that have been agreed with a view to having a contract in place for the 1st April 2018. A high level, five-year financial plan / envelope has been agreed and recently refreshed for this place within the STP. Further detailed work to identify any alignment issues currently being undertaken. Although there has been an escalation to expert determination for Unbundled Rehabilitation, all partners continue to align 2017/18 forecast outturns with a view to reaching an agreed position before the end of the year.	Michael Ash-McMahon	Executive Director Chief Finance Officer	**12**	**5**		15-Feb-2018
ES.32 Lack of wider stakeholder support for delivery of plans	Articulation of a clear vision that all stakeholders support. The impact for the CCG is that it is dependent on strong joint working with many of its partners and from local people in order to effectively address the financial deficit and transform services to improve population health.	The impact for patients is that they are unable to understand how services are and will be delivered to meet their needs and improve their health now and into the future. Local people will not be able to understand the public health needs locally and how people need to, and can be enabled to, care for themselves more effectively and maintain	The CCG has now transitioned into delivery of its 2017/18 programmes as outlined in the Operational Plan. Many of the workstreams are being developed collaboratively with partners including the programmes for unplanned care and planned care which are being jointly scoped and delivered with YTHFT under the Heads of Term for the contract.	The CCG continues to work with partners to develop the detailed joint programme which will deliver the ambition articulated in the approved Vale-Scarborough system medium-term plan. The financial plan for 5 years that must be delivered through the medium term system plan is currently being further developed in light of the confirmed allocations to the CCGs and there is a requirement for a refreshed financial, activity and operational plan for the CCG to be approved by 30th April for submission to NHSE	Caroline Alexander	Executive Director Service Transformation	**12**	**12**		15-Feb-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
		good health for longer.	Additionally, the CCG will work to clearly identify the impact (benefits and improvement in outcomes) on the local populations in each of the three ACS localities as requested at CYC Scrutiny meeting in March 2017. This includes a request from the CCG to partners to jointly consider how the system will support (fund or otherwise) non-recurrent investments required to support system delivery. This will be shared on a regular basis as the programmes are developed. The CCG AO meets regularly with the local councillors across the VoY locality in order to engage around the system challenges and how the CCG is enabling the system transformation. Councillors have offered support to the CCG Engagement programme as the CCG engages with local people and organisations. The first lay member summit was held on Friday 7th April.	and the HCV STP. The CCG's Commissioning Intentions for 2018/19 have also been approved and shared with providers and partners.						
ES.34 There is a potential risk that the Constitution may not be fit for purpose and adequately define statutory duties.	The current constitution does not reflect structure. Whilst in legal directions interim arrangements were acceptable. Now Accountable Officer has been recruited on a permanent basis the CCG needs to start to resolve this. Whilst the structure does not reflect the constitution the decision making power of the CCG is more restricted and potentially open to challenge.		The CCG constitution review is underway to reflect the current structure. Currently the CCG is operating within the confines of legal directions and therefore has mitigated the risk of the outdated constitution however the CCG needs to develop an appropriate constitutional framework as a matter of urgency. There remain some	A revised version of the Constitution is being prepared to reflect the appointment of a clinical chair.	Abigail Combes; Helena Nowell	Accountable Officer	12	4		13-Feb-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
			outstanding matters for resolution before the constitution can be approved by Council of Members and sent to NHSE for approval.							
ES.36 CCG General Practice Strategy & Vision	The CCG needs to develop/agree a strategy and vision for General Practice that aligns with system/locality strategy and supports the delivery of sustainable General Practice services and locality workstreams. This strategy needs Exec ownership and leadership to enable the system vision of shifting work from specialist Acute to out of hospital settings. Without this, there is a risk that member Practices will not have a clear and agreed vision for how they support and drive wider system transformation - in turn risking non-delivery of key objectives and financial recovery.		Documents are in development to address key areas re. i) helping Practices to manage demand (with support from other agencies) and ii) a vision and future business model for General Practice (with greater working at scale). Also, an action plan is in development to inform resource requirements to deliver key priorities around estates, IT, workforce and demand management. These documents are being reviewed by SMT in order to prioritise work and assign resource.	An agreed vision and strategy for General Practice is needed to underpin wider strategic plans to move work out of Acute settings. This work requires clinical leadership and engagement/input across member Practices. The recent appointment of Dr Kev Smith as Director of Primary Care and Population Health is a significant step forward in providing the CCG Exec level leadership that is required to deliver this.	Shaun Macey	Executive Director Primary Care and Population Health	**12**	**4**	———	25-Jan-2018
ES.37 General Practice Capacity				Strategic plans to deliver financial sustainability are dependent on redesigning system pathways to manage care closer to home for patients, and reduce avoidable secondary care activity. This is predicated on a shift of workload out of hospitals and into GP-led services in the community. General Practice in Vale of York, whilst currently fairly stable and providing high quality services, will need significant investment if it is to manage an increase in demand due to both demographic growth and a shift of activity out of hospital settings.	Shaun Macey	Executive Director Primary Care and Population Health	**12**			18-Jan-2018
ES.38 System Estates Strategy				In order to support strategic plans around moving activity and funding around the system, and meeting	Michael Ash-McMahon	Executive Director Chief Finance Officer	**12**			18-Jan-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
				demographic growth, the CCG needs to develop an overarching strategic estates strategy for the system that Providers are aligned with. This is a complex piece of work, and will include NHSPS, third-party owned, and privately-owned premises. Steph Porter leading from a CCG perspective.						
JC.19 Constitution Target - Planned Care - Cancer 62 day waits	85% or above of patients should receive their first definitive treatment within 62 days of an urgent GP referral for suspected cancer. Those waiting longer than 62 days are appropriately reviewed and managed.	Delays in patients receiving diagnostics and cancer treatment which may result in worse outcomes.	YHFT is prioritising timed pathways with under performance on 62 Day targets focusing on Lung and Upper GI. As a result of the YHFT audit against the 10 High Impact Changes additional funding has been received to increase MRI and CT scan capacity. RCAs are undertaken on all 62 Day breaches and 104 day clinical harm reviews which are reviewed by the YHFT Cancer Board.	YHFT achieved 62 Day Cancer Standard in December 2017	Fliss Wood	Executive Director Service Transformation	**12**	**6**		14-Feb-2018
JC.28 Constitutional Target-Cancer 14 Day Fast Track	Failure to meet the constitutional target for at least 93% of cancer fast track patients to be seen within 2 weeks. This also has the potential to impact on the 62 day Cancer target.	Delay in diagnosis may impact on the staging of the cancer and potential poorer patient outcomes, and more complex care required.		YHFT achieved 2WW fast track target in November but failed again in December 2017	Fliss Wood	Executive Director Service Transformation	**12**	**8**		14-Feb-2018
JC-PROG.01 Dementia - Failure to achieve 67% coding target in general practice.	Non delivery of mandatory NHSE targets Lack of sufficient providers in some areas resulting in delayed transfers of care or limited choice available to patients meeting new standards	Further pressure from NHS England to rectify this. Service users may not be appropriately flagged and therefore ongoing referrals from primary care will not have the relevant information to make reasonable adjustments for their carers support.	CCG/PCU leads have devised a comprehensive action plan. CCG to provide focussed support targeting the larger practices with the lowest coding rates. All practices will be encouraged to re-run the toolkit and review all records identified.	The dementia coding target for local practices still presents a challenge. There will be a renewed push to drive the coding over the coming weeks prior to the year end. The clinical director will help those practices with the biggest challenge to overcome this. Further work is ongoing in terms of encouraging practices to drive performance and achieve better outcomes for service users with dementia. NHS England	Paul Howatson	Executive Director Service Transformation	**12**	**9**		15-Feb-2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
			Controls include: Programme meeting and TEWV CMB	dementia summit meeting will take place in March 2018 for the CCG.						
UPC.10 Constitution target – Urgent Care - VoYCCG failure to meet 4 hour A&E target	The % of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge should equal or exceed 95%. This is a constitution target and failure to meet this target could result in patient safety concerns and financial penalties.	Impact on patient experience and potentially patient safety if patients are not seen in a timely manner.	The Winter Plan has been signed off by the A&E Delivery Board and is being mobilised with a target to achieve 92% bed occupancy. Ambulance handovers at YHFT - plan agreed with YAS to manage and escalate when experiencing high volume of ambulance arrivals to prevent delays. The Finance and Performance Report provides a full update every month.	Ongoing work as per winter and recovery plans. See individual plans for details.	Becky Case	Executive Director Service Transformation	**12**	**8**		05-Feb-2018
ES.23 There is a potential risk that the CCG receives a qualified external audit opinion	There is a risk that the financial management and position of the organisation is such that it will require a qualified external audit opinion.		Subject to delivery of agreed financial plan as and when accounts signed off.	Work is on-going to return the CCG to financial balance over the medium term, but with changes to the CEP proposals there is a risk that a qualified VfM audit opinion will be given throughout the 2017/19 contracting period.	Michael Ash-McMahon	Executive Director Chief Finance Officer	**9**	**4**		15-Feb-2018

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Item Number: 7

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Commissioning Intentions 2018/19

Purpose of Report
To Ratify

Reason for Report

The Commissioning Intentions, issued week commencing 8 January following Governing Body approval in private on 4 January, identify what will be done in 2018/19 to ensure that the services commissioned by Vale of York CCG are safe and effective and that they are commissioned within the financial parameters that apply; at the same time initiating the changes that are needed to the health and care system to achieve stability and long term sustainability.

They inform organisations within the Humber Coast and Vale Sustainability and Transformation Partnership (HCVSTP) and NHS England of the CCGs commissioning priorities. They are also of interest to patients and the public and reflect the priorities that were identified through engagement events that took place in July and August 2017.

The document provides an overview on how the commissioning intentions fit within the overall strategic direction for the CCG and the wider Health and Care system; the main body of the document describes the strategic context and the specific commissioning priorities for 2018/9.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks	**Covalent Risk Reference and Covalent Description**
☒Financial ☒Legal ☒Primary Care ☒Equalities	
Emerging Risks (not yet on Covalent)	
Recommendations The Governing Body is asked to ratify the Commissioning Intentions2018/19.	

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	Lisa Marriott Senior Account Manager New Care Models Programme | Five Year Forward View NHS England

Vale of York
Clinical Commissioning Group

Commissioning Intentions 2018 – 2019

Published January 2018

1 PRIORITIES FOR 2018/19; OVERVIEW

These commissioning intentions identify what will be done in 2018/19 to ensure that the services commissioned by NHS Vale of York CCG are safe, effective and are within the financial parameters that apply; at the same time initiating the changes that are needed to the health and care system to achieve stability and long term sustainability.

This needs all organisations within the health and care system to work together in concert, putting people and communities ahead of individual organisational concerns. There is a commitment to do this; the challenges that are faced are beyond the ability of individual organisations to solve, but by working together we will be able to achieve the fundamental shift that is needed.

There is a real opportunity to act in 2018/19 so that commitment in principle becomes a reality in practice - to achieve the best outcomes for the people that we serve.

What does this mean in practice?

This will start with improving the ability of individuals and communities to take responsibility for their own physical and mental health and well-being. Based on the "primary care home" model, they will be supported to do this by professionals working together across traditional health and care boundaries and by making full use of the valuable resources offered by the voluntary sector. By strengthening primary and out of hospital care, better personalised and preventative care can be provided for local communities; when health care is needed, this can be provided closer to home in a way that is easier to navigate, which in turn will reduce reliance on hospital services.

This is consistent with national and local strategies – and importantly, it is what people in the Vale of York told us they wanted.

- **How will this affect People and Communities?**

There will be greater emphasis on supporting people to take more responsibility for their own health and well-being, with improved access to primary care and simplified care pathways that are better integrated and easier to navigate. As well as allowing people to have greater choice and control through personalised health budgets e.g. patients with long-term conditions.

- **How will this affect General Practice and Primary Care?**

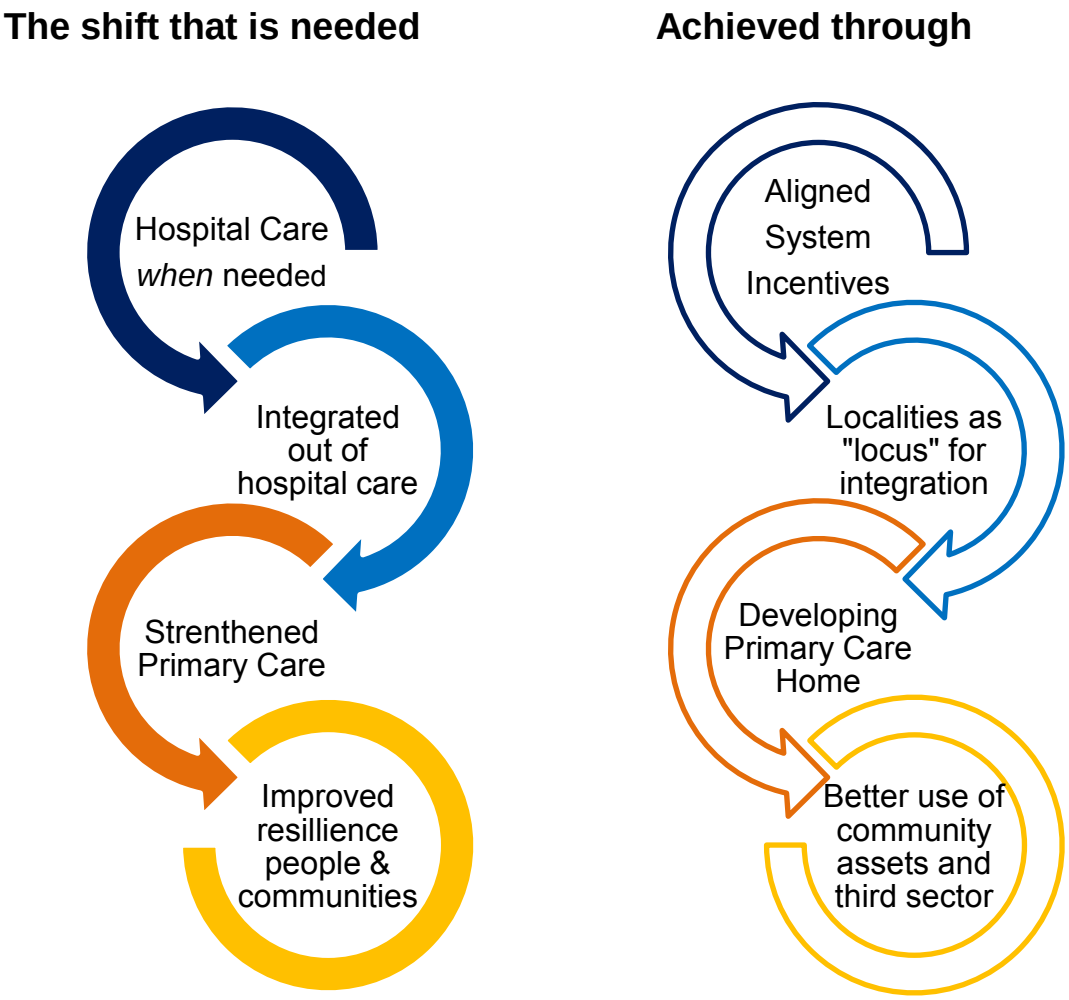
General Practice and Primary Care have a unique understanding of the needs of local communities. Locality working will be central to making sure that the different needs of local communities are reflected in the decisions that are made. This is reflected in changes to CCG governance that puts the clinical voice at the centre of decision making; GPs now have the opportunity to be the voice of their local area.

- **How will this affect care outside hospital?**

There will be a greater emphasis on out of hospital care that supports and supplements General Practice and Primary Care. This will mean that people have an integrated response to their needs, particularly when they are complex or they have both mental and physical care needs. For both acute and mental health providers this will require a change in focus to services that are more integrated at a local level. There is also an ambition to go beyond 'joint commissioning' across health and social care, with a progressively ambitious approach, aiming for implementation of 'cross sector' commissioning from April 2019.

- **How will this affect hospital care?**

Hospitals are a valuable resource and are uniquely placed to provide certain aspects of care; for example, where specific clinical expertise and/or technical capability are needed. Shifting the balance of care as described above will require a shift in resource away from acute hospital care. For mental health provision this will also mean a greater emphasis on making sure that there is more focus on the most vulnerable people (often those with complex needs)



2 PURPOSE OF THE DOCUMENT

The purpose of this document is to inform organisations within the Humber Coast and Vale Sustainability and Transformation Partnership (HCVSTP) and NHS England of the CCGs commissioning priorities for 2018/19.

The commissioning intentions will also be of interest to patients and the public and reflect the priorities that were identified through engagement events that took place in July and August 2017.

The document is in three parts;

Part A - STRATEGIC CONTEXT

1. The national context; Operational and planning guidance 2017-19
2. Wider system collaboration; Humber Coast and Vale
3. York-Scarborough Recovery and Transformation
4. NHS Vale of York CCG Strategic Priorities
5. Patient and public engagement
6. Commissioning Landscape; financial context
7. Regulatory environment
8. Clinical Priorities

Part B - COMMISSIONING INTENTIONS; PRIORITIES FOR 2018/19

1. Primary Care and General Practice
2. Joint Commissioning
3. Services for people with Mental ill-health
4. Services for people with learning disabilities
5. Services for people of all ages with autism
6. Services for children with special needs in education
7. Acute Transformation
8. Urgent and emergency care
9. Planned care; improving Referral to Treatment times and Elective Care
10. Maternity services; Better Births
11. Cancer services and waiting times
12. Commissioning For Quality

PART C – CONCLUSIONS; NEXT STEPS

A STRATEGIC CONTEXT

The document builds on work carried out during 2017/18; it reflects national, STP and local priorities and is consistent with the principles agreed by STP partners and the NHS Operational Planning and Contracting Guidance 2017-19[1], in achieving the 'triple aim' of, improved health and wellbeing, transformed quality of care and sustainable finance, as described in the Next Steps on the Five Year Forward View (2017).

1 National context; Operational Planning and Contracting Guidance 2017-19

The nine 'must do' priorities identified in 2016/17, remain priorities for 2018/9 and need to be delivered within the financial resources available;

1. Being part of and contributing towards a Sustainability and Transformation Partnership (STP);
2. Improving the financial position;
3. Improving Primary Care in line with the GP Forward View;
4. Improving Urgent and Emergency Care;
5. Improving Referral to Treatment times and Elective Care; (including implementation of the national maternity services review, Better Births, through local maternity systems).
6. Improving cancer services and waiting times;
7. Improving services for people with mental ill health;
8. Improving services for people with learning disabilities and;
9. Improving quality in organisations.

These have been used in conjunction with the CCGs Strategic Priories, as a framework to describe commissioning intentions for 2018/9 (as described in section 9).

2 Wider system collaboration

The CCG is a member of the Humber Coast and Vale Sustainability and Transformation Partnership (HCVSTP)[2] who have identified six priorities;

- healthier people,
- better "out of hospital" care,
- better "in hospital care"
- better mental health care,
- better cancer care and
- balancing the books

The focus for achieving the first two priorities will be addressed through "place based" programmes of work, where Vale of York is working in collaboration with NHS Scarborough and Ryedale CCG (S&R CCG) York Teaching Hospital NHS Foundation Trust (YTHFT) and Local Authority partners. The remaining programmes will be approached with partners across the STP, reflecting the way that local people use health and care services.

3 York-Scarborough Recovery and Transformation

The recovery and transformation programme that has been developed jointly with NHS Scarborough and Ryedale CCG works across;

[1] https://www.england.nhs.uk/deliver-forward-view/

[2] http://humbercoastandvale.org.uk/our-vision/

- the place-based strategies of the two respective CCG systems
- a single acute transformation programme across the planning footprint of York Teaching Hospital NHS Foundation Trust

Using the combined acute commissioning resources of the two CCGs, the overarching aims are to;

- maximise the use of evidence based prevention
- establish whole system clinical pathways that operate optimally to maximise service productivity and efficiency
- adopt a 'home first' approach to supporting the frail and elderly
- integrate planning and commissioning of wider community services such as Continuing Healthcare and Mental Health

The overall system redesign will shift the emphasis away from hospital and bed-based care towards a greater focus on primary and community based care, supporting patients in their home wherever possible.

The development of locality "hubs" as a means of improving population health through better community engagement and as a locus for primary care development is central to achieving this.

The establishment of the Scarborough and Ryedale Multi-speciality Community Provider (MCP) and the emergence of Primary Care Home in the Vale of York are evidence of how this approach is being put into practice

4 NHS Vale of York CCG Strategic Priorities

The focus in 2018/9 will be on meeting the core requirements of patient safety, achieving national/constitutional standards and achieving financial sustainability, while making progress on three strategic objectives; development of primary care, joint commissioning with Local Authority partners and acute transformation, all of which are designed to achieve the strategic change needed for long term financial and service stability and sustainability.

5 Patient and public engagement

The following themes emerged from the consultation events that took place during 2017;

- the need to improve access to and the quality of primary care
- the importance of having timely access to good quality mental health services
- increasing the focus on prevention and using the third sector/community assets to more effectively support people to look after themselves
- the importance of considering the needs of different communities; increasing the scope of local services to prevent people having to travel to use hospital services

All of which are consistent with the overall approach that is outlined above.

6 Commissioning Landscape; financial context

The financial challenges facing Vale of York are well recognised, there is a recurrent deficit position of £22m, which needs to be closed to get back to annual balance.

The CCGs medium term (four year) financial strategy was approved by the Governing Body in March 2017. Its aim is to reach a balanced and sustainable financial position, which also;

- aligns with existing system plans, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan (which the CCG is a partner to)
- meets key statutory financial targets and business rules

- is consistent with the CCG's vision and supports the delivery of the CCG objectives
- recognises and meets the scale of the challenge in the Five Year Forward View
- delivers operational and constitutional targets

The approach, which was supported by NHS England, was to focus on achieving stability in 2017/18, moving on to address longer term sustainability. There is evidence that this is being achieved (e.g. the forecast outturn for YTHFT for 2017/18 is in line with plan). The focus in 2018/9 will be to consolidate progress made and continue to addresses the underlying causes of financial deficit.

The CCG believes that in order to deliver real change, a radical new approach to system leadership, commissioning and delivery is required. This view is shared by organisations across the Vale of York, East Riding and Scarborough and Ryedale NHS system, with a shared commitment to support principles that reflect the collective responsibility for the needs of patients. They recognise the importance of genuine, collaborative, clinical leadership and the importance of financial and contracting structures that facilitate a shared view of NHS resources and patient needs. All which provide the incentives that shift the focus from individual organisational need to "system benefit".

The priorities for 2018/19 are aimed at achieving this objective.

6.1 Acute services; aligned incentive contract

There is agreement in principle from YTHFT to an "aligned incentives contract", which better incentivises positive outcomes for patients and more effective use of resource within the health system. During the remainder of 2017/18 joint work will be undertaken to work through the operational requirements of this approach for implementation in 2018/19.

The aim is to work to the principal that, where possible, care should be delivered as close to home as possible and hospital services used only for those people whose care requires it. This will ensure that best use is made of relatively scarce and expensive clinical resources and is consistent with evidence based practice and the views of patients and public. This approach will also remove perverse incentives that hinder the use of technology to support care and treatment e.g. the use of telephone rather than face-to-face consultation.

6.2 Mental Health and Learning Disability services

The current contract agreement with Tees, Esk and Wear Valleys Foundation Trust (TEWV) is based on a mutual recognition that where possible care should be provided in community-based settings, using hospital services only when necessary. The contract is outcomes-based and includes the requirements of both parties to work together to achieve this objective. In addition, as a result of the opening of a new mental health inpatient facility the CCG will work with TEWV to rationalise the estates.

6.3 Primary care

In line with national priorities, there is a commitment to properly resourcing primary care, so that services are sustainable and are able to develop in a way that supports the ambition of reducing dependency on the secondary care sector.

The plan will be to fully utilise the investment identified for primary care in 2018/19. There is agreement from the CCG Executive Committee

- to make the £3.00 per head available in full in 2018/19 for schemes for improved sustainability
- to make the £3.34 per head available in full in 2018/19 for schemes for extended hours

In addition, the £313,000 will be available from the Primary Medical Services (PMS) premium for investment in primary care.

6.4 Joint commissioning

The intent is to increase the commitment to joint commissioning with partner organisations; the details of this will be confirmed in the early part of 2018/19.

6.5 Improving efficiency and effectiveness of commissioning

The recovery and transformation programme that has been developed with NHS Scarborough and Ryedale CCG utilises the combined acute commissioning resources of the two CCGs and uses a joint approach where this creates greater consistency for providers.

The NHS Vale of York CCG will work with NHS Scarborough and Ryedale CCG to further concentrate expertise and resources in 2018/9, providing more effective contract management through economies of scale. The aligned single contract for acute services will allow more effective contract management, simplification of contracting arrangements will also benefit the provider e.g. there will be no requirement to provide multiple sets of information.

In addition, contracting intentions will be aligned across the HCVSTP to ensure a consistent approach to financial planning.

6.6 Quality Innovation Productivity and Prevention (QIPP)

The approach taken in 2017/18 was to ensure that there was a firm evidence base to inform decisions in relation to areas of cost reduction (e.g. using age profiles and benchmarking information) which resulted in effective delivery of targets and evidence that performance for QIPP has improved. This approach will continue in 2018/19 (details and breakdown of schemes are in Appendix 1)

QIPP Summary	**2017/18**	**2018/19**
Approved Financial Plan	**£14.4m**	**£14.3m**

Detailed financial plans for 2018/19 will be refreshed in March 2018 therefore QIPP plans are expected to change as plans are developed and finalised.

6.7 Prescribing; drugs, devices and products; joint approach with NHS S&R CCG

CCGs have made significant savings from prescribing budgets, but there are opportunities to go further. Restrictions can be applied to; not prescribing drugs available as over the counter medications; closer adherence for prescribers on NICE guidelines and further restrictions on use and choice of medicines, products and devices.

The priority for 2018/19 will be to target more radical options to reducing spend on pharmacy, products (such as continence) and expensive devices.

7 Regulatory Environment

There have been well recognised challenges for the NHS Vale of York CCG and the wider health economy. The CCG aims to take itself out of legal directions in 2018/19 and to respond positively to the CQC review. We recognise that there may be challenges for other

organisations in relation to regulation; we will work with them to make sure that the needs of patients are paramount when addressing any issues.

8 Clinical Priorities

There are a number of opportunities presented by Right Care for improvements in efficiency and clinical outcome, as well as those where there is an opportunity to provide care more effectively out of hospital (as detailed below) these provide the basis for prioritising specific programmes.

Right Care			Demand/Capacity
Spend & outcome	**Outcomes**	**Spend**	
• Gastro-intestinal • Musculoskeletal • Endocrine • Neurological • Circulation	• Endocrine • Gastro-intestinal • Maternity • Circulation • Respiratory	• Musculoskeletal • Neurological • Gastro-intestinal • Circulation • Trauma & injuries	• Ophthalmology • ENT • Dermatology

PART B COMMISSIONING INTENTIONS; PRIORITIES FOR 2018/19

The CCG's three strategic pathways; development of primary care, joint commissioning with Local Authority partners and acute transformation, together with the Operational Planning Guidance and "nine must do's", form a framework to describe the specific priorities for 2018/19.

1 Primary Care and General Practice

The GP Forward View (April 2016) sets out a plan to transform primary care over the next five years with the plan to invest £2.4bn nationally by 2020/21; tackling workforce, workload, and supporting redesign, including practice transformation, development of "at scale" providers, stimulating implementation for the "10 High Impact Changes to release time to care" and improving in hours access.

The role of general practice is central to the provision of effective services to patients, therefore the CCG is committed to the implementation of the GP Forward View and strengthening the role of primary care clinicians in CCG leadership.

Priorities for 2018-19 are to;

- Continue to commission General Medical Services (delegated in 2015) working with practices to develop extended hours. These services will be procured in 2018/19.
- Promote the development of safe and sustainable primary care, through encouraging practices to work at scale. The development of locality "hubs" is a priority as a means of improving population health, through better community engagement and as a locus for primary care development.
- Support the development of effective partnerships between practices, to improve long term sustainability and to realise economies of scale. This will increase the capacity capability of primary care, to reduce dependency on secondary care by providing services in primary care where this is more effective, using indicative budgets and gain/loss share as a means of facilitating this.

- Support the development of effective partnerships with Local Authority partners, recognising the interrelationship between mental and physical health and the social care aspects of heath and well being
- Support the ability to form effective partnerships with the third sector, seeking to mobilise these valuable resources so that people and communities can be supported to improve their own health and well-being e.g. by further developing social prescribing.

2 Joint Commissioning

The CCG and local partners recognise the need to improve the ways in which services are commissioned, especially for people, families, and communities where both health and social care can work together to achieve better outcomes. The added value from joint commissioning will come from increasing:

- co-production
- personalisation
- prevention and early intervention
- Asset Based Community Development (ABCD)
- community capacity
- self-directed support and self-care

The CCG aims to achieve integration of Health and Social Care by 2020 in line with national intentions, using the BCF and the iBCF as ways of bringing about both strategic and operational change and is committed to further developing joint commissioning, in line with the priorities and principles agreed in the Vale of York Joint Commissioning Strategy 2016-2020.

The CCG will work with partners in the Health and Wellbeing Boards and Humber Coast and Vale Sustainability and Transformation Partnership, and with the local authorities in their respective joint commissioning arrangements; using the Better Care Fund (BCF) and the Improved Better Care Fund (iBCF) in a way that;

- Contributes to the medium and longer term objectives to move away from needs primarily being met by statutory agencies, towards working with individuals and communities to support self-help and self-care;
- Supports people in their own homes and communities to avoid the need for admissions to residential and nursing care, and urgent hospital care and helps them to return to their home after a hospital.

Priorities for 2018/19 are to;

- Agree a progressively more ambitious “cross sector” commissioning strategy; with a focus on defining the scope of joint ambition in the first half of 2017/18, transition in the second half of 2017/18 and aiming for full implementation in 2018/19.
- Continue the development of joint commissioning arrangements with local authorities, including establishing a joint commissioning capability with City of York Council, bringing together expertise and shared programmes of work
- Further align the existing commitment to prevention and early intervention, with asset based and strengths based approaches, supporting individual and community resilience, including improving access to universal information and advice
- Align the development of the Local Digital Roadmap with opportunities across the wider public sector, in particular the progress in York towards the Digital City; sharing information to improve patient care and extend our performance management capabilities
- Develop a comprehensive accommodation needs assessment and strategy for York

- Meet the national conditions and deliver the goals of the BCF and iBCF, including working towards integration, extending the scope of the fund, improving outcomes for people and meeting performance standards
- Continue developments in Continuing Health Care (CHC)
- Address delayed transfers of care through whole system working
- Further develop the range of intermediate care and rehabilitation/reablement services
- Optimise the potential for Personal Budgets and Personal Health Budgets to align systems and processes, joining up around the individual; simplifying the arrangements and minimising bureaucracy
- Ensure our plans and activities support the system wide response to the CQC Local System Review, which took place in October/November 2017.

3 Services for People with Mental ill-health

The CCG is committed to realising the ambitions of the Mental Health Five-Year Forward View, the Mental Health Crisis Care Concordat and achieving the standards and detailed in the NHS Operational Planning and Contracting Guidance.

The CCG will continue to work with the voluntary sector and other partners to focus on maintaining psychological well-being and preventing mental illness by developing individual and community resilience and recognising the early signs of mental ill-health, intervening early to prevent deterioration; working with partners to jointly commission services that help people of any age, with an existing mental illness live with and manage their condition effectively.

This is particularly important for children and young people as this clearly has an impact on long term health and well-being.

The importance of collaboration with other statutory organisations and the voluntary sector is reflected in the Vale of York Joint Commissioning Strategy, the York Health and Wellbeing Strategy, and other joint strategies and in the contractual agreement between the CCG and Tees, Esk and Wear Valleys Foundation Trust (TEWV). Joint working and the development of further service integration will be a continued focus in 2018/19.

In 2018/19 the CCG will work with partners on a programme of work to achieve a step change in improving mental health service performance against national standards, particularly in early intervention psychosis, improving access to psychological therapies (IAPT), dementia diagnosis and children's and young people's mental health services, in line with the agreed Local Transformation Plan[3] where joint work is needed with TEWV to develop joint plans to achieve targets. The CCG will continue to work with CCG colleagues in North Yorkshire, to make use of commissioning expertise (e.g. in commissioning children's and young people's mental health services), we will also continue to work with NHS England to support co-commissioning for the local provision of specialised services.

Children and young people

The CCG aims to meet the national ambition to develop integrated services for children's and young people's mental health services. Where possible care should be provided in the community; when an in-patient stays is needed, this should only take place where clinically appropriate; length of stay should be as short as possible, it should be as close to home as

[3] http://www.valeofyorkccg.nhs.uk/data/uploads/publications/local-transformation-plan-2017/local-transformation-plan-2017-submission-31-oct-2.pdf

possible and out of area placements should only take place when clinically necessary. Moving to a position where all general in-patient units for children and young people are commissioned on a 'place-basis' by locality, so that they are integrated into local care pathways.

Priorities for 2018/19 are;

- To commission improved access to 24/7 crisis resolution and liaison mental health services
- To address the needs of children and young people with eating disorders the CCG priorities are
  - to commission dedicated eating disorder teams
  - to set clear trajectories for access and waiting time standards; with a target of 95% of children in need to receive treatment within one week for urgent cases, and four weeks for routine cases
  - to measure patient experience and changes in rates of admission to inpatient services

Adult Mental Health

The CCG will develop enhanced community mental health models, which will focus care out of hospital in "hubs" reflecting the agreed strategy to decrease the inpatient bed base in the hospital provision that replaces Bootham Park as well as the strategic development of locality "hubs" as the locus for the provision of integrated physical and mental health services.

The physical health needs of people with mental illness also need to be addressed. The CCG aims that more people have their physical health needs met by increasing early detection and expanding access to care assessment and intervention each year.

Priorities for 2018/19 are to;

- Increase access to Psychological Therapies (IAPT) for people with common mental health conditions with the majority of new services being integrated with physical healthcare (with a target of 19% access in 2019)
- Develop an integrated approach to that is focused on supporting people who are vulnerable and/or have complex needs (including people who need care after under section 117) aiming to reduce the number of out of area contracts (mental health placements)
- Continue to work with primary care providers to increase the rate of diagnosis for dementia to 60% (aiming for 67% by 2019 in line with national targets)
- To address the needs of people in care homes, we aim to strengthen the provision of MH support (to provide advice, training and skilled reviews, particularly for those people with dementia). We will also review the options for skilled residential and nursing care for clients with dementia.
- To address the needs of people with MH problems admitted to general acute care the priorities are to;
  - support the acute psychiatry liaison service within York Teaching Hospitals NHS FT,
  - work with YDHFT to understand the causes of frequent attendance, aiming to reduce attendances at the Emergency Department and admissions to hospital by putting in place alternatives to support people before their condition reaches crisis point

4 Services for people with learning disabilities

The CCG will implement plans that have been agreed with Local Authority partners to meet the requirements of Transforming Care. Reducing CCG commissioned beds in line with

national targets; enhancing community provision for people with Learning Disability and/or autism, moving people from assisted living units into community placements. In addition, to ensure that children and young people with special educational needs and disability (including those with a learning disability) have equity of access to health services, particularly ensuring that primary care facilities are accessible and that young people in transition to adult services are well supported. We recognise the challenge of securing skilled providers to support those people with behaviours that challenge and will be working to address this.

5 People of all ages with autism

The priority for 2018/19 is to develop a strategy for autism, based on the principle of early intervention and a "best value" approach, with an initial focus on redesign of the care pathway.

6 Children with special needs in education

The CCG will work with YTHFT and City of York Council to develop a joint approach for the provision of a school nursing service for children with special needs in education. Services in special schools will be integrated with those for children aged 0-19 in education (provided by CYC) and in conjunction with the children's community nursing and therapies team (provided by YTHFT) to put in place a year round service. Developing a specification that focuses on achieving outcomes that meet the needs of children and that reflect the views of families (identified through the engagement that has taken place

7 Acute Transformation

The dynamic interaction between demand and supply is recognised; reduction in demand will not achieve cost improvement without an accompanying reduction in capacity. The availability of capacity is itself a major stimulus for clinical demand, but without changing the pattern of demand, merely reducing capacity will result in extended urgent and elective waiting times. The target areas for medium-term financial recovery are:

a) Demand management

Outpatients; there is already a move from historic face-to-face outpatient services to a more efficient clinical consultancy system, including; advice and guidance, clinical triage; 'e' consultations and greater use of shared care protocols with primary care, aiming to reduce significantly the capacity required for outpatient clinic capacity.

Patient optimisation; there are a range of clinical thresholds and restrictions on procedures of limited clinical value. This will be extended by a broader programme of patient optimisation, where non-urgent patient referrals will be supported to optimise health before treatment, aiming to reduce the demand into elective care.

b) Sustainability and productivity

Site and service consolidation; there are a large number of sites and points of access in operation for a range of services, duplicating services and adding to cost. This creates the opportunity for operating clinical capacity more efficiently.

Emergency and urgent care pathway improvement; there have been significant performance challenges in urgent and emergency care, although there has been improvement, the aim will be to manage acute hospital demand with no increase in acute

capacity, taking opportunities to release costs where realistic aiming to achieve the 95% ED target and manage the likely increase in demand occurring in the medium-term.

c) Cost reduction

Market and supply management; there is significant expenditure on care provided by non-NHS providers. Demand management actions will support reducing demand for elective care. The first target will be to reduce the use of non-NHS capacity. Further consideration will be given to strengthening core NHS capacity to avoid premium sub-contracting.

Estate rationalisation; there is recognition that services can no longer be provided at the current number of sites. The programme will rationalise service provision to a smaller number of sites consistent with safe clinical practice. This may result in the partial or complete withdrawal of NHS care from several sites in the locality. There will be a strategic review of community based bedded care with a subsequent rationalisation to support a 'home first' approach. Realignment will continue across the two main hospital sites.

Priorities for 2018/19 are in the following areas;

- Planned care and demand management (already operational) incorporating outpatients, optimisation and reducing the need for non-NHS care
- Urgent and emergency care; this will form part of the work programme of the A&E Delivery Board and link into the place-based work programmes in each sub-locality, including integrated out of hospital care
- Clinical pathway redesign; producing model speciality systems for care delivery in the major clinical specialisms
- Estate rationalisation and overhead reduction; focussing on releasing cost from reduced capacity aligned to reduced demand and the wider site reconfiguration across the system. The clinical pathway work-streams will drive the clinical models that shape the site service provision.

8 Urgent and emergency care

The CCG will focus on the requirements in the Planning Guidance that relate to constitutional standards, including access times in the Emergency Department (ED) and in the Ambulance Service.

There is recognition that for urgent and emergency care to work well for patients there needs to be an integrated and proactive approach to unplanned care. Progress has been made on reducing flows into the hospital system however meeting A&E targets remains a challenge.

The Integrated Urgent Care Service Specification (IUCSS) 2017 will form the basis for commissioning an integrated 24/7 urgent care access, clinical advice and treatment service which incorporates NHS 111 call handling and former GP out of hours services, with an emphasis on localities which are able to provide enhanced services to prevent or reduce ambulance call outs, hospitals attendances and admissions.

Priorities for 2018/19 are to;

- Sustain the areas of practice that meet the IUCSS and take action where there is an identified gap, specifically;
  - implement the roll out of Urgent Treatment Centres and enable appointment slots that can be booked directly from 1st contact (via NHS 111)
  - extend the Out of Hours contract for two years in line with the original contract award
  - enhance primary care, including extending hours for GP and ensuring dedicated capacity for urgent care

- Continue joint work with provider Trusts on the systematic assessment of patients to support prompt treatment, using intelligence to identify those people who use A&E on a frequent basis (often with complex physical and/or mental health care needs) who would be better supported out of hospital.
- Increase the focus on working with partner organisations; LAs and the care home sector, to facilitate discharge from hospital - aligning the use of the BCF with the strategy for urgent and emergency care.
- Develop a proactive approach in primary care, through risk stratification for unscheduled care; building on the success of the Integrated Care Team approach in York to embed this approach in the north locality and to implement in the Selby locality.
- Work with the third sector to extend the use of social prescribing to address social needs and promote psychological and physical health and well-being.
- Work with STP partners to ensure the achievement of the requirements for 7 day working.

9 Planned care; improving Referral to Treatment times and Elective Care

Clinical priorities for 2018/19 are focused in areas where there are opportunities for transformation and improvement identified through Right Care or where there is opportunity to provide care more effectively out of hospital; there are a number of clinical specialties where this is possible (see section 8) This programme is aligned with NHS S&R CCG where there is joint work on common priorities.

The CCG is committed to working with YTFT to balance demand and capacity in order to deliver sustainable waiting time performance and meet standards for Referral to Treatment times (RTT).

Service priorities for 2018/9
Note; 2- 8 are part of the joint planned care programme with S&R

- Neurology; to develop improved community provision to support people living with Parkinson's disease and Multiple-sclerosis
- Gastro-intestinal; to develop a commissioning policy for the criteria for endoscopy and consider the option of all referrals for endoscopy being directed to the referral support service
- Musculoskeletal/trauma and orthopaedics*; to implement shared decision-making as mandatory for elective care and to review and redesign the trauma and injury pathway
- Diabetes (STP wide): subject to agreement, implement the final phase of the Diabetes Prevention Programme; being a pilot site for the Digital Prevention Programme utilising digital technology and virtual coaching to help prevent diabetes in patients identified as pre-diabetic, or patients who are obese and at increased risk of becoming pre-diabetes. Evaluate the outcomes resulting from funding gained from the NHSE Diabetes Transformation Fund considering the impact of the multi-disciplinary foot care and diabetes treatment targets pilots.
- Circulation (cardiovascular); to continue active management of atrial fibrillation in primary care, instigating proactive management of hypercholesterolemia and hypertension
- Ophthalmology; to consider the potential for procurement for minor eye care services; developing a single provider model to generate suitable scale for the provision of safe and effective services
- ENT; put in place a commissioning statement for the use of micro-suction for removal of earwax; it is not planned to routinely commission this service in 2018/19 and secondly, to implement a virtual clinic approach between ENT and Audiology

- Dermatology; indicative budgets and a risk/gain share approach have been used in 2017/8 as a means of supporting the transfer of care from secondary into primary care. This approach will be continued, consider and scope transfer of approximately 20% of outpatient activity into a community setting. This will allow valuable hospital resource to be used to treat more complex cases. Also in relation to the Minor Surgery DES consider removing requirement for GPs to ask for consultant permission to undertake punch biopsies.

10 Maternity services; Better Births

CCGs and provider trusts submitted detailed, comprehensive plans to NHS England to set out how the recommendations the National Maternity Review (Better Births) will be implemented across the STP by 2020. The CCG is actively engaged with partners locally and STP level to begin to address four priorities identified in the Humber Coast and Vale Local Maternity System Plan 2017/20[4];

- Choice, Personalisation and Continuity of Care
- Safer care
- Better postnatal and perinatal mental health
- Multi-professional working / working across traditional boundaries

There are comprehensive STP wide action plans to begin to progress towards the achievement of these objectives; for NHS Vale of York CCG there is a focus on ensuring the plan and any service developments meet the different needs of local communities which differ both in demographic and geography.

Priorities for 2017/8 are

- To begin to implement the Local Maternity System Plan priorities for 2018/19 at a local level
- To continue to work with providers to reduce stillbirths, neonatal and maternal deaths and brain injuries caused during or soon after birth,
- To further develop perinatal mental health services to focus on early intervention, increase access to evidence-based specialist perinatal mental health care including sustainability of services
- To work with YTFT to continue extending choice on where birth takes place
- To ensure the learning disability LD community and other vulnerable groups have appropriate service provision
- To work with other stakeholders to optimise health promotion during pregnancy

11 Cancer services and waiting times

The Humber Coast and Vale Cancer Alliance is working with all CCGs and providers within HCVSTP to implement the changes needed to achieve the ambitions of the national cancer strategy and the NHS Constitution cancer targets.

All providers will be expected to start the new financial year delivering the cancer waiting times targets or have a clear local action plan to progress delivery to an agreed trajectory, aligned plans with plans that have been agreed across the Cancer Alliance

Locally there is a need to improve performance for urgent cancer 14 day referrals and the 62-day referral to treatment standard. There is also a requirement to support progress towards the target that by 2020, patients with suspected cancer will have a diagnosis within 28 days of being referred. Increasing both MRI and CT scan capacity and improving

[4] http://humbercoastandvale.org.uk/2017/05/15/better-births/

radiology reporting capacity is critical to achieving this; the CCG supports the collaborative work on joint approaches including the 'shared services' initiative aimed at maximising reporting capability across the HCVSTP area.

Priorities for 2018/19 are;

- To work with YHFT to support implementation of the recommendations of the NHSI Intensive Support Team (report due in January 2018) to improve the 62 Day performance.
- To support work to agree and implement timed pathways between YHFT and the tertiary centres in Hull and Leeds
- To support selected GP practices across the Vale of York to pilot a 'direct to test' for colorectal referrals for appropriate patients
- To support Cancer Alliance work to improve the diagnostic capacity regionally and locally to improve 62-day RTT performance

12 Commissioning For Quality

During a time of increasingly constrained resources and the need to achieve value for money, it is essential that the CCG maintains a focus on quality, so that the safety, experience and effectiveness of the services that we commission are not compromised.

The CCGs independent assurance role will be strengthened to ensure that quality is central to any service change, commissioning policy (e.g. in relation to clinical interventions where evidence suggests that there is limited clinical benefit) or transformation programme.

There will be dedicated resource to support the sustainability and quality of care in care homes, recognising the important role that they play in providing safe care to the vulnerable; availability of beds, preventing admission to hospital and reducing delayed transfers of care'

Priorities for 2018/9 are to;

- Coordinate our approach with S&R CCG; taking the lead for quality of acute services on behalf of both organisations
- Support the development of high quality primary and community services to realise the aim of providing a care closer to home rather than in hospital
- Use the primary care assurance reporting method developed in 2017/8 to report on performance in primary care, using intelligence to identify more in depth consideration of specific areas e.g. workforce.
- Work with providers to embed the approach to learning from serious incidents and never events, by continuing to be involved at an early-stage of the process
- Develop and implement a quality improvement plan for care homes using information intelligence to identify where the greatest impact will be

PART C – CONCLUSIONS; NEXT STEPS

These intentions build on the key messages we have heard from members of the public, they are also consistent with our desire to start to change the wider care system so that it becomes financially sustainable in the medium-term.

Our next step will be to share the intentions with provider organisations and our partners with a view to securing the service improvements and the wider system change that we have signalled.

Impact Split by Workstream

	Total	2016/17 FYE	2017/18	2018/19	2019/20	2020/21
Planned Care	14,142	3,242	3,639	4,998	1,077	1,186
Unplanned Care	13,719	11	2,595	4,254	4,316	2,543
Primary Care	236	36	75	125	0	0
Prescribing	6,242	309	1,305	1,628	1,500	1,500
MH, LD and Complex Care	10,990	890	1,850	3,000	2,500	2,750
Back Office	852	0	444	336	72	0
Total	**46,181**	**4,488**	**9,908**	**14,341**	**9,464**	**7,980**
		14,396				

Impact Split by MTFS heading

	Total	2016/17 FYE	2017/18	2018/19	2019/20	2020/21
Elective orthopaedics	3,000	0	750	2,250	0	0
Out of hospital care	14,972	786	2,824	4,503	4,316	2,543
Contracting for outpatients	2,000	0	1,000	1,000	0	0
Continuing healthcare and funded nursing care	9,555	255	1,550	2,500	2,500	2,750
Prescribing	6,242	309	1,305	1,628	1,500	1,500
High cost drugs	2,089	85	233	632	181	958
Sub-Total	**37,859**	**1,435**	**7,662**	**12,513**	**8,496**	**7,751**
Other	8,322	3,053	2,246	1,827	968	228
Total	**46,181**	**4,488**	**9,908**	**14,341**	**9,464**	**7,980**
		14,396				

Item Number: 9

Name of Presenter: Tracey Preece

Meeting of the Governing Body

Meeting Date: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Report Month 10

Purpose of Report
For Information

Reason for Report

To brief members on the financial performance of the CCG and achievement of key financial duties for 2017/18 as at the end of January 2018.

To provide details and assurance around the actions being taken.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

Covalent Risk Reference and Covalent Description

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

Emerging Risks (not yet on Covalent)

The CCG has effectively closed down a number of key variable / risk areas including York Teaching Hospital NHS Foundation Trust, Continuing Healthcare, Funded Nursing Care and Mental Health Out of Contract expenditure. Those that remain are of a much lower value and risk of variation. Although these are covered off within some of the broader risks described in

Covalent it is worth noting them specifically here:

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

Recommendations

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

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

Appendix 1 – Finance dashboard
Appendix 2 – Running costs dashboard

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

Report produced: February 2017

Financial Period: April 2017 to January 2018 (Month 10)

Summary of Key Financial Statutory Duties

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation					7.5	6.7	0.9	G➔
In-year total expenditure does not exceed total allocation (Programme and Running costs)					452.3	474.8	(22.5)	R🡻
Better Payment Practice Code (Value)	95.00%	99.47%	4.47%	G➔	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	97.74%	2.74%	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					466.9	468.2	(1.3)	R🡻

Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
Running costs spend within plan	6.1	5.5	0.6	G🡹	7.3	6.7	0.6	G➔
Programme spend within plan	377.9	390.7	(12.7)	R🡻	451.4	468.2	(16.8)	R🡻
Actual Surplus / (Deficit) within plan (In-year)	(5.3)	(17.5)	(12.2)	R🡻	(6.3)	(22.5)	(16.2)	R🡻
Actual Surplus / (Deficit) within plan (Cumulative)					(30.1)	(46.3)	(16.2)	R🡻
Risk adjusted forecast deficit					(22.5)	(22.5)	0.0	G
Cash balance at month end is within 1.25% of monthly drawdown (£k)	414	335	79	G				
QIPP delivery (see section 8)	11.5	6.2	(5.3)	R🡹	14.4	7.4	(7.0)	R🡹

Key Messages

See Detailed Narrative for supporting information.

- **Financial Plan:** the CCG continues to report against a planned deficit of £6.3m.
- **Forecast:** the outturn deficit of £22.5m is now just a straight forecast of the anticipated year-end position and remains within the previously reported risk adjusted forecast of £16.0m with a further £6.5m identified as risk as at Month 9.
- **Underlying position:** the forecast underlying position is stabilising and is largely in line with the 2017/18 opening underlying position of £22.4m.
- **Month 10 Year-to-date:** the Month 10 position is away from plan by £12.2m. This is a deterioration from Month 9 of nearly £3.0m driven primarily by York FT (£1.6m) with CHC (£508k) and mental health out of contract (£589k) also areas of deterioration this month.
- **Financial Recovery Board:** the first meeting took place in January and will report to the Finance & Performance Committee. Governance arrangements are being finalised.

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

Dashboard Heading	Overall Forecast £m
YTHFT	194.2
Other Acute Commissioning	44.5
Mental Health Services	47.8
Community Services	29.2
Continuing Care	27.5
Funded Nursing Care	3.9
Other Commissioning	26.1
Primary Care Prescribing	50.3
Primary Care	41.8
Running Costs	6.7
0.5% CQUIN	1.0
0.5% Risk Reserve	2.0
Contingency	0.0
Total Expenditure	**474.8**
In-Year Allocation	**452.3**
Surplus / (Deficit)	**(22.5)**
31st March Plan	**(16.0)**
Variance – Gap to deliver £16.0m	**(6.5)**

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

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

QIPP Summary	£m
QIPP Target	14.4
Delivered at Month 9	(6.2)
Forecast to deliver in remainder of year	(1.2)
QIPP gap (included in overall gap)	**7.0**

- **Cash:** the CCG met its internal Key Financial Measure to have a month-end cash holding within 1.25% of the monthly draw down. The CCG has had its Maximum Cash Drawdown (MCD) amended to reflect the Month 9 outturn of a £16.0m deficit but will need a further adjustment to reflect the position above.

- **Key Actions & Areas for Discussion**:
  - **Level of risk (Acute)** – Significant and extensive negotiations have taken place and progress has been made with York Teaching Hospital NHS Foundation Trust since finalising the month 10 position with an agreed year-end settlement at £195.1m to incorporate activity and all areas of dispute. This represents a positive middle-ground position for the CCG and mitigates any further risk for the remainder of 2017/18. A year-end settlement agreement was also reached for other main associate commissioners as part of the arrangement.
  - **Disputes and Challenges** – It is worth noting that although this settlement closes 2017/18, several of the dispute areas still require clinical and contracting resolution for 2018/19 and beyond and work continues in this regard.
  - **Level of risk (Other)** – Significant progress was made towards minimising this with an agreement across the four North Yorkshire CCGs last week of principles and process to establish an agreed outturn for CHC, FNC and mental health out of contract. This was reflected in the forecast outturn in Month 10 and has been supported by Mazars.
  - **Prescribing** - Pharmacy costs now include the full anticipated impact from No Cheaper Stock Obtainable (NCSO) items of £1.8m within the forecast outturn.

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

Report produced: February 2018

Financial Period: April 2017 to January 2018 (Month 10)

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1. Red / Amber financial statutory duties and measures

- *'In-year total expenditure does not exceed total allocation'* – forecast expenditure is £22.5m higher than the CCG's in-year allocation.
- *'CCG cash drawdown does not exceed maximum cash drawdown'* – the cash drawdown required for the year currently exceeds the Maximum Cash Drawdown (MCD) as advised by NHS England. Although this has reduced following the adjustment to the MCD to reflect the Month 9 forecast expenditure, CCGs are not allowed to exceed this so a further adjusted MCD will be required from NHS England or the CCG must ensure it manages its working capital to stay within the original MCD. The CCG has already started to consider how it could potentially manage its payments in the final months of the year should no further adjustment be made.
- *'Programme spend within plan'* – programme spend is forecast to overspend by £16.8m. This is offset by an under-spend on running costs of £0.6m which results in the overall position being £16.2m worse than plan.
- *'Actual position is within plan (in-year)'* – the in-year position of a £22.5m deficit now reflects the anticipated year end outturn expenditure position including all risks and mitigations that the CCG must now manage to and deliver.
- *'Actual position is within plan (cumulative)'* - the cumulative position has moved in line with the above.
- *'Risk adjusted deficit'* – there is no risk adjusted deficit at Month 10 as the actual forecast now reflects the CCG's anticipated outturn position.
- *'QIPP delivery'* – year to date QIPP delivery is 53.9% of plan which equates to £5.3m under delivery.

2. Month 10 & Year-to-date Supporting Narrative

The plan at Month 10 was for a deficit of £5.3m; however the actual deficit is £18.0m, £12.7m worse than planned.

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

		£m
QIPP plan		14.4
Original CEP proposals	9.7	
Underlying position improvement	(1.9)	
Net CEP		7.8
Total savings plan as at June 12th		**22.2**
Removal of net CEP		(7.8)
Year to Date Delivery		(6.2)
Forecast further delivery		(1.2)
Shortfall		**7.0**

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust	(£8.0m)	The bulk of this relates to slippage on QIPP schemes, £4.9m, because the majority of the Health Optimisation proposals are impacting the Independent Sector providers. Further detail on the trading pressure is within the contract trading report.
Out of Contract Placements and SRBI	(£2.3m)	Increased trading costs in both Out of Contract and SRBI placements. This has included the reclassification of several patients to the Vale of York previously reported to the North Yorkshire CCGs as part of the on-going transfer and review of PCU services.
Ramsay and Nuffield Health	£1.4m	Ramsay is currently under trading by £1.6m however this is partly offset by an over-trade with Nuffield of £220k.
Reserves	(£1.5m)	This reflects the impact of prior year pressures where estimates were made at year end. It also includes the release of the contingency and the £2.8m CEP adjustment.
Continuing Care and Funded Nursing Care	(£1.8m)	Funded Nursing Care is currently underspent by £515k which is more than offset by an overspend in Continuing Healthcare of £2.3m.
Other acute contracts	(£0.6m)	Overspends on Mid Yorkshire Hospitals NHS Trust (£188k), Harrogate and District NHS Foundation Trust (£201k), South Tees NHS Foundation Trust (£92k), Leeds Teaching Hospitals NHS Trust (£105k) and Hull and East Yorkshire Hospitals NHS Trust (£14k), offset by an underspend on North Lincs & Goole NHS Foundation Trust (£56k).

Other Prescribing	(£0.8m)	Increased costs on ONPOS offset by an under-spend on Primary Care Prescribing.
Running costs	£0.6m	There have been and remain a number of vacancies throughout the year that have been managed to help deliver the YTD underspend.
Other Primary Care	£0.5m	Slippage in the Out of Hospital QIPP means the associated investment has not yet been committed.
York Teaching Hospital NHS Foundation Trust – MSK	£0.5m	Contract is currently under trading due to lower levels of activity and vacancies and has now been agreed as a block amount for 2017/18 that reflects the actual cost of delivery.
Primary Care Prescribing	£0.1m	Underspend on Primary Care Prescribing offset by overspend on Other Prescribing for increased costs in relation to ONPOS and the associated QIPP. Increase in rebate income for 2016/17 not previously accrued.
Primary Care Commissioning	(£0.2m)	QOF achievement in 2016/17 better than expected and non-recurrent maternity payments.
York Teaching Hospital NHS Foundation Trust – Community	£0.1m	Underspend on non-medical prescribing.
Other variances	(£0.2m)	
Total impact on YTD position	**(£12.2m)**	

3. Financial Plan & Forecast Outturn Supporting Narrative

The current financial plan (as submitted to NHS England 12th June under CEP) is an in-year deficit of £6.3m, resulting in a cumulative deficit of £30.1m. The forecast as at Month 10 is an in-year deficit of £22.5m which is consistent with both the risk-adjusted Month 9 position and the financial plan approved by the Governing Body in April.

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

Reported forecast outturn key variances

Description	Value	Reason
York Teaching Hospital NHS Foundation Trust	(£9.8m)	This variance now reflects the anticipated outturn as at the time of closing the month-end position. The bulk of this relates to slippage on QIPP schemes, £8.3m, as the majority of the Health Optimisation proposals are impacting the Independent Sector providers and the Out of Hospital programme has not generated any savings.
Reserves	(£5.4m)	This relates largely to the impact of the removal of the CEP schemes £7.8m, but also includes the cost of prior year pressures, £1.0m.
Ramsay and Nuffield Health	£1.7m	Ramsay is forecast to under trade by £2.0m which is offset by an over-trade with Nuffield Health of £264k.
Out of Contract Placements and SRBI	(£2.1m)	Increased trading costs in both Out of Contract and SRBI placements.

Other acute contracts	(£0.6m)	Overtrading positions including £113k on Leeds Teaching Hospitals NHS Trust, £240k on Harrogate & District NHS FT and £202k on Mid Yorkshire Hospitals NHS Trust.
York Teaching Hospital NHS Foundation Trust – MSK	£0.7m	Contract cap agreed with YHFT as part of an aligned incentive style agreement and investment of £500k no longer required.
Running Costs	£0.6m	Achievement of running cost QIPPs
Prescribing	(£1.0m)	Overtrading position on Other Prescribing (£943k) partly in relation to ONPOS, and on Primary Care Prescribing (£61k).
CHC and FNC	(£0.4m)	Overtrading position on CHC (£1.5m) and under trading position on FNC (£1.1m).
York Teaching Hospital NHS FT - Community	£0.1m	Forecast under-spend on non-medical prescribing of £141k.
Other Primary Care	£0.5m	Slippage in the Out of Hospital QIPP means the associated investment has not yet been committed, off-set by £223k for PMS premium monies.
Other variances	(£0.5m)	
Total impact on FOT position	**(£16.2m)**	

4. Allocations

The cumulative allocation at Month 10 is as follows:

Description	Recurrent/ Non-recurrent	Category	Value
Allocation brought forward			£428.3m
Pre-assessment	Non Recurrent	Programme	£13k
Pre-assessment LTHT - secondary care dental	Non Recurrent	Programme	£2k
BCF - support funding	Non Recurrent	Programme	£63k
CYP IAPT Trainee support costs	Non Recurrent	Programme	£6k
Acute hospital urgent & emergency liaison MH	Non Recurrent	Programme	£125k
Total allocation at Month 10			**£428.5m**

5. Gap and key delivery challenges

The CCG is now producing a straight forecast outturn position with no additional risks and mitigations. This means the CCG will need to manage and deliver no worse than the current forecast deficit of £22.5m over the remainder of the year. It is important to note within this that as part of reporting the Month 10 financial position and the associated forecast outturn the CCG has closed down several key variables that may impact the deliverability of the overall position:

- **York Teaching Hospital NHS Foundation Trust** – Significant and extensive negotiations and progress has been made since finalising this month 10 position with an agreed settlement of an outturn of £195.1m.
- **Complex Care areas of spend** – Significant progress has been made towards minimising the variability of Continuing Healthcare, Funded Nursing Care and Mental Health Out of Contract spends with an agreement across the four North Yorkshire CCGs to the principles and process to establish an agreed outturn. This has been reflected in the

forecast outturn in Month 10 and represents methodology and an approach that has been supported by Mazars in principle.

- **Prescribing** – Pharmacy costs now include the full anticipated impact from No Cheaper Stock Obtainable (NCSO) items of £1.8m within the forecast outturn.
- **NHS Property Services** – Discussions have progressed with NHS Property Services, with regards to the historic position for 2015/16 and 2016/17 where both parties have agreed a full and final settlement position. Work is on-going for 2017/18, but agreeing an historic position within previously reported financial positions reduces the previously reported risk in this area.

6. Underlying Position

The underlying position reported at Month 10 based on the forecast deficit is detailed below:

Description	Value
Deficit at Month 10	**(£22.5m)**
Adjust for non-recurrent items -	
Non-recurrent allocation adjustments	(£0.5m)
Non-recurrent allocation expenditure adjustments	£0.5m
Repayment of system support	£0.3m
0.5% headroom	£2.0m
Non recurrent QIPP (BMI & Smoking)	(£2.7m)
Prior year pressures	£0.9m
Prescribing Indicative Budgets mobilisation payments	£0.3m
Syrian Refugee income	(£0.1m)
Underlying financial position	**(£21.8m)**

The CCG continues to work closely with NHS England to ensure consistency in the reporting and communication of the stabilising underlying recurrent position.

7. Balance sheet / other financial considerations

The CCG met its internal Key Financial Measure to have a month-end cash holding within 1.25% of the monthly draw down.

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

8. QIPP programme and Capped Expenditure Process schemes

8a. QIPP progress table

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
PLANNED CARE							
Anti-Coagulation service	194	Apr-17	213	-38	259	-65	
Cataract Thresholds	161	Apr-17	250	0	300	0	In plan from 2018/19
Faecal Calprotectin	PC4	Oct-16	53	-31	53	-31	
Biosimilar high cost drugs gain share	016	Apr-17	279	124	318	163	
Remove SpR block from contract	168	Apr-17	793	793	952	952	
Commissioning for Value (PNRC)	006	Apr-17	125	0	150	0	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	2,500	2,233	3,000	2,718	
RightCare - Circulation (Heart Disease)	008	Oct-17	67	67	100	100	
RightCare - Gastroenterology	009	Apr-18	0	0	0	0	In plan from 2018/19
RightCare - Respiratory (COPD)	010	Apr-18	0	0	0	0	In plan from 2018/19
RightCare - Orthopaedics / MSK	011	Oct-17	500	0	750	0	In plan from 2018/19
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	667	0	1,000	0	In plan from 2018/19
UNPLANNED CARE							
Community Podiatry	IC4	May-17	322	277	393	339	
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	351	294	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	217	187	217	187	
Community Equipment service re-procurement	187	Apr-17	418	0	418	0	New contract in place but costs higher than expected.
Patient Transport - contracting review	190a	Apr-17	11	11	11	11	
Unplanned Care Programme (including urgent care and out of hospital care)	149	Jul-17	641	0	824	0	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	630	168	756	202	Scheme up and running.
Review of community inpatient services - Phase II	019b	Oct-17	133	0	200	0	
RightCare Phase 2 - Trauma & Injuries	017	Apr-18	0	0	0	0	In plan from 2018/19
Patient Transport project - re-procurement	190b	Apr-18	0	0	0	0	In plan from 2018/19

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
PRIMARY CARE							
Dermatology Indicative Budgets	195	Apr-17	36	28	36	28	
GP IT - NYNET	003	May-17	150	150	183	183	
Roll out indicative budgets to other specialities	020	Jul-17	58	0	75	0	
PRESCRIBING							
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	231	231	277	277	
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	106	106	128	128	
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	89	89	106	106	
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	50	50	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	62	62	75	75	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	750	750	900	900	
CCG wide: Continence & Stoma Care	199	Oct-17	36	36	53	53	
COMPLEX CARE							
Continence Supplies	C1	Apr-17	23	5	23	5	
CHC review 1 to 1 care packages	024a	Apr-17	98	0	98	0	
CHC review: Short Breaks	024b	Apr-17	51	0	51	0	
CHC review panel decisions (jointly funded packages of care)	024c	Apr-17	83	0	83	0	
Complex Care - CHC and FNC benchmarking	024d	Oct-17	1,033	0	1,550	0	
Recommission MH out of contract expenditure	025	Apr-17	250	0	300	0	
BACK OFFICE							
Commissioning support (eMBED) contract savings	004	Apr-17	173	173	207	207	
Vacancy control	027	Apr-17	45	403	54	412	
Total identified QIPP			11,493	6,167	14,396	7,378	
QIPP shortfall			0	0	0	7,014	
Additional QIPP required as a result of removing CEP			0	0	0	7,840	
Total QIPP requirement			11,493	6,167	14,396	22,236	

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

Appendix 1 – Finance dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			Forecast Outturn Previous Month			Forecast Outturn Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioned Services																		
Acute Services																		
York Teaching Hospital NHS FT	153,979	161,994	(8,014)	137,790	144,226	(6,435)	16,189	17,768	(1,579)	184,446	194,237	(9,791)	184,446	184,446	0	0	9,791	(9,791)
Yorkshire Ambulance Service NHS Trust	10,698	10,698	0	9,628	9,628	0	1,070	1,070	0	12,838	12,838	0	12,838	12,838	0	0	0	0
Leeds Teaching Hospitals NHS Trust	6,888	6,993	(105)	6,176	6,387	(211)	712	606	106	8,276	8,389	(113)	8,261	8,545	(284)	15	(156)	171
Hull and East Yorkshire Hospitals NHS Trust	2,502	2,516	(14)	2,249	2,375	(127)	253	141	112	2,994	3,002	(8)	2,994	3,141	(147)	0	(138)	138
Harrogate and District NHS FT	1,535	1,736	(201)	1,372	1,567	(196)	163	168	(5)	1,843	2,083	(240)	1,843	2,104	(261)	0	(21)	21
Mid Yorkshire Hospitals NHS Trust	1,745	1,933	(188)	1,570	1,778	(208)	175	155	20	2,087	2,288	(202)	2,087	2,323	(236)	0	(34)	34
South Tees NHS FT	1,053	1,144	(92)	944	1,020	(76)	108	124	(16)	1,258	1,367	(109)	1,258	1,358	(100)	0	9	(9)
North Lincolnshire & Goole Hospitals NHS Trust	470	414	56	422	379	43	48	36	12	565	498	67	565	507	58	0	(9)	9
Sheffield Teaching Hospitals NHS FT	179	165	14	161	147	14	18	18	0	215	201	14	215	201	14	0	0	0
Non-Contracted Activity	3,260	3,260	(0)	2,934	2,934	(0)	326	326	(0)	3,912	3,825	87	3,912	3,852	60	0	(27)	27
Other Acute Commissioning	769	733	36	693	657	35	77	76	1	923	896	27	923	902	21	0	(6)	6
Ramsay	5,624	4,028	1,597	5,033	3,585	1,448	591	442	148	6,721	4,744	1,977	6,721	4,661	2,059	0	83	(83)
Nuffield Health	2,448	2,668	(220)	2,191	2,279	(87)	257	390	(132)	2,926	3,190	(264)	2,926	3,043	(117)	0	147	(147)
Other Private Providers	867	937	(71)	780	862	(82)	87	76	11	1,040	1,134	(94)	1,040	1,153	(113)	0	(19)	19
Sub Total	**192,018**	**199,220**	**(7,202)**	**171,945**	**177,825**	**(5,881)**	**20,073**	**21,394**	**(1,321)**	**230,044**	**238,695**	**(8,651)**	**230,029**	**229,075**	**954**	**15**	**9,619**	**(9,604)**
Mental Health Services																		
Tees Esk and Wear Valleys NHS FT	33,035	33,160	(125)	29,736	29,723	14	3,299	3,438	(139)	39,644	39,795	(150)	39,530	39,511	18	115	283	(169)
Out of Contract Placements and SRBI	4,356	6,657	(2,301)	3,920	5,632	(1,711)	436	1,025	(589)	5,227	7,316	(2,090)	5,227	7,089	(1,862)	0	227	(227)
Non-Contracted Activity - MH	351	364	(12)	316	312	4	35	52	(17)	421	434	(12)	421	417	4	0	17	(17)
Other Mental Health	194	194	0	175	175	(0)	19	19	0	250	249	0	233	233	0	16	16	0
Sub Total	**37,936**	**40,375**	**(2,439)**	**34,147**	**35,841**	**(1,694)**	**3,789**	**4,534**	**(745)**	**45,542**	**47,794**	**(2,252)**	**45,411**	**47,251**	**(1,840)**	**131**	**544**	**(413)**

	YTD Position			YTD previous month			YTD Movement			Forecast Outturn			YTD previous month			YTD Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Community Services																		
York Teaching Hospital NHS FT - Community	16,363	16,275	88	14,747	14,626	121	1,616	1,649	(33)	19,596	19,526	70	19,596	19,384	212	0	142	(142)
York Teaching Hospital NHS FT - MSK	2,231	1,736	495	1,958	1,551	407	273	185	88	2,777	2,107	670	2,777	2,106	671	0	1	(1)
Harrogate and District NHS FT - Community	2,207	2,306	(99)	1,989	2,120	(131)	218	186	32	2,643	2,745	(101)	2,643	2,762	(118)	0	(17)	17
Humber NHS FT - Community	821	822	(1)	739	736	3	82	86	(4)	985	987	(2)	985	982	3	0	5	(5)
Hospices	1,039	1,038	1	935	934	1	104	104	(0)	1,247	1,246	1	1,247	1,246	2	0	0	(0)
Longer Term Conditions	382	388	(6)	344	349	(5)	38	39	(1)	458	467	(8)	458	465	(7)	0	1	(1)
Other Community	1,779	1,742	37	1,579	1,525	55	200	217	(18)	2,179	2,091	87	2,179	2,223	(45)	0	(132)	132
Sub total	**24,823**	**24,307**	**516**	**22,291**	**21,841**	**451**	**2,531**	**2,466**	**65**	**29,885**	**29,168**	**717**	**29,885**	**29,168**	**717**	**0**	**0**	**(0)**
Other Services																		
Continuing Care	21,840	24,111	(2,271)	19,766	21,528	(1,763)	2,075	2,583	(508)	25,990	27,494	(1,504)	25,990	26,935	(946)	0	558	(558)
Funded Nursing Care	4,171	3,656	515	3,754	3,309	444	417	347	70	5,005	3,863	1,142	5,005	4,301	703	0	(438)	438
Patient Transport - Yorkshire Ambulance Service NHS Trust	1,674	1,708	(34)	1,508	1,534	(26)	167	174	(8)	2,007	2,057	(50)	2,007	2,057	(50)	0	(0)	0
Voluntary Sector / Section 256	432	467	(35)	375	427	(51)	57	41	16	547	553	(7)	547	553	(7)	0	(0)	0
Non-NHS Treatment	482	478	4	435	432	3	47	47	0	576	572	4	576	572	3	0	(0)	0
NHS 111	678	668	9	610	602	8	68	66	2	813	801	12	813	801	12	0	0	0
Better Care Fund	9,229	9,299	(70)	8,306	8,315	(9)	923	984	(61)	11,138	11,297	(159)	11,075	11,151	(76)	63	146	(83)
Other Services	1,832	1,862	(29)	1,647	1,676	(28)	185	186	(1)	2,203	2,244	(41)	2,203	2,249	(46)	0	(5)	5
Sub total	**40,339**	**42,251**	**(1,912)**	**36,401**	**37,823**	**(1,422)**	**3,938**	**4,428**	**(490)**	**48,278**	**48,880**	**(602)**	**48,215**	**48,620**	**(405)**	**63**	**260**	**(197)**

	YTD Position			YTD previous month			YTD Movement			Forecast Outturn			YTD previous month			YTD Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Primary Care																		
Primary Care Prescribing	42,024	41,886	138	37,872	37,545	327	4,153	4,341	(189)	50,196	50,257	(61)	50,196	49,690	506	0	567	(567)
Other Prescribing	561	1,402	(841)	505	1,090	(586)	56	312	(256)	673	1,616	(943)	673	1,519	(846)	0	97	(97)
Local Enhanced Services	1,545	1,268	277	1,359	1,121	238	187	147	39	1,918	1,948	(30)	1,918	1,950	(31)	0	(2)	2
Oxygen	219	249	(29)	197	223	(25)	22	26	(4)	263	298	(34)	263	295	(32)	0	2	(2)
Primary Care IT	832	877	(45)	751	799	(48)	82	78	4	1,146	1,167	(21)	1,146	1,173	(27)	0	(6)	6
Out of Hours	2,639	2,695	(56)	2,376	2,382	(6)	264	314	(50)	3,167	3,223	(55)	3,167	3,199	(32)	0	24	(24)
Other Primary Care	617	114	502	528	69	459	89	46	43	856	343	513	856	661	195	0	(318)	318
Sub Total	**48,439**	**48,492**	**(54)**	**43,587**	**43,228**	**359**	**4,852**	**5,264**	**(412)**	**58,220**	**58,851**	**(631)**	**58,220**	**58,486**	**(267)**	**0**	**364**	**(364)**
Primary Care Commissioning	**34,849**	**35,046**	**(196)**	**31,376**	**31,539**	**(163)**	**3,474**	**3,507**	**(33)**	**41,797**	**41,797**	**0**	**41,797**	**42,030**	**(232)**	**0**	**(232)**	**232**
Trading Position	**378,404**	**389,689**	**(11,286)**	**339,747**	**348,097**	**(8,350)**	**38,657**	**41,593**	**(2,936)**	**453,767**	**465,186**	**(11,419)**	**453,558**	**454,630**	**(1,073)**	**209**	**10,555**	**(10,346)**
Prior Year Balances	0	986	(986)	0	1,022	(1,022)	0	(36)	36	0	986	(986)	0	1,022	(1,022)	0	(36)	36
Reserves	(2,349)	0	(2,349)	(2,114)	0	(2,114)	(235)	0	(235)	352	1,999	(1,648)	352	3,591	(3,240)	0	(1,592)	1,592
Contingency	1,874	0	1,874	1,686	0	1,686	187	0	187	2,248	0	2,248	2,248	2,248	0	0	(2,248)	2,248
Unallocated QIPP	0	0	0	0	0	0	0	0	0	(4,994)	0	(4,994)	(4,994)	0	(4,994)	0	0	0
Reserves	**(475)**	**986**	**(1,461)**	**(427)**	**1,022**	**(1,449)**	**(47)**	**(36)**	**(12)**	**(2,394)**	**2,985**	**(5,379)**	**(2,394)**	**6,861**	**(9,256)**	**0**	**(3,876)**	**3,876**
Programme Financial Position	**377,929**	**390,675**	**(12,747)**	**339,319**	**349,118**	**(9,799)**	**38,609**	**41,557**	**(2,948)**	**451,373**	**468,171**	**(16,798)**	**451,164**	**461,492**	**(10,328)**	**209**	**6,679**	**(6,470)**
In Year Surplus / (Deficit)	(5,287)	0	(5,287)	(4,758)	0	(4,758)	(529)	0	(529)	(6,345)	0	(6,345)	(6,345)	0	(6,345)	0	0	0
In Year Programme Financial Position	**372,642**	**390,675**	**(18,034)**	**334,561**	**349,118**	**(14,558)**	**38,081**	**41,557**	**(3,476)**	**445,028**	**468,171**	**(23,143)**	**444,819**	**461,492**	**(16,673)**	**209**	**6,679**	**(6,470)**
Running Costs	**6,071**	**5,496**	**575**	**5,464**	**4,926**	**538**	**607**	**570**	**37**	**7,287**	**6,668**	**619**	**7,287**	**6,668**	**619**	**0**	**(1)**	**1**
Total In Year Financial Position	**378,713**	**396,172**	**(17,459)**	**340,025**	**354,045**	**(14,019)**	**38,688**	**42,127**	**(3,439)**	**452,315**	**474,838**	**(22,523)**	**452,106**	**468,160**	**(16,054)**	**209**	**6,678**	**(6,469)**
Brought Forward (Deficit)	(19,799)	0	(19,799)	(17,819)	0	(17,819)	(1,980)	0	(1,980)	(23,759)	0	(23,759)	(23,759)	0	(23,759)	0	0	0
Cumulative Financial Position	**358,914**	**396,172**	**(37,258)**	**322,206**	**354,045**	**(31,839)**	**36,708**	**42,127**	**(5,419)**	**428,556**	**474,838**	**(46,282)**	**428,347**	**468,160**	**(39,813)**	**209**	**6,678**	**(6,469)**

Appendix 2 – Running costs dashboard

Directorate	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			Forecast Outturn Previous Month			Forecast Outturn Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Governing Body/ COO/Execs	733	716	18	660	661	(1)	73	55	18	880	906	(27)	880	888	(9)	0	18	(18)
System Resource & Performance	1,479	1,163	316	1,330	1,019	311	149	144	4	1,777	1,414	362	1,777	1,441	336	0	(26)	26
Planning & Governance	996	837	160	897	759	138	100	78	22	1,196	997	199	1,196	1,011	185	0	(14)	14
Joint Commissioning	415	380	35	374	328	46	42	52	(11)	498	471	27	498	451	47	0	19	(19)
Transformation & Delivery	289	244	45	260	219	40	29	24	5	347	294	53	347	297	50	0	(3)	3
Medical Directorate	787	740	47	708	672	36	79	67	11	945	899	46	945	908	37	0	(9)	9
Finance	816	787	29	730	723	8	86	65	21	988	952	36	988	961	27	0	(9)	9
Quality & Nursing	561	438	123	505	374	131	55	63	(8)	671	521	150	671	499	172	0	22	(22)
Recharges & PCU	213	193	20	196	171	24	17	21	(4)	247	214	33	247	212	35	0	2	(2)
Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QIPP	(218)	0	(218)	(196)	0	(196)	(22)	0	(22)	(261)	0	(261)	(261)	0	(261)	0	0	0
Overall Position	**6,071**	**5,496**	**575**	**5,464**	**4,926**	**538**	**607**	**570**	**37**	**7,287**	**6,668**	**619**	**7,287**	**6,668**	**619**	**0**	**(1)**	**1**

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Item Number: 10

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Meeting Date: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Integrated Performance Report Month 9 2017/18

Purpose of Report
For Information

Reason for Report

This document provides a triangulated overview of CCG performance across all NHS Constitutional targets and then by each of the 2017/18 programmes incorporating QIPP, Contracting and Performance information. The report captures validated data for Month 9 for performance and contracting, and Month 10 for finance and QIPP. The report should be read alongside the Finance Report and the Month 9 Contract Report.

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

28 risks as captured in the Risk report for February 2018

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 December 2017
Month 09 2017/18

NHS
Vale of York
Clinical Commissioning Group

CONTENTS

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

Cancer 2 Week Wait	Vale of York CCG's performance in December 2017 against the Cancer 2 week wait target was 93.5%, which while a decline from 96.4% in November, still continues to meet the 93% target. The only two areas to fail target at speciality level were Urological Malignancies which fell just 0.1% under target at 92.9%, and Skin at 83.9%. There were 54 total Vale of York patient breaches, and Skin accounted for 29 of these. York Trust's December 2 week wait performance was 92.5%, down from 93.4% in November and no longer meeting 93% target.	There is a dedicated cancer performance review session incorporated into the next sub CMB meeting on the 27th February to ensure joint confirmation of all areas where there are cancer performance pressures as at Q4. This will support an update to CCGs and from March 2018 the S&R CCG Cancer clinical lead Jenni Lawrence will be attending the YFT internal Cancer Board. Areas of focus include: - progress with FIT testing for colo-rectal to support pressures on the lower GI service for 2WW urgent referrals - long delays in urology (both CCGs) and H&N (S&R CCG) for 62 day performance (and associated clinical harm reviews) The CCG has confirmed its cancer priorities to the HCVSTP Cancer commissioning group (SPAM) in line with those incorporated in the commissioning intentions for 18/19.
Cancer 62 day Treatment	Although Vale of York CCG's performance against the Cancer 62 day treatment target in December was dropped slightly to 87.0% from 87.4% in November, this continues to exceed the 85% target. There were 12 breaches from a cohort of 92 patients; 4 in Urological, 3 in Lower Gastrointestinal, and 1 each across 5 other specialities. Despite 4 breaches in Urological cancers this speciality still met target with 86.7% as it was from a cohort of 30, however the 3 breaches in Lower Gastrointestinal were from a cohort of just 5 patients so performance was just 40% in this speciality. York Trust's performance improved to 87.2% from 86.4% in November.	As above

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :		
Dementia Diagnosis Rates	65+ Dementia Diagnosis rate increased from 60.7% in December 2017 to 60.9% in January 2018	
CHC	Backlog of patients waiting over 28 days for assessment has reduced from 65% in November to 59.1% in December. However, the CHC decision support tool 80% target was not achieved in December. The overall stabilisation of CHC assessment performance, the implementation of the new discharge to assess and improvement in data validation and reporting should all be noted.	Verbal update from Denise Nightingale as required.
CAMHS: patients with a second contact within 9 weeks	Improvement in performance from 82.6% to 83.2% in December 2017	

Performance Headlines

DETERIORATION IN PERFORMANCE :

A&E 4 hr	York Trust's performance against the 4 hour standard in December 2017 was 83%, a significant decrease from 91.7% in November. There were also a number of breaches of the 12 hour target in December with 5 patients waiting over 12 hours from decision to admit to admission. January performance has declined further to 81.5%, with 14 breaches of the 12 hour target. Provisional performance for WE 4th February was 84.2% with 2 breaches of the 12 hour target. The overall unvalidated January position was 81.5%.	Update on winter performance from Andrew Philips at Committee on 22/2/18. Scheduled winter review on behalf of AE Delivery Board scheduled for WC 19th February. Feedback to Committee in March 2018. The CCG and local Vale-Scarborough system response to the recent national planning guidance around Winter Planning and urgent and emergency care for 2018/19 will be presented to Committee in March 2018. To note: 2018/19 Provider sustainability funding [PSF] will be linked to the delivery of the A&E 4 hour target
Diagnostics 6 Week Wait	Vale of York CCG's performance against the 6 week target was 97.9% in December 2017 against target of 99%, from 98.15% in November. This equates to 74 breaches of a total cohort of 3,599. The specialities with the highest number of breaches were Sleep Studies (16), CT (15) and MRI (14). Of these breaches the majority were at YTHFT, who in total accounted for 48 of the 74 CCG patient breaches. York Trust's performance also declined in December to 97.5%, from 98.5% in November.	The business case to support investment in sleep studies equipment is currently progressing through CCG approvals process.

Performance Headlines

DETERIORATION IN PERFORMANCE :		
RTT 18 Week target	Vale of York CCG's performance dropped slightly from 89.15% in November 2017 to 88.1% in December. The unvalidated January performance was 85.5%. The December performance equates to 1,852 breaches of the 18 week target from a total cohort of 15,609. Over a quarter of all breaches were in Ophthalmology with 476 patients waiting over 18 weeks. The next highest number of breaches was in General Surgery (245), followed by Urology (190) and ENT (149). There were also three 52 week breaches in December 2017, one at Leeds Teaching Hospitals NHS Trust in General Surgery, and two at North Lincolnshire and Goole NHS Foundation Trust, one in Ophthalmology and one in Trauma and Orthopaedics. York Trust's performance in December was 85.8%, down from 87.4% in November.	The 52 week breaches are being escalated with the relevant providers and feedback provided if further escalation required. Elective care performance has been impacted by the decision to suspend activity over the winter period in December and January. A full stocktake of the elective care position by specialty will be held with YFT and both CCGs at the end of February. This will inform the baseline for performance moving into 2018/19 and support the approach for RTT recovery in response to national planning guidance. To note: NHSE have requested bids for additional monies to support elective care, cancer care and diagnostics performance improvement in Q4 17/18. The central allocation was over-subscribed and there is not confirmation as yet on any local Vale-Scarborough allocation from NHSE.
EIP	To note the impact of the two breaches on the overall performance deterioration (small numbers of overall patients)	Update from Denice Nightingale as required
CAMHS: patients aged 17.5 yrs+ with a transition plan in place	Deterioration in % patients aged 17.5 years with transition plan in place from 75.4% in November to 61.6% in December	Update from Denice Nightingale as required
IAPT	Deterioration in both IAPT prevalence and recovery from November to December	Update from Denice Nightingale as required

Performance Headlines

SUGGESTED ISSUES FOR DISCUSSION:

1. Winter performance update: agenda item to be presented by Andrew Phillips

2. Proposition to dedicate the March 2018 Finance and Performance Committee to:

- Review of performance throughout 2017/18 to form the agreed final performance statement for the CCG Annual Report in April 2018

- Confirm and challenge the performance priorities (all indicators within the refreshed CCG Integrated Assurance Framework [IAF]) with each Executive Lead and team to ensure that all 18/19 workstreams include and align both financial recovery and performance recovery. This would support decisions around how CCG capacity is allocated to deliver recovery

- Feedback from the RTT performance stock-take with YFT to ensure that the baseline position for RTT is jointly understood moving in 2018/19

3.

Performance Summary:
All Constitutional Targets 2017/18

Validated data to December (Month 09)

NHS
Vale of York
Clinical Commissioning Group

VoY CCG - NHS Constitution - 2017/18

Generated on: 15 February 2018

ALL
Green
Amber/Red

EMBED HEALTH CONSORTIUM

Planned Care

Indicator	Level of Reporting		Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Referral to Treatment																					
Referral to Treatment pathways: incomplete	CCG	Actual	90.3%	90.5%	90.7%	89.7%	90.2%	90.2%	89.7%	89.3%	88.8%	89.2%	89.2%	88.1%	90.0%	89.3%	88.8%	89.4%	91.4%		↓
		Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		
Number of >52 week Referral to Treatment in Incomplete Pathways	CCG	Actual	0	0	2	2	2	0	1	0	0	0	0	3	4	1	3	8	5		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Diagnostics																					
Diagnostic test waiting times	CCG	Actual	1.76%	2.00%	2.12%	3.76%	3.49%	2.83%	2.18%	1.63%	1.60%	1.99%	1.85%	2.06%	2.83%	1.60%	2.06%	2.06%	2.12%		↓
		Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		
Cancer																					
All Cancer 2 week waits	CCG	Actual	90.2%	97.0%	93.3%	90.5%	89.6%	90.4%	85.9%	85.2%	88.1%	86.8%	96.4%	93.5%	90.2%	86.4%	92.1%	89.6%	93.6%		↑
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Breast Symptoms (Cancer Not Suspected) 2 week waits	CCG	Actual	95.7%	95.7%	98.3%	91.9%	95.5%	96.6%	96.8%	96.8%	100.0%	97.6%	91.3%	93.0%	95.2%	97.6%	93.4%	95.3%	96.3%		↓
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Cancer 31 day waits: first definitive treatment	CCG	Actual	96.3%	98.2%	96.6%	95.0%	98.9%	97.8%	97.4%	97.4%	96.6%	95.2%	98.2%	98.3%	97.5%	97.2%	96.9%	97.2%	98.0%		↑
		Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		
Cancer 31 day waits: subsequent cancer treatments-surgery	CCG	Actual	97.1%	92.1%	100.0%	95.2%	93.8%	96.9%	88.1%	97.7%	95.5%	85.1%	94.2%	97.1%	95.3%	93.1%	92.5%	93.5%	95.0%		↑
		Target	94.0%	94.0%	94.0%	94.0%	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
Cancer 31 day waits: subsequent cancer treatments-anti cancer drug regimens	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		-
		Target	98.0%	98.0%	98.0%	98.0%	96.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%		
Cancer 31 day waits: subsequent cancer treatments-radiotherapy	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	99.8%	99.6%		-
		Target	94.0%	94.0%	94.0%	94.0%	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
% 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	82.4%	74.0%	78.7%	83.6%	74.3%	76.6%	82.0%	87.3%	74.1%	72.5%	87.5%	87.0%	77.8%	81.2%	82.1%	80.5%	81.8%		↑
		Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	CCG	Actual	94.7%	93.3%	85.7%	83.3%	100.0%	100.0%	88.2%	100.0%	94.4%	88.9%	90.0%	86.7%	94.6%	94.7%	88.4%	92.7%	91.9%		↓
		Target	90.0%	92.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	CCG	Actual	66.7%	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	100.0%	88.5%		
		Target																			
Cancelled Operations																					
Cancelled Operations - York	YFT (Trust Wide)	Actual			7.8%			1.9%			1.1%			0.4%	1.9%	1.1%	0.4%	1.1%	5.1%		
		Target			2.0%			11.7%			1.4%			1.0%	11.7%	1.4%	1.0%	5.1%	3.1%		
No urgent operations cancelled for a 2nd time - York	YFT (Trust Wide)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Mixed Sex Accommodation																					
Mixed Sex Accommodation (MSA) Breaches (Rate per 1,000 FCEs)	CCG	Actual	0.1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.1	0		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Number of MSA breaches for the reporting month in question	CCG	Actual	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

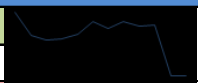
Unplanned Care

Indicator	Level of Reporting		Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
A&E																					
A&E waiting time - total time in the A&E department, SitRep data	% of YFHT activity (CCG weighted)	Actual	78.3%	81.5%	89.4%	92.9%	88.1%	91.9%	87.1%	88.2%	83.2%	86.7%	91.7%	83.0%	90.9%	86.2%	87.0%	87.5%	86.4%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	4302	3991	4551	4485	4802	4714	4937	4716	4590	4795	4554	4869	14001	14243	14217	46860	55185		↑
A&E - % Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	63.3%	68.7%	81.7%	87.5%	79.6%	86.1%	77.7%	79.1%	71.2%	77.1%	86.3%	72.0%	83.5%	77.7%	81.6%	79.5%	76.6%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 3, SitRep data	% of YFHT activity (CCG weighted)	Actual	1483	1397	1652	1785	1818	1730	1894	1927	1704	1749	1517	1,630	5333	5525	4897	17238	20011		↓
A&E Attendances - Total, SitRep data	% of YFHT activity (CCG weighted)	Actual	7,291	6,807	7,881	8,083	8,466	8,201	8,755	8,599	8,024	8,319	7,611	8,157	24,749	25,377	24,088	81,602	95,514		↓
A&E Attendances - VoY CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	6,914	6,256	7,205	7,069	7,617	7,258	7,660	7,095	7,138	7,820	7,704	8,142	21,944	21,893	23,666	67,503	86,952		↑
A&E waiting time -% of patients seen and discharged within 4 hours -CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	73.33%	79.49%	90.02%	90.38%	83.89%	88.74%	82.14%	84.95%	81.09%	85.23%	87.75%	78.47%	87.59%	82.71%	85.19%	84.65%	83.55%		↓
	CCG (SUS Data)	Actual	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
Trolley Waits																					
12 hour trolley waits in A&E - Vale of York CCG	CCG	Actual	6	2	0	0	1	0	2	0	0	0	0	3	1	2	3	6	19		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12 hour trolley waits in A&E - York	YFT (Trust Wide)	Actual	45	6	9	0	3	0	2	1	1	2	0	5	3	4	7	28	85		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Ambulance performance - YAS																					
Category 1 - Response within 8 Minutes	YAS (Region)	Actual	62.4%	69.8%	75.4%	75.4%	74.1%	68.2%	71.4%	66.8%					69.9%	68.8%		69.5%	67.4%		
		Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%					75.0%	75.0%		75.0%	75.0%		
Achieved 8 Min	YAS (Region)	Actual	252.096	216	265	269	259	261	281	267					789	809		1337	1171		
Total Calls (C1)	YAS (Region)	Actual	404	309	352	357	390	382	394	400					1129	1176		1923	1736		
Category 1 - Tail of Performance 75%	YAS (Region)	Actual				00:08:20	00:08:03	00:09:06	00:08:21	00:09:07					00:08:30	00:08:44		00:08:35			
Category 1 - Tail of Performance 100%	YAS (Region)	Actual				00:44:14	00:25:56	00:24:03	00:31:26	00:39:56					00:31:24	00:35:41		00:33:07			
Category 2R (resource) - Response within 19 minutes by a resource	YAS (Region)	Actual	85.5%	85.3%	83.5%	85.0%	86.9%	86.9%	83.3%	76.5%					86.3%	79.9%		83.4%	83.0%		
Category 2R - Tail of Performance 95%	YAS (Region)	Actual				00:27:25	00:24:04	00:30:40	00:30:54	00:29:53					00:27:23	00:30:24		00:28:35			
Category 2R- Tail of Performance 100%	YAS (Region)	Actual				00:42:35	00:37:19	01:02:20	01:12:04	00:53:05					00:47:25	01:02:35		00:53:29			
Category 2T (transport) - Response within 19 Minutes by DCA unless RRV arrives and DCA not required	YAS (Region)	Actual	69.4%	69.2%	76.6%	80.0%	77.5%	75.9%	73.0%	75.2%					77.8%	74.0%		76.3%	69.5%		
Category 2T - Tail of Performance 95%	YAS (Region)	Actual				00:34:50	00:31:24	01:01:00	00:38:18	00:40:31					00:42:25	00:39:24		00:41:13			
Category 2T - Tail of Performance 100%	YAS (Region)	Actual				02:22:47	01:20:47	23:24:31	01:53:29	02:59:26					09:02:42	02:26:27		06:24:12			
Category 3R (Resource) - Response within 40 Minutes by a resource	YAS (Region) (	Actual	84.5%	83.9%	87.3%	91.4%	90.6%	90.6%	88.6%	89.2%					90.9%	88.9%		90.0%	84.8%		
Category 3R - Tail of Performance 95%	YAS (Region)	Actual				01:10:35	00:50:41	00:50:10	00:58:36	00:54:18					00:57:09	00:56:27		00:56:52			
Catergory 3R - Tail of Performance 100%	YAS (Region)	Actual				01:41:40	01:41:01	02:21:42	02:06:15	01:39:51					01:54:48	01:53:03		01:54:06			
Category 3T (Transport) - Response within 40 minutes by DCA unless RRV arrives and DCA is not required	YAS (Region)	Actual	76.9%	79.2%	87.7%	90.2%	89.7%	83.0%	79.5%	77.9%					87.8%	78.7%		84.3%	80.3%		
Category 3T - Tail of Performance 95%	YAS (Region)	Actual				01:27:56	00:51:25	15:08:40	01:11:36	01:10:23					05:49:20	01:11:00		03:58:00			
Category 3T - Tail of Performance 100%	YAS (Region)	Actual				01:58:55	03:03:13	23:43:28	03:13:24	03:43:33					09:35:12	03:28:28		07:08:31			
Category 4T (Transport) - Response within 90 Minutes of locally determined	YAS (Region)	Actual	88.7%	94.3%	90.7%	91.8%	91.0%	83.3%	89.2%	76.0%					88.6%	82.6%		86.2%	91.3%		
Category 4H - (Hear and Treat) Hear and Treat within 90 Minutes	YAS (Region)	Actual	94.1%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%					100.0%	98.6%		99.5%	96.4%		

Ambulance Handover Time

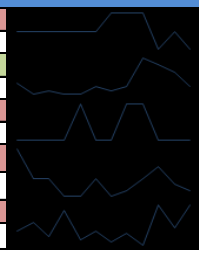
Indicator	Level of Reporting		Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Ambulance handover time - % Delays over 30 minutes (Scarborough General Hospital)	Trust Site	Actual	39.00%	44.20%	21.80%	7.40%	18.30%	14.90%	16.80%	22.30%	31.40%	30.30%	8.30%	32.10%	12.90%	23.30%	23.90%	20.20%	29.40%		↑
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	510	533	294	117	182	222	260	357	456	436	112	472	521	1073	1020	2614	4771		
		Den	1307	1207	1346	1572	994	1487	1552	1601	1450	1440	1352	1470	4053	4603	4262	12918	16224		
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	Trust Site	Actual	17.10%	23.10%	6.00%	2.60%	6.40%	5.00%	5.00%	6.10%	12.80%	13.70%	1.80%	12.40%	4.40%	7.80%	9.50%	7.30%	12.90%		↓
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	224	279	81	41	64	74	77	98	186	197	25	183	179	361	405	945	2088		
		Den	1307	1207	1346	1572	994	1487	1552	1601	1450	1440	1352	1470	4053	4603	4262	12918	16224		
Ambulance handover time - % Delays over 30 minutes (York Hospital)	CCG	Actual	30.10%	20.00%	7.00%	4.10%	10.90%	7.00%	11.00%	10.60%	13.90%	9.80%	7.00%	26.70%	7%	11.80%	14.80%	11.40%	16.20%		
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	596	352	131	78	209	126	200	188	245	192	128	544	413	633	864	1910	3813		↑
		Den	1978	1760	1869	1906	1921	1794	1820	1767	1765	1954	1841	2039	5621	5352	5834	16807	23476		
Ambulance handover time - % Delays over 60 minutes (York Hospital)	CCG	Actual	16.70%	7.80%	0.90%	0.90%	3.70%	1.30%	4.10%	2.80%	4.50%	3.20%	1.80%	14.10%	2%	3.80%	6.50%	4.10%	7.00%		↑
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
		Num	330	137	16	17	71	23	75	49	79	62	33	287	111	203	382	696	1655		
		Den	1978	1760	1869	1906	1921	1794	1820	1767	1765	1954	1841	2039	5621	5352	5834	16807	23476		

Mental Health/ IAPT

Indicator	Level of Reporting	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
IAPT																					
% of people who have depression and/or anxiety disorders who receive psychological therapies	CCG	Actual	1.10%	0.70%	0.62%	0.64%	0.72%	0.94%	0.82%	0.93%	0.86%	0.88%			2.30%	2.61%	0.88%	5.79%	13.32%		↓
		Target	1.25%	1.25%	1.25%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%			2.00%	2.00%	0.7%	4.66%	8.57%		
% of people who are moving to recovery	CCG	Actual	46.43%	50.00%	53.85%	42.50%	54.17%	42.31%	40.91%	37.93%	41.67%	53.85%			45.56%	40.00%	53.85%	45.10%	47.04%		↑
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
% of people who have depression and/or anxiety disorders who receive psychological therapies	CCG	Actual	1.1%	0.7%	0.6%	0.6%	0.7%	0.9%	0.8%	0.9%	0.9%	0.9%			2.3%	2.6%	0.9%	5.8%	13.3%		↓
Number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey)	CCG	Actual	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0			31260.0	31260.0	31260.0	31260.0	31260.0		-
Number of people who receive psychological therapies	CCG	Actual	345	220	195	200	225	295	255	290	270	275			720	815	275	1810	4165		↓
		Target	391	208	208	208	208	208	208	208	208	208			624	624	208	1456	2679		
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	93.55%	93.33%	93.10%	97.62%	96.15%	92.59%	95.65%	96.77%	96.15%	97.62%			95.79%	96.25%	97.62%	96.31%	83.60%		↑
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%			95.00%	95.00%	1	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	98.55%	100.00%	100.00%	100.00%	100.00%	98.31%	98.04%	98.28%	100.00%	100.00%			99.31%	98.77%	100.00%	99.17%	87.15%		↑
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%			90.00%	90.00%	1	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	80.65%	80.00%	82.76%	90.48%	80.77%	77.78%	82.61%	80.65%	84.62%	76.19%			84.21%	82.50%	76.19%	82.03%	66.24%		↓
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%			75.00%	75.00%	1	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	94.20%	95.45%	92.31%	80.00%	42.22%	49.15%	47.06%	62.07%	75.93%	90.91%			55.56%	61.96%	90.91%	63.81%	78.03%		↑
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	1	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	51.61%	46.67%	44.83%	57.14%	84.62%	85.19%	134.78%	109.68%	123.08%	92.86%			72.63%	121.25%	92.86%	94.47%	66.56%		↓
		Target	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%			40.00%	40.00%	0	40.00%	40.00%		
Average number of treatment sessions	CCG	Actual	6	6	7	6	8	7	6	5	5	6			7	5	6	6	5		↑
% of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days	CCG	Actual			99.2%			96.2%			98.8%			94.0%	96.2%	98.8%	94.0%	96.3%	96.9%		
		Target			95.0%			95.0%			95.0%			95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		

Dementia																				
Estimated diagnosis rate for people with dementia.	CCG	Actual	55.2%	55.1%	55.4%	58.4%	58.3%	58.7%	59.1%	59.4%	59.6%	60.2%	61.0%	60.7%	58.7%	59.6%	60.7%	60.7%	55.4%	
		Target	62.8%	62.8%	66.7%	66.7%	62.8%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	

HCAI and Quality

Indicator	Level of Reporting		Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Hospital Infections																					
Incidence of healthcare associated infection (HCAI): MRSA	CCG ATTRIBUTED	Actual	1	1	1	1	1	1	2	2	2	0	1	0	3	6	1	10	9		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile).	CCG ATTRIBUTED	Actual	7	4	5	4	4	6	5	6	14	12	10	6	14	25	28	67	61		↓
		Target	7	6	6	7	6	8	4	7	6	7	5	9	21	17	21	59	78		
Incidence of healthcare acquired infections (HCAI): MRSA - York FT	YFT TRUST APPORTIONED	Actual	0	0	0	0	1	0	0	1	1	0	0	0	1	2	0	3	6		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile) - York FT	YFT TRUST APPORTIONED	Actual	10	5	5	2	2	5	2	3	5	7	4	3	9	10	14	33	46		↓
		Target	3	5	3	3	1	3	3	2	1	3	2	8	7	6	13	26	45		
Healthcare acquired infection (HCAI) measure (Escherichia Coli infections)	CCG ATTRIBUTED	Actual	24	27	22	31	21	24	20	23	19	33	25	33	76	62	91	229	307		↓
		Target	27	36	23	26	21	24	20	27	25	20	26	27	71	72	73	216	269		
Serious Incidents/ Never Events																					
Number of Serious Incidents (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	7	7	5	6	1	9	7	4	3	9	5	5	16	14	19	49	117		↓
Number of Never Events (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	3		-
Smoking at time of Delivery																					
Maternal smoking at delivery.	CCG	Actual			12.3%			10.1%			12.0%			7.5%	10.1%	12.0%	7.5%	9.9%	11.0%		
		Target			12.1%			12.1%			12.1%			12.1%	12.1%	12.1%	12.1%	12.1%	12.1%		

Programme Overview - Planned Care

Validated data to December (Month 09)

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

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

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

NHS
Vale of York
Clinical Commissioning Group

YORK TEACHING HOSPITAL REFERRALS*

- Overall, referrals into York Teaching Hospital for the year to date have decreased by 0.1% (105) in comparison to the same period in 2016/17 (working day adjusted). Referrals via a GP have reduced by 3% (1656), whilst consultant to consultant referrals have increased by 6% (612) and other referrals have increased by 3% (939). The main specialties driving the increase are Cardiology and Paediatrics. Referrals into Geriatric Medicine and Trauma and Orthopaedics have significantly reduced by 28% and 9% respectively.

Speciality	Total Referrals (Year on Year comparison)			Change Apr-Jan 2017 v's Apr-Jan 2018 by Referral Type				% Change (Apr-Jan 2017v's Apr-Jan 2018)			
	Apr-Jan 2016	Apr-Jan 2017	Apr-Jan 2018	GP	Cons:cons	Other	Total Change	GP	Cons:cons	other	Total change
320: Cardiology	12,240	12,571	13,812	232	34	975	1,241	7%	4%	12%	10%
100: General Surgery	10,048	10,385	10,384	24	-110	85	-1	0%	-7%	9%	0%
130: Ophthalmology	9,203	9,954	9,947	-226	130	89	-7	-4%	16%	2%	0%
110: Trauma And Orthopaedic Surgery	9,127	9,727	8,834	96	-84	-905	-893	7%	-10%	-12%	-9%
120: Ear, Nose And Throat	6,082	6,232	5,929	-357	8	46	-303	-8%	3%	3%	-5%
502: Gynaecology	5,213	5,210	5,341	-118	58	191	131	-3%	21%	69%	3%
501: Obstetrics	4,632	4,487	4,508	-5	42	-16	21	-6%	840%	0%	0%
330: Dermatology	4,555	4,598	4,433	-271	81	25	-165	-7%	24%	25%	-4%
420: Paediatrics	3,315	3,786	3,941	-32	-45	232	155	-2%	-4%	30%	4%
101: Urology	3,764	3,749	3,709	-332	129	163	-40	-12%	20%	63%	-1%
301: Gastroenterology	4,063	3,738	3,644	-280	115	71	-94	-10%	21%	17%	-3%
340: Respiratory Medicine -Thoracic	1,908	2,031	2,040	-95	46	58	9	-6%	13%	30%	0%
430: Geriatric Medicine	2,467	2,626	1,878	-274	304	-778	-748	-23%	86%	-71%	-28%
302: Endocrinology	1,727	1,682	1,807	91	7	27	125	11%	4%	4%	7%
400: Neurology	1,750	1,820	1,714	116	-249	27	-106	9%	-45%	84%	-6%
190: Anaesthetics	1,362	1,365	1,475	7	25	78	110	1%	14%	25%	8%
410: Rheumatology	1,398	1,453	1,456	-41	28	16	3	-3%	24%	15%	0%
315: Palliative Medicine	1,300	1,395	1,446	-41	2	90	51	-10%	8%	9%	4%
370: Medical Oncology	1,184	1,308	1,353	-8	7	46	45	-24%	1%	10%	3%
300: General Medicine	1,168	1,246	1,317	20	31	20	71	2%	443%	22%	6%
401: Clinical Neuro-Physiology	704	821	841	26	22	-28	20	58%	6%	-7%	2%
303: Haematology (Clinical)	1,222	838	671	-171	-20	24	-167	-30%	-8%	171%	-20%
160: Plastic Surgery	423	571	580	20	5	-16	9	13%	1%	-20%	2%
430: Mental Health Assessment And Liaison Service	0	0	434	0	0	434	434	0%	0%	0%	0%
361: Nephrology	474	429	381	-53	10	-5	-48	-22%	15%	-4%	-11%
510: Ante-Natal Clinic	355	358	366	17	2	-11	8	6%	0%	-13%	2%
822: Clinical Biochemistry	77	88	132	13	29	2	44	19%	153%	100%	50%
823: Haematology	56	74	70	-8	0	4	-4	-80%	0%	6%	-5%
Other	158	62	56	-6	5	-5	-6	-46%	17%	-25%	-10%
Grand Total	**89,975**	**92,604**	**92,499**	**-1,656**	**612**	**939**	**-105**	**-3%**	**6%**	**3%**	**-0.1%**

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

QIPP: PLANNED CARE AND PRESCRIBING - MONTH 10

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PLANNED CARE									
Anti-Coagulation service	194	Apr-17	213	213	-38	259	259	-65	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Cataract Thresholds	161	Apr-17	250	250	0	300	300	0	
Faecal Calprotectin	PC4	Oct-16	53	53	-31	53	53	-31	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Biosimilar high cost drugs gain share	016	Apr-17	279	279	124	318	318	163	Etanercept in place from 2016/17, YTD based on forecast until validated acute data available. Rituximab now in forecast from Oct (was in plan from Apr) due to second biosimilar coming to market later but with lower expected price
Remove SpR block from contract	168	Apr-17	793	793	793	952	952	952	In contract, delivery on track
Commissioning for Value (PNRC)	006	Apr-17	125	125	0	150	150	0	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	2,500	2,500	2,233	3,000	3,000	2,718	Scheme up and running, YTD saving based on forecast profile until validated acute data available
RightCare - Circulation (Heart Disease)	008	Oct-17	67	67	67	100	100	100	
RightCare - Gastroenterology	009	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
RightCare - Respiratory (COPD)	010	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
RightCare - Orthopaedics / MSK	011	Oct-17	500	500	0	750	750	0	
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	667	667	0	1,000	1,000	0	

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PRESCRIBING									
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	231	231	231	277	277	277	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	106	106	106	128	128	128	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	89	89	89	106	106	106	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	50	50	50	75	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	62	62	62	75	75	75	YTD based on forecast profile until schemes confirmed and prescribing data available
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	750	750	750	900	900	900	YTD based on forecast profile until schemes confirmed and prescribing data available
CCG wide: Continence & Stoma Care	199	Oct-17	36	36	36	53	53	53	

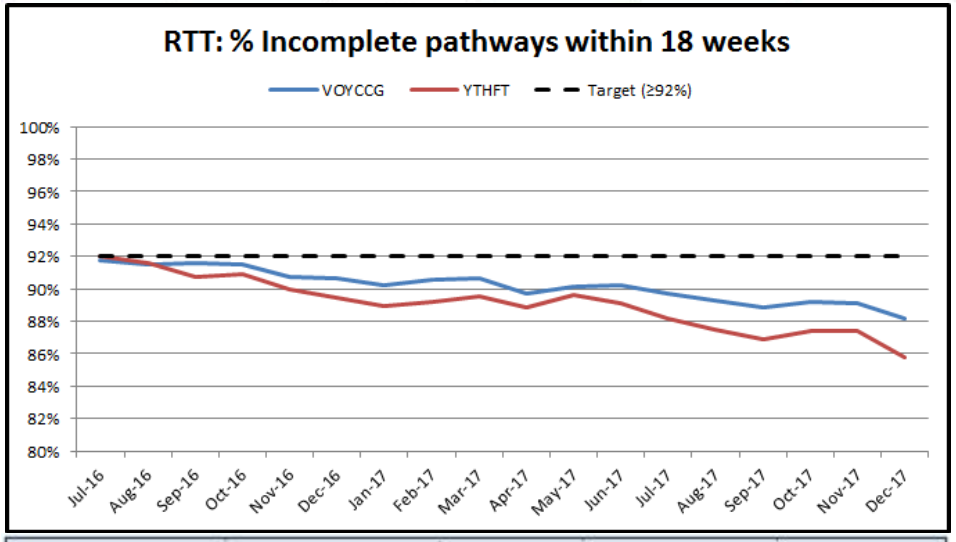
QIPP: PLANNED CARE AND PRESCRIBING – MONTH 10

KEY QUESTIONS: UNPLANNED CARE QIPP

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

PERFORMANCE PLANNED CARE: REFERRAL TO TREATMENT (RTT)

RTT: % Incomplete pathways within 18 weeks (Target ≥92%)					
Vale of York CCG			York Trust		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
89.2%	88.1%	↓	87.4%	85.8%	↓



Treatment Function	Total VOYCCG Incomplete Pathways	No. of 18 week breaches	% VOYCCG pathways within 18 weeks	52 week breaches
Cardiothoracic Surgery	9	-	100.0%	0
Geriatric Medicine	100	1	99.0%	0
General Medicine	186	2	98.9%	0
Gastroenterology	867	45	94.8%	0
Other	1,556	104	93.3%	0
Neurology	467	33	92.9%	0
Neurosurgery	14	1	92.9%	0
Trauma & Orthopaedics	1,610	116	92.8%	1
Cardiology	924	67	92.7%	0
Rheumatology	447	37	91.7%	0
Gynaecology	861	73	91.5%	0
ENT	1,387	149	89.3%	0
Dermatology	1,011	140	86.2%	0
General Surgery	1,754	245	86.0%	1
Plastic Surgery	164	29	82.3%	0
Ophthalmology	2,611	476	81.8%	1
Urology	994	190	80.9%	0
Thoracic Medicine	647	144	77.7%	0
Grand Total	**15,609**	**1,852**	**88.1%**	**3**

Vale of York CCG's performance in December decreased marginally from 89.24% to 88.1%. This equates to 1,852 breaches of the 18 week target, from a cohort of 15,609 patients.

York Trust's RTT performance in December 2017 was 85.8% and dropped further below the STF trajectory of 92%.

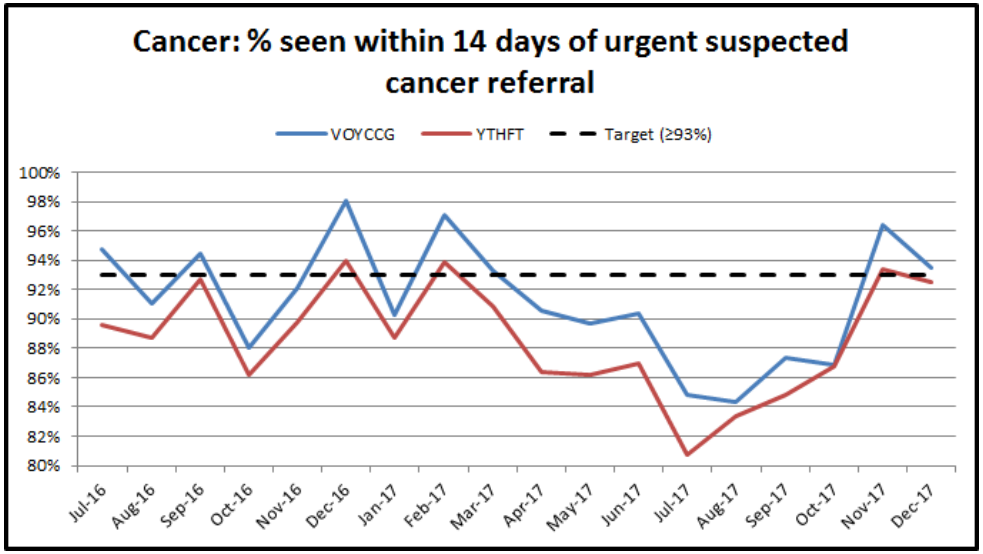
The Trust experienced sustained pressure linked to influenza strains and respiratory viruses within the local community during both December 2017 and January 2018. Winter pressures impacted on bed capacity at York Hospital and RTT performance as priority was given to urgent electives with the majority of routine electives being cancelled. 243 operations were cancelled due to bed shortages and non-clinical reasons in December 2017. Some day case surgery went ahead but the overall impact has resulted in an admitted backlog of 1,808 and a non-admitted backlog of 2,047 as at week ending 4th February 2018.

Long waits continue to be a significant concern in particular for Sleep Services, Urology, Ophthalmology, Max Fax, General Surgery and Dermatology. York Trust has submitted a bid to NHSE for additional funding to support elective care post-winter and a business case has been forward to the CCG Executive Committee for approval for funding to replace Sleep Studies equipment Long wait patients are reviewed weekly and prioritised through theatre planning and bed meetings.

The Trust is currently engaged with the NHSI productivity team to support effective theatre utilisation and productive working. This is incorporated within their internal planned care Board.

PERFORMANCE PLANNED CARE: CANCER TWO WEEK WAITS

Cancer: % 2WW referrals seen within 14 days (Target ≥93%)					
Vale of York CCG			York Trust		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
96.4%	93.5%	↓	93.4%	92.5%	↓



Tumour Type	VOYCCG: Total Referrals	Number of 2WW breaches	VOYCCG: % within 14 days
Other Cancer	3	0	100.0%
Lung	11	0	100.0%
Testicular	4	0	100.0%
Childrens	1	0	100.0%
Haematological Malignancies	2	0	100.0%
Head and Neck	61	1	98.4%
Upper Gastrointestinal	52	1	98.1%
Breast	174	6	96.6%
Gynaecological	56	2	96.4%
Lower Gastrointestinal	172	7	95.9%
Urological Malignancies	112	8	92.9%
Skin	180	29	83.9%
Sarcoma	0	0	N/A
Brain/Central Nervous System	0	0	N/A
Grand Total	**828**	**54**	**93.5%**

Vale of York CCG achieved 93.5% performance in December 2017, meeting the target of 93%.

However, York Trust's performance declined in December 2017 to 92.5% and they consequently did not achieve the 93% target.

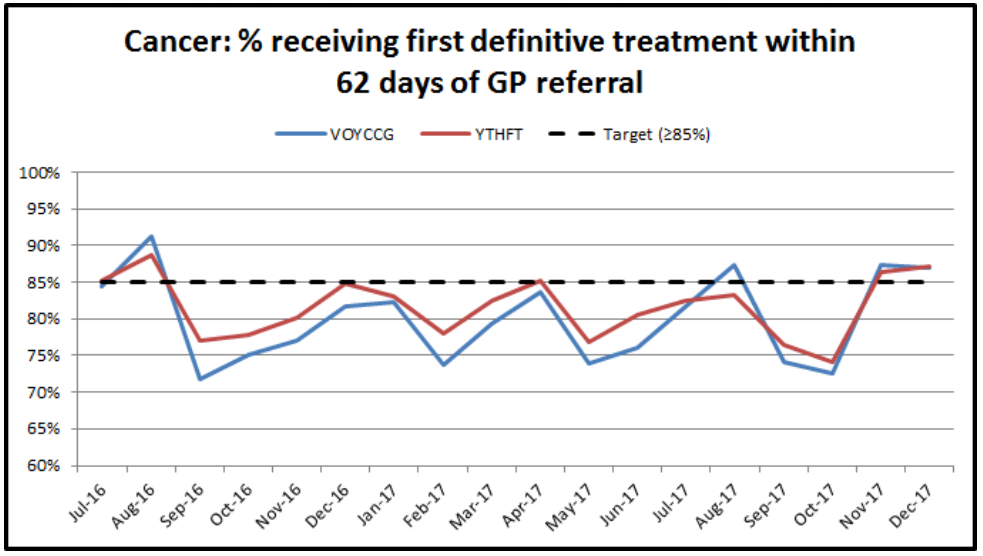
In total there were 54 breaches of the two week wait target for Vale of York CCG patients in December 2017. The majority of these delays (26) were due to inadequate outpatient capacity, 23 of these related to suspected skin cancer. 21 delays related to patient cancellations, 2 were due to cancelled clinics, 1 admin delay, with the remaining 4 breaches being categorised as 'other'.

The Malton 'one stop shop' commenced in November 2017 and work continues with the CCG to manage fast track referral demand.

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

PERFORMANCE PLANNED CARE: CANCER 62 DAYS

Cancer: % treated within 62 days of urgent GP referral (Target ≥85%)					
Vale of York CCG			York Trust		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
87.4%	87.0%	↓	86.4%	87.2%	↑



Tumour Type	VOYCCG: Total Treated	VOYCCG: 62 day breaches	VOYCCG: % within 62 days
Gynaecological	1	0	100.0%
Upper Gastrointestinal	3	0	100.0%
Breast	13	0	100.0%
Skin	25	1	96.0%
Urological (Excluding Testicular)	30	4	86.7%
Head & Neck	5	1	80.0%
Lung	5	1	80.0%
Haematological (Excluding Acute Leukaemia)	3	1	66.7%
Other	2	1	50.0%
Lower Gastrointestinal	5	3	40.0%
Grand Total	**92**	**12**	**87.0%**

Vale of York CCG achieved the 62 Day target of 85% in December 2017 with performance of 87%, equating to 12 breaches of a total 92 patients.

York Trust also met the target, with performance at 87.2% in December 2017, up from 86.4% in November.

The main reasons for the delays were access to diagnostics, late referrals and patient availability/needing time to think. The longest waiting times are for Urology and Lower Gastro patients.

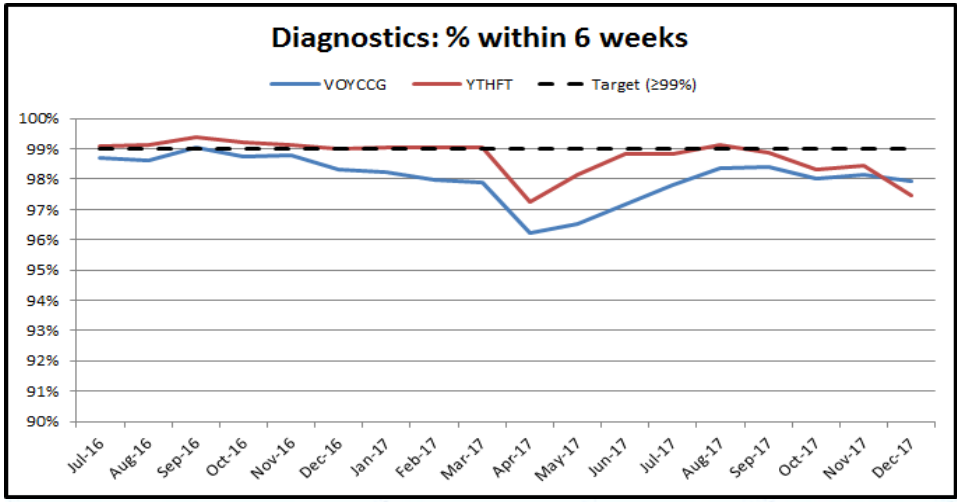
Clinical Harm Reviews are completed on all patients waiting over 104 days. A review is also underway to provide assurance that all possible options for diagnostics have been considered to reduce waiting times for patients.

The NHSI Elective Intensive Support Team visited York Trust in January to review 62 day processes and two clinical pathways – Lung and Haematology. Formal feedback is expected in February 2018 and is being requested to support dedicated cancer review session with YFT at sub CMB on 28th February.

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

PERFORMANCE PLANNED CARE: DIAGNOSTICS

Diagnostics: % within 6 weeks (Target ≥99%)					
Vale of York CCG			York Trust		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
98.2%	97.9%	↓	98.5%	97.5%	↓



Diagnostic Type	Total VOYCCG Waiting List	Total >6 weeks	within 6 weeks
BARIUM_ENEMA	23	0	100.00%
DEXA_SCAN	134	0	100.00%
ELECTROPHYSIOLOGY	1	0	100.00%
AUDIOLOGY_ASSESSMENTS	342	1	99.71%
ECHOCARDIOGRAPHY	211	1	99.53%
NON_OBSTETRIC_ULTRASOUND	932	6	99.36%
MRI	753	14	98.14%
FLEXI_SIGMOIDOSCOPY	89	2	97.75%
COLONOSCOPY	146	4	97.26%
CT	518	15	97.10%
GASTROSCOPY	238	7	97.06%
CYSTOSCOPY	83	3	96.39%
PERIPHERAL_NEUROPHYS	49	2	95.92%
URODYNAMICS	29	3	89.66%
SLEEP_STUDIES	51	16	68.63%
Grand Total	**3599**	**74**	**97.94%**

Vale of York CCG achieved 97.9% against the 99% target for patients waiting less than 6 weeks for a Diagnostic Test in November 2017. There were a total of 74 breaches out of 3,599 on the waiting list.

The largest number of breaches was in Sleep Studies at York Hospital and the Trust has submitted a business case to the CCG to upgrade the equipment which will improve efficiency and reliability and reduce the number of 'failed tests' currently experienced. There were 14 MRI breaches, 11 of which were at York Teaching Hospitals Foundation Trust. The Trust has submitted a bid to NHSE to provide additional funding to increase MRI capacity to accommodate the 'winter backlog' and the MRI patients waiting for GA clinics.

CT breaches at Hull and East Yorkshire Hospitals NHS Trust (HEY) increased with 12 breaches for Vale of York CCG patients and a further 17 breaches for Scarborough and Ryedale CCG patients. Currently demand is higher than CT capacity at Hull.

York Teaching Hospitals Foundation Trust's overall performance was 97.5% in November 2017 and did not meet the diagnostic target. The key issues in December continue to be MRI breaches requiring GA sessions, Sleep Studies equipment failure and delays in Endoscopy due to Consultant sickness.

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 – No** **Cancer 62 day standard – Yes** **RTT – No**	**Diagnostics:** • Capacity and demand work continues for cystoscopy and MRI as part of recovery and sustainability plans in Diagnostics. • York Trust has submitted a bid to NHSE for additional funding to increase diagnostic capacity and reduce the 'winter backlog'. This includes funding for additional:- • Endoscopy waiting list initiatives at both York and Scarborough, • Radiology -additional scanning and reporting • Cardiology ECHO ECP activity • Cytology Screening – to support 14 day turnaround times for cervical screening • Histopathology – to reduce 14 day and 62 day backlogs improving diagnostic turnaround times. **Cancer:** • NHSI Intensive Support Team working with York to improve 62 Day process and clinical pathways for Lung and Haematology. • YTHFT's Cancer Board has been reconfigured with 4 work groups focused on: timed pathways, diagnostics, quality surveillance and patient outcomes, living with and beyond cancer. • A clear understanding of the best approach to the management of patients with vague symptoms and design of a pathway to be piloted at York. • Clear understanding of the key issues within diagnostics and agreed actions required to reduce pressures • 3 additional radiographers trained to report plain film by June 2018, reporting 3000 plain film per annum and releasing consultant radiologist time to report an additional 6,000 complex radiographs. 2 WTE radiographers in post to support additional workload
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
	Diagnostics – sleep studies business case for investment. On-going CT capacity on east coast/ Hull. RTT performance recovery plan for 2018/19 to be developed jointly with YFT as part of delivering the Medium Term system plan and within an Aligned Incentives Framework [AIC]

Programme Overview - Unplanned Care

Validated data to December (Month 09)

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

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

NHS
Vale of York
Clinical Commissioning Group

QIPP: UNPLANNED CARE MONTH 10

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
UNPLANNED CARE									
Community Podiatry	IC4	May-17	322	322	277	393	393	339	New contract in place from 1st May 2017. YTD saving based on forecast profile until validated activity information available
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	351	351	294	421	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	217	217	187	217	217	187	New contract in place but costs higher than expected. YTD saving based on forecast until expenditure data available
Community Equipment service re-procurement	187	Apr-17	418	418	0	418	418	0	New contract in place but costs higher than expected. YTD saving based on forecast until expenditure data available
Patient Transport - contracting review	190a	Apr-17	11	11	11	11	11	11	Scheme in place since May 2016, FYE in April. YTD saving based on plan until expenditure data available
Unplanned Care Programme (including urgent care and out of hospital care)	149	Jul-17	641	641	0	824	824	0	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	630	630	168	756	756	202	Scheme up and running, YTD saving based on forecast profile until validated acute data available
Review of community inpatient services - Phase II	019b	Oct-17	133	133	0	200	200	0	
RightCare Phase 2 - Trauma & Injuries	017	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*
Patient Transport project - re-procurement	190b	Apr-18	0	0	0	0	0	0	*In plan from 2018/19*

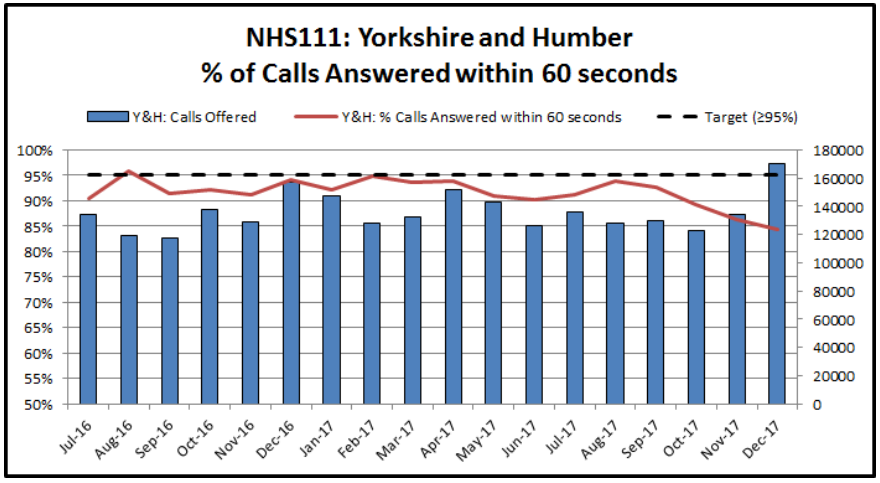
QIPP: UNPLANNED CARE MONTH 10

KEY QUESTIONS: UNPLANNED CARE QIPP

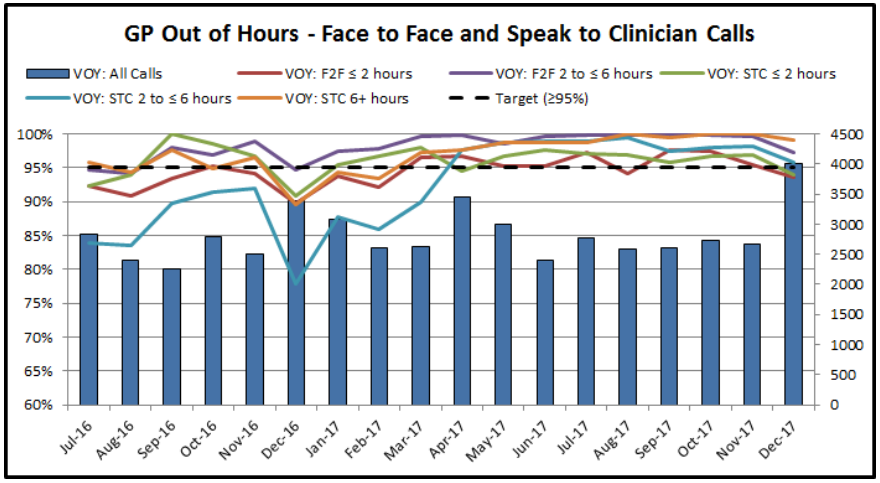
Are QIPP targets being met and are you assured this is sustainable?	What mitigating actions are underway?	Is further escalation required?
See highlights from financial recovery incorporated in Finance report		

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

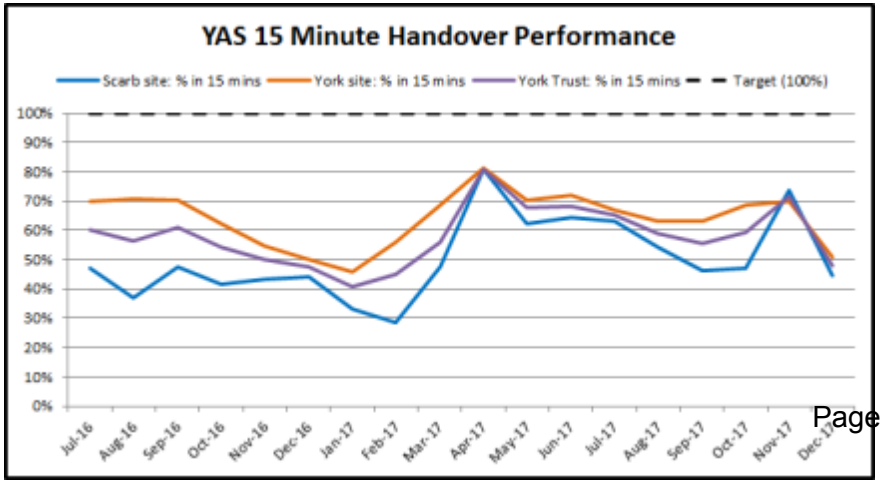
NHS111: Yorkshire and Humber					
Calls Offered			% Answered within 60 seconds		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
134,469	170,251	↑	86.4%	84.4%	↓



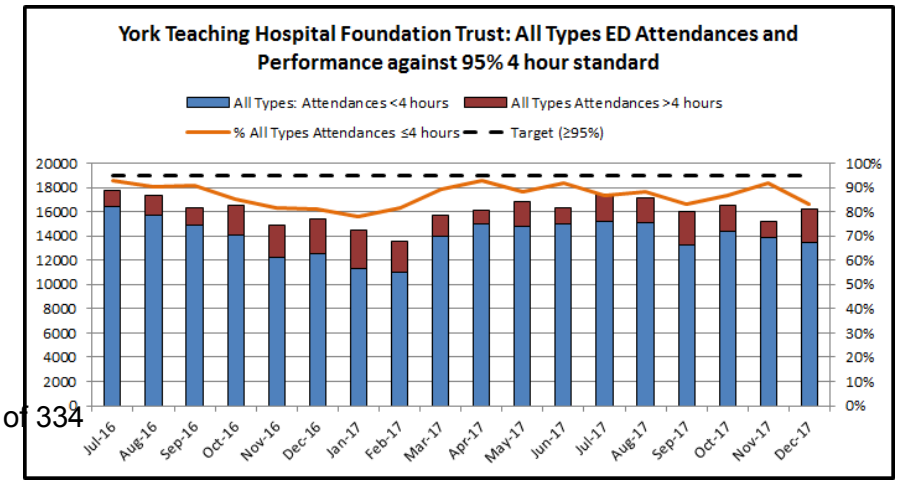
GP Out of Hours - Face to Face and Speak to Clinician Calls					
F2F calls within ≤2 hours (Target 95%)			STC calls within ≤2 hours (Target 95%)		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
95.4%	93.6%	↓	96.9%	94.0%	↓



YAS 15 Minute Handover Performance					
Scarborough site (Target 100%)			York site (Target 100%)		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
73.7%	44.6%	↓	69.7%	50.7%	↓

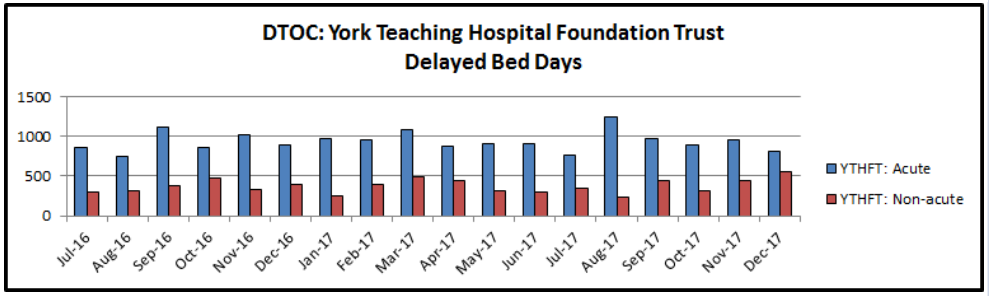


York Teaching Hospital Foundation Trust: ED 4 hour standard					
All Types Attendances			All Types % within 4 hours		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
15,158	16,236	↑	91.7%	83.0%	↓

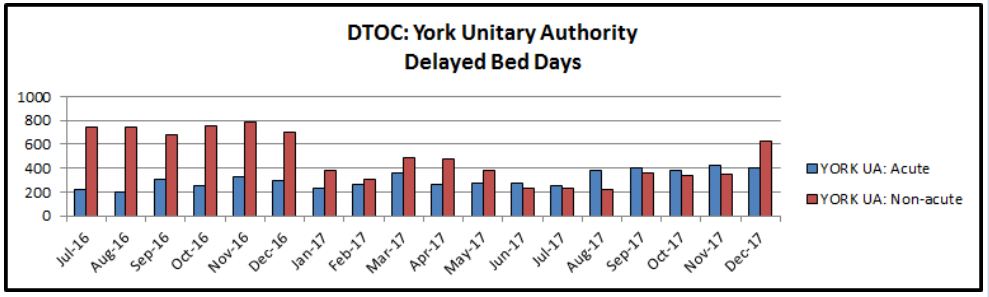


PERFORMANCE UNPLANNED CARE: DELAYED TRANSFERS OF CARE

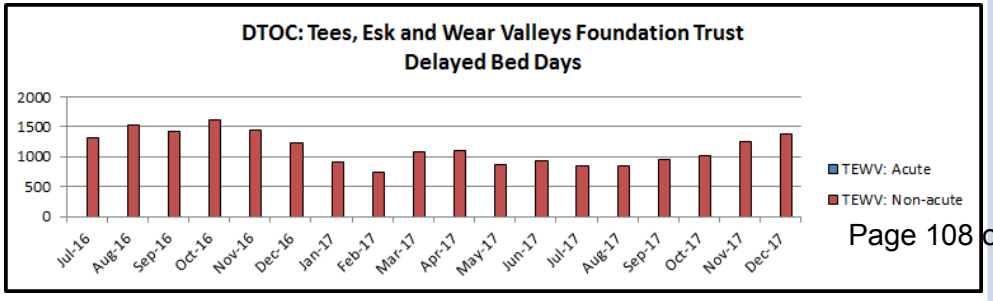
DTOC: YTHFT Delayed Bed Days					
Acute			Non-acute		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
955	802	⇩	439	556	⇧



DTOC: York UA Delayed Bed Days					
Acute			Non-acute		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
427	399	⇩	350	626	⇧



DTOC: TEWV Delayed Bed Days					
Acute			Non-acute		
Nov-17	Dec-17	DoT	Nov-17	Dec-17	DoT
N/A	N/A	N/A	1258	1376	⇧



The number of bed days for acute DTOCs at York Trust reduced to 802 in December 2017 from 955 in November 2017. However the number of beds days for non-acute DTOCs increased to 556 in December from 439 in November 2017. The overall number of non-acute bed days in York Unitary Authority increased significantly from 350 to 626.

York Hospital experienced sustained pressure linked to the influenza strains and respiratory viruses within the local community in December. Patients were cohorted on Ward 23 which was designated the 'flu ward' during December and January 2018. Any patient who could be moved to either a Community Hospital or step down bed was discharged there until they were medically fit, leading to the increase in the number of non-acute bed days for YTHFT.

Another reason for the increase in non-acute reporting in December is down to TEWV DTOCs which have increased recently. There are a number of complex TEWV patients in York and NYCC who have gone out to CHC brokerage but they have been unable to find a placement, due in part to the shortage of EMI nursing beds in York and North Yorkshire. There is a meeting on 14th February to discuss these complex discharges.

CYC, NYCC and ERCC are being proactive in providing financial resource but there are some areas that are difficult to recruit to even with money available. Carers are often working mums and consequently cannot or do not want to work during school holidays, which puts extra pressure on the system as the councils cannot provide the volume of carers required to meet demand, meaning patients can end up waiting in hospital until the required care is available.

PERFORMANCE UNPLANNED CARE: DELAYED TRANSFERS OF CARE (continued)

Actions to address the poor performance include:

1. With effect from Saturday 2 December 2017 Social Workers and Care Staff are working 7 days per week to facilitate discharges from York Hospital.
2. Vale of York CCG purchased ad hoc step down beds to accommodate 7 rehab patients from York Trust in January 2018.
3. CYC increased the number of hours for packages of home care from providers in January 2018 to assist with discharges.
4. Continuing health care – executive lead in place to direct a programme of work, including systems/process/capacity pressures. CHC nurses now co-located at Archways with hospital discharge team and social workers.

KEY QUESTIONS : PERFORMANCE UNPLANNED CARE

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

- **4-hour standard:** Performance deteriorated significantly on some occasions over the Christmas and New Year period and into January 2018.
- **Ambulance Handovers:** Handover performance dipped on several occasions during the above pressure on performance but has recovered well each time. A number of standing and ad-hoc diverts have been in place.
- **YAS response times**: There is an ARP meeting for the region in February that will help inform the best way to continue to monitor targets.
- **OOH GP:** services have recovered in January 2018 and show improvement.
- **EDFD:** YTHFT have acknowledged errors in coding and counting although relate some of these to diagnostic tests performed. Contracting putting forward a new financial proposal. Clinical model will still require review.
- **NHS111:** performance recovered well after the New Year and maintains a good level of provision.
- **DTOC:** There has been a significant drop in performance during December and January although new capacity (including weekend discharge support) continues to come online and discharge hub has commenced.
- **Utilisation review**: VoY and S'boro have confirmed they are not planning to repeat this report at this time. Ongoing use of existing data continues.

Note; twice daily system communication calls have been taking place at peak times.

What mitigating actions are underway?

- **4-hour standard:** YTHFT have been informed by NHSI that they will not receive the STF funding allocated as targets have not been met. Discussions are ongoing; potentially this is a system loss of £1.2m.
- **Ambulance Handovers:** close monitoring during performance dips has meant flexible diverts, additional operational staff and rapid escalation have all been able to continue to support teams.
- **YAS response times:** monitoring continues prior to ARP meeting.
- **OOH GP:** No mitigating actions required at present; monitoring continues.
- **EDFD:** Contracting working on latest proposal. Need review team.
- **NHS111:** No mitigating actions required at present; monitoring continues.
- **DTOC:** Complex discharge group met at start of February, actions progressing, One Team work ongoing, Integrated Discharge Hub meeting daily, additional weekend support in place. Spot purchase taking place and CHC beds ring-fenced.
- **Utilisation review:** individual actions from the AEDB are being escalated as required.

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

- **4-hour standard:** currently we are not meeting the joint trajectory, although NHSE have been supporting system calls and understand that all actions are being undertaken to manage performance. Rollout of winter funding supported schemes continues. 31/03 is still the system 90% recovery date.
- **Ambulance Handovers:** current performance matches that seen regionally; monitoring to continue.
- **YAS response times:** monitoring continues prior to ARP meeting.
- **OOH GP:** not applicable at present.
- **EDFD**: Revised paper due by 28/02.
- **NHS111**: not applicable at present.
- **DTOC**: trajectory now agreed, actions underway, winter funding to support. Escalation of issues to senior teams taking place.
- **Utilisation review**: not applicable at present.

Is further escalation required?

- **4-hour standard:** Daily system calls (and twice daily as required) have been taking place over the last period and are continuing. NHSE and on-call Director escalation is taking place as required. All partners are communicating need effectively and offering joint support. First week of February (Rotation week) was difficult, but back at 85%+ at present.
- **Ambulance Handovers**: updated plans circulated, emphasis on team working.
- **YAS response times**: No
- **OOH GP**: No
- **EDFD**: Not at present
- **NHS111**: No
- **DTOC**: Yes, escalation is continuing with a significant system focus and support from winter planning.

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

Validated data to December (Month 09)

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

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

NHS
Vale of York
Clinical Commissioning Group

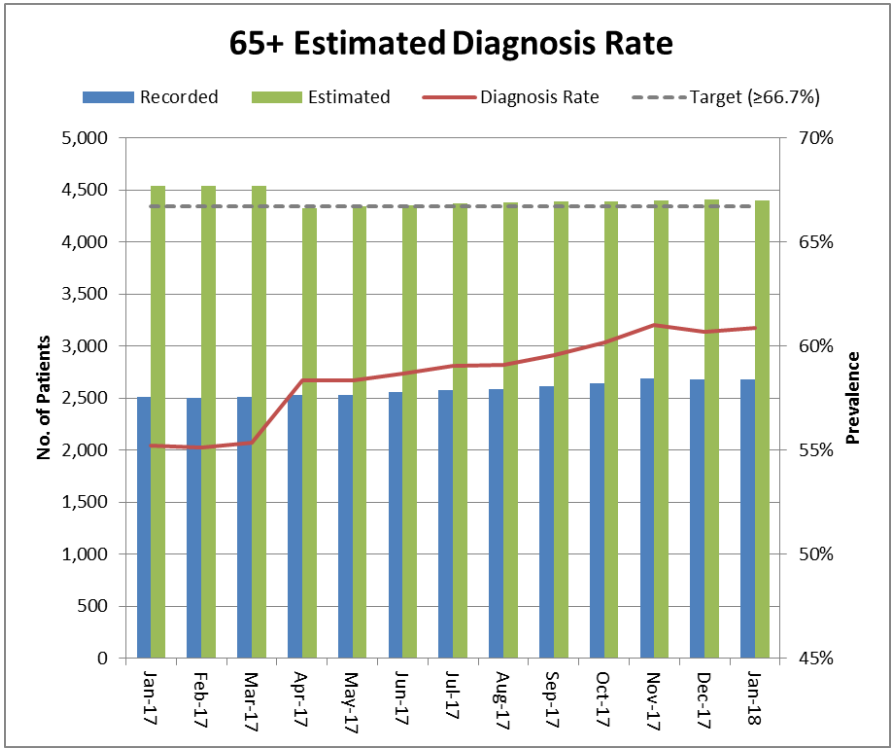
MENTAL HEALTH, LEARNING DISABILITY SERVICES, COMPLEX CARE & CHILDREN: CONTRACT MONTH 10

	Cumulative To Date			Forecast Outturn		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Mental Health Services						
Tees Esk and Wear Valleys NHS Foundation Trust	33,035	33,160	(125)	39,644	39,795	(150)
Out of Contract Placements and SRBI	4,356	6,657	(2,301)	5,227	7,316	(2,090)
Non-Contracted Activity - MH	351	364	(12)	421	434	(12)
Other Mental Health	194	194	0	250	249	0
Total	**37,936**	**40,375**	**(2,439)**	**45,542**	**47,794**	**(2,252)**
Continung Healthcare						
Continuing Care	21,840	24,111	(2,271)	25,990	27,494	(1,504)
Funded Nursing Care	4,171	3,656	515	5,005	3,863	1,142
Total	**26,011**	**27,767**	**(1,756)**	**30,995**	**31,357**	**(362)**

See QIPP delivery highlights from financial recovery incorporated in Finance report

PERFORMANCE : MENTAL HEALTH

Dementia				
65+ Estimated Diagnosis Rate				
Oct-17	Nov-17	Dec-17	Jan-18	DoT
60.2%	61.0%	60.7%	60.9%	↑



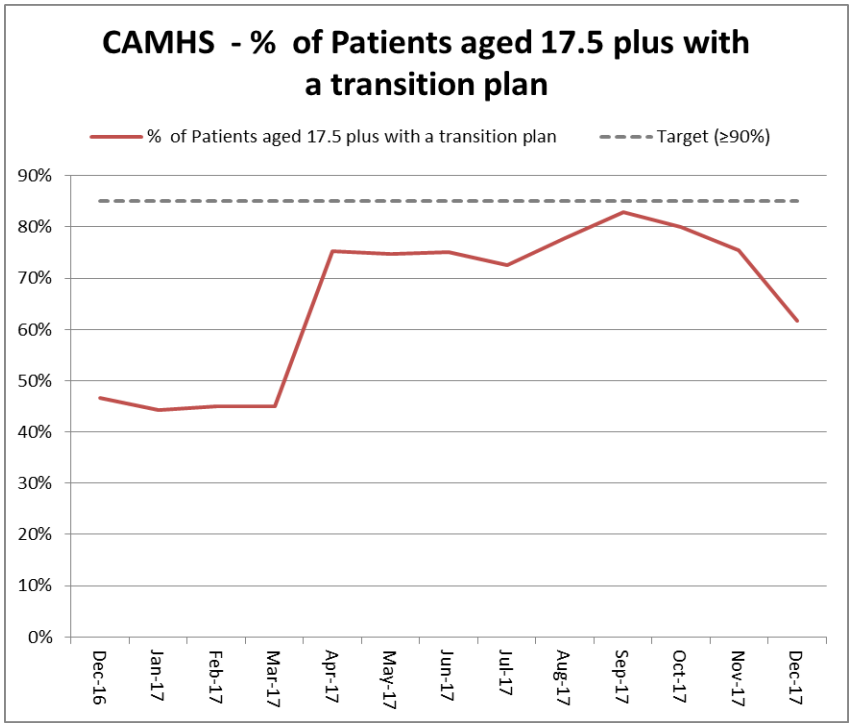
Practice Name	Jan-18	Estimated Prevalence	Prevalance	Additional Number Required to Achieve 66.7%
BEECH TREE SURGERY	177	230	77.0%	Target Met
DALTON TERRACE SURGERY	42	99	42.4%	24
EAST PARADE MEDICAL PRACTICE	18	39	46.2%	8
ELVINGTON MEDICAL PRACTICE	97	122	79.5%	Target Met
ESCRICK SURGERY	51	80	63.8%	2
FRONT STREET SURGERY	38	95	40.0%	25
HAXBY GROUP PRACTICE	413	458	90.2%	Target Met
HELMSLEY SURGERY	27	55	49.1%	10
JORVIK GILLYGATE PRACTICE	103	164	62.8%	6
KIRKBYMOORSIDE SURGERY	56	97	57.7%	9
MILLFIELD SURGERY	72	109	66.1%	1
MY HEALTH GROUP	179	304	58.9%	24
PICKERING MEDICAL PRACTICE	107	203	52.7%	28
POCKLINGTON GROUP PRACTICE	110	197	55.8%	21
POSTERNGATE SURGERY	139	230	60.4%	14
PRIORY MEDICAL GROUP	475	710	66.9%	Target Met
SCOTT ROAD MEDICAL CENTRE	61	74	82.4%	Target Met
SHERBURN GROUP PRACTICE	81	104	77.9%	Target Met
SOUTH MILFORD SURGERY	41	100	41.0%	26
STILLINGTON SURGERY	26	51	51.0%	8
TADCASTER MEDICAL CENTRE	57	102	55.9%	11
TERRINGTON SURGERY	6	14	42.9%	3
THE OLD SCHOOL MEDICAL PRACTICE	41	87	47.1%	17
TOLLERTON SURGERY	16	44	36.4%	13
UNITY HEALTH	44	85	51.8%	13
YORK MEDICAL GROUP	203	447	45.4%	95
TOTAL	**2680**	**4,300**	**62.3%**	**185**

65+ Dementia Diagnosis rate increased from 60.7% in December 2017 to 60.9% in January 2018

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

PERFORMANCE : MENTAL HEALTH

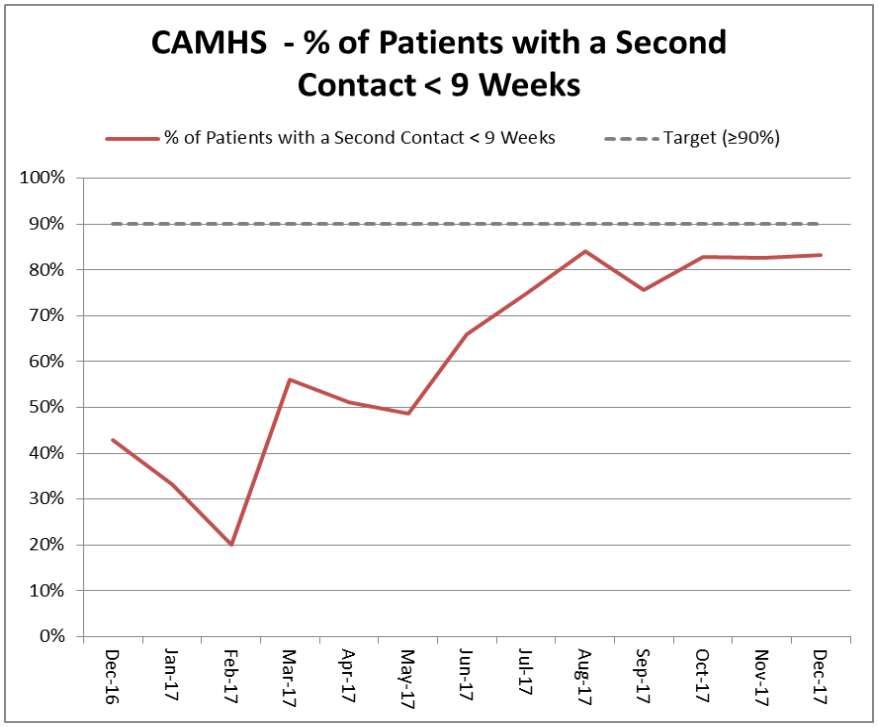
CAMHS				
% of Patients aged 17.5 plus with a transition plan				
Sep-17	Oct-17	Nov-17	Dec-17	DoT
82.8%	80.0%	75.4%	61.6%	↓



The position for December is 62.64%, which is attributable to 28 breaches out of 73 patients.

Reason	Count
New to Service	8
Next Attendance	7
Discharged	7
No Recent Engagement	5
Completed	1
	28

CAMHS				
% of Patients with a Second Contact < 9 Weeks				
Sep-17	Oct-17	Nov-17	Dec-17	DoT
75.6%	82.9%	82.6%	83.2%	↑



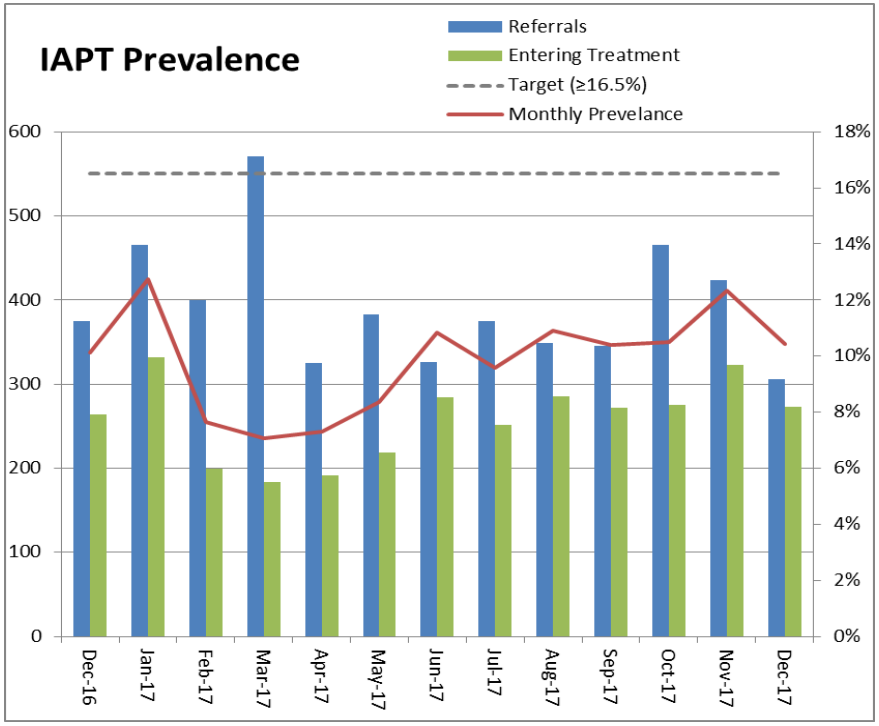
The position for December is 83.15%, which is attributable to 15 breaches out of 89 patients.

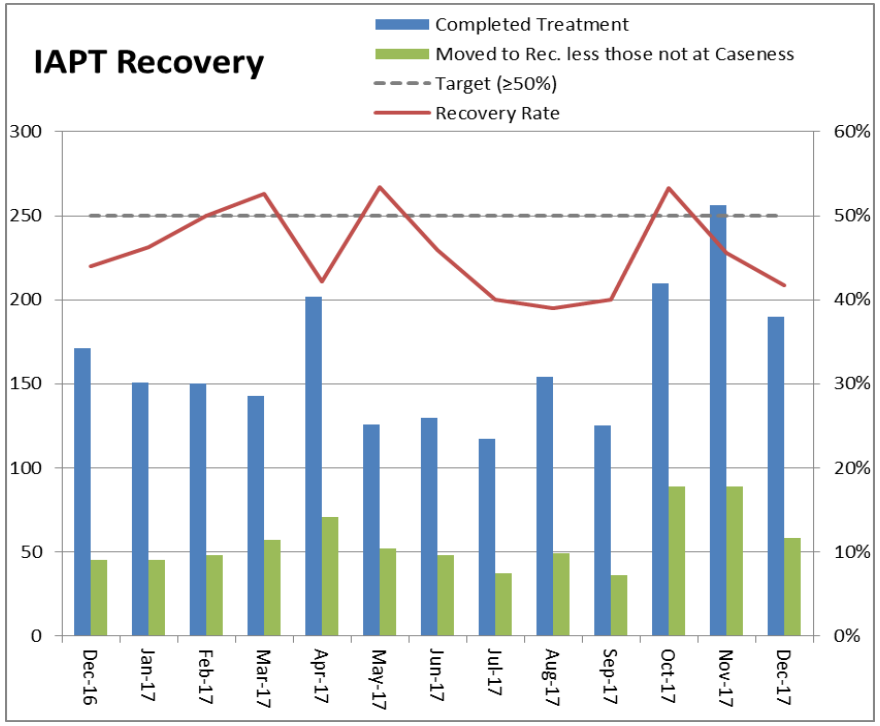
Reason	Count
Staff Capacity	9
Availability of Specialist Workers	3
Other (1 Data Quality, 1 Crisis, 1 Patient Choice)	3
	15

PERFORMANCE : MENTAL HEALTH

IAPT Prevalence				
Org.	**Oct-17**	**Nov-17**	**Dec-17**	**DOT**
TEWV	10.0%	11.6%	10.3%	↓
Humber	21.7%	29.6%	13.9%	↓
Combined	**10.5%**	**12.3%**	**10.4%**	↓

IAPT Recovery				
Org.	**Oct-17**	**Nov-17**	**Dec-17**	**DOT**
TEWV	50.6%	44.0%	39.6%	↓
Humber	76.2%	56.7%	62.5%	↑
Combined	**53.3%**	**45.6%**	**41.7%**	↓



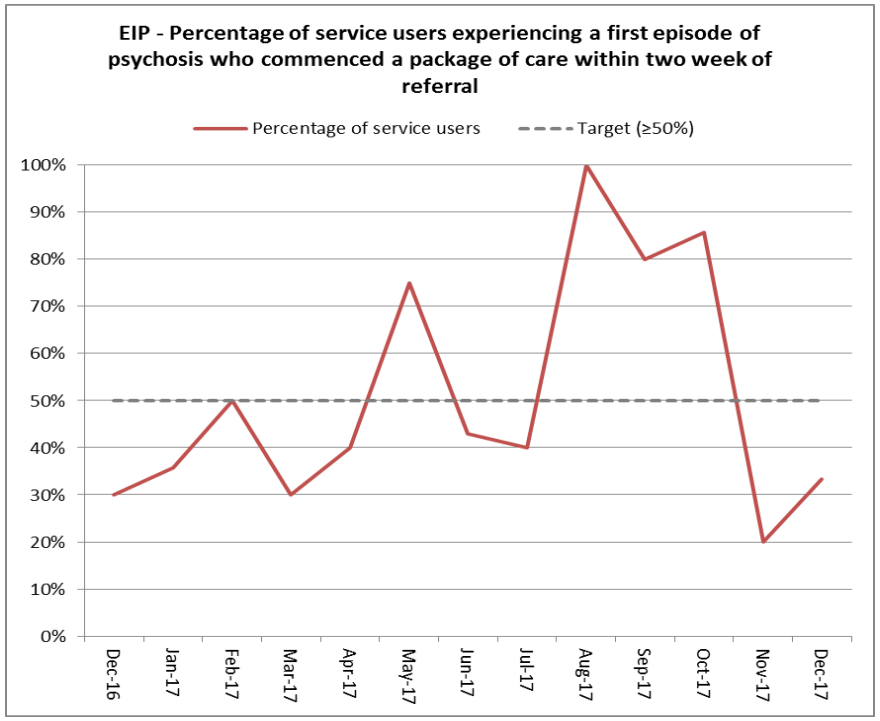


The position for December is 10.4% across TEWV and Humber. This is a reduction from 12.3% in November. There has been a drop off in activity in December with only 273 patients entering treatment compared to 323 in November.

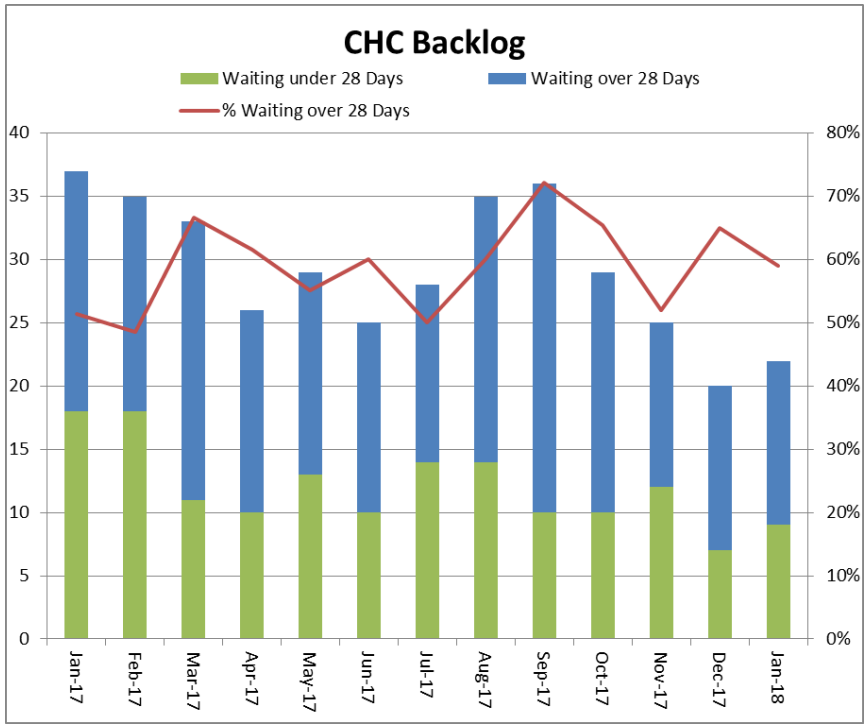
The position for December is 41.7% across TEWW and Humber. This is a reduction from 45.6% in November. Humber's position improved over the period but TEWV saw a drop off in the number moving to recovery.

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				
Sep-17	Oct-17	Nov-17	Dec-17	DoT
80.0%	85.7%	20.0%	33.3%	↑



Continuing Healthcare			
Backlog			
Nov-17	Dec-17	Jan-18	DoT
52.0%	65.0%	59.1%	↓



Months Waiting					
1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	Total
3	6	1	1	1	12

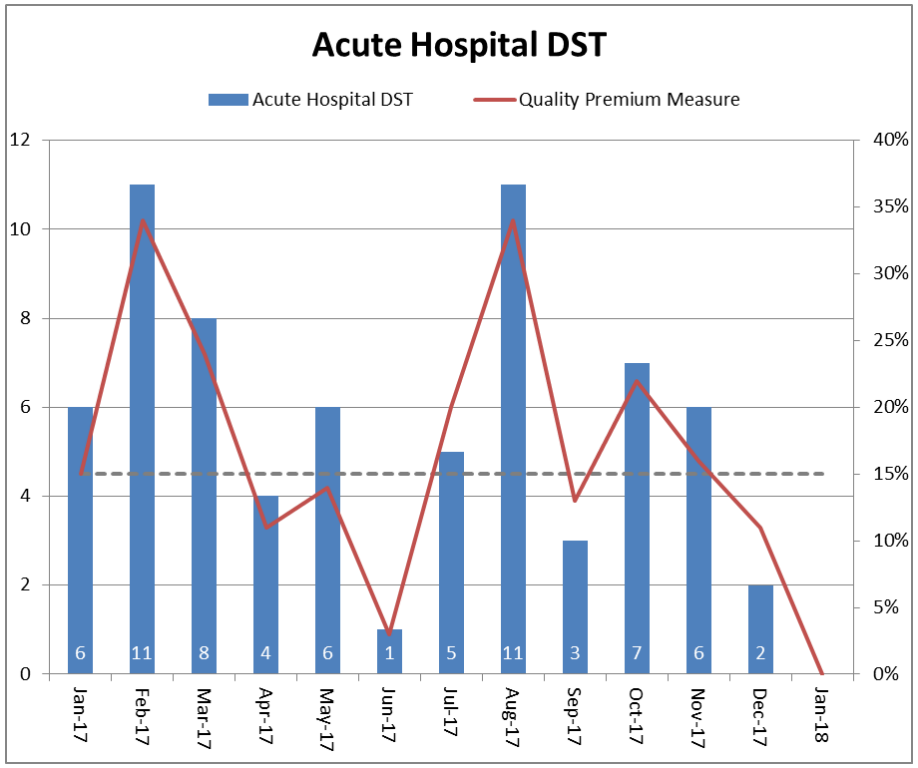
The adverse movement in the position is attributable to 2 breaches.

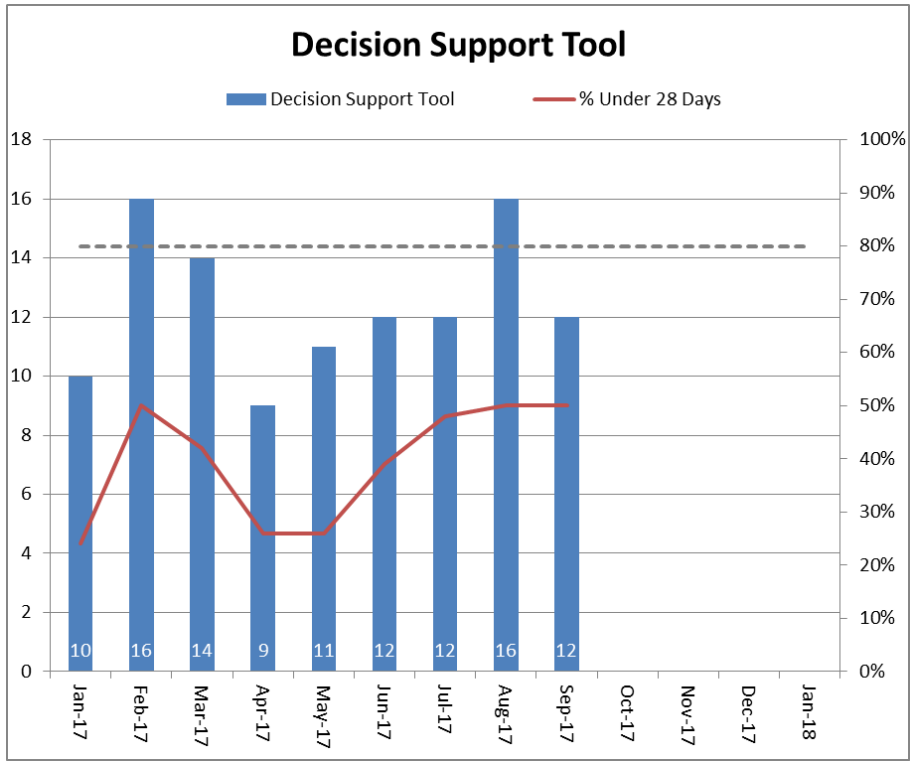
- 1 breach was attributed to staff vacancy which is being addressed by vacancy control
- 1 breach due to the patient rearranging their initial appointment.

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

NB. Incorrect arrow above – should be positive DoT

PERFORMANCE : MENTAL HEALTH / CONTINUING HEALTHCARE





Target of less than 15% of DSTs done in an acute setting – performance has improved. Now 0% for January 2018 due to Discharge to assess pathway.

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

Note: From Oct-17 a new process has been put in place that now only report DSTs completed in period.

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

Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
Mental Health: **IAPT :** No **Dementia :** No **CAMHS :** No **EIP:** No **Psych Liaison**: No **CHC :** **Monthly Acute Hospital DST Activity :** Yes **Decision Support Tool :** No	**IAPT** : The CCG continues to monitor progress against the action plan at the CMB. The Performance Sub-group received a report giving the CCG assurance of achieving 15% by 31/3/2018 and clearance of the backlog identified by the IST. CMB is expecting a business case on 19th February which will outlines TEWV's long term plans for achieving targets up until 2021. Unvalidated data for January shows an access rate of 15.3% **Dementia** : Discussions with primary care colleagues have taken place to understand the drivers to get over the inertia in progress. Several GP leads have been approached directly to provide support and action. The Clinical Lead will be undertaking direct clinical caseload review with the practices with the most significant gaps in coding. **CAMHS** : Performance and progress on the action plan will be monitored by CMB. **EIP** : A deep dive conducted by NHS England/TEWV/CCG identifies a gap in resources and additional referrals to the service due to unprecedented levels of activity. **Psychiatric Liaison :** The CCG is evaluating the current level of activity and will continue to monitor the shortfall in performance at the monthly CMB. **CHC:** continuing to validate FNC reviews to assess how many require a full DST and how many an annual review, supported by NECs CSU as part of QIPP programme. NECs not currently started the work. **PHB**: targets for increasing the numbers are not being met-review of opportunity and process underway. **DST**s done out of hospital improving due to discharge to assess pathway & performance management.
Is there a trajectory and a date for recovery / improvement?	**Is further escalation required?**
IAPT : Yes – Action plan in place to achieve 15% access and 50% recovery sustainably during Qtr4 2017/18. This is lower than the current national target of 16.8%. Work is underway to develop plans for increasing targets beyond 2018 and depends on future investment. **Dementia :** The tasks in the action plan support progress towards delivery of the national target of 66.7% and this will be reviewed regularly. Additional remedial actions are being implemented as further mitigation. **CAMHS :** Work is on-going with TEWV to meet required performance targets. **EIP** : Continues to be monitored at CMB and identified as a	**IAPT recovery:** Verbal update to F & P Committee. **Dementia :** Verbal update to F & P Committee. **CAMHS :** Verbal update to F & P Committee **EIP** : Verbal update to F & P Committee **Psychiatric Liaison :** No escalation required at this stage. ***CHC :*** *No further escalation at present but verbal update to F&P Committee on 22nd February, if required.*

Programme Overview - Primary care

January 2018

Scheme Name	Ref	Planned start date	YTD Planned savings £000	YTD Expected savings £000	YTD Actual savings £000	Forecast Outturn Planned savings £000	Forecast Outturn Expected savings £000	Forecast Outturn Actual savings £000	Comments
PRIMARY CARE									
Dermatology Indicative Budgets	195	Apr-17	36	36	28	36	36	28	Scheme in place since 2016/17, saving in 2017/18 is FYE. YTD saving based on forecast until validated acute data available
GP IT - NYNET	003	May-17	150	150	150	183	183	183	Scheme up and running?
Roll out indicative budgets to other specialities	020	Jul-17	58	58	0	75	75	0	

See QIPP delivery highlights from financial recovery incorporated in Finance report

Annex 1: Supporting performance reports

Validated data to December (Month 09)

ANNEXES

To be shared before Committee (due Tuesday 20th Feb)	**Public Performance Report** York Trust overview of Performance.
To be shared before Committee (due Tuesday 20th Feb)	**Performance Headlines** York Trust detailed Performance report covering key metrics inc. Emergency Care Standard, Cancer, RTT & Diagnostics.
 NHSE Elective funding bid YFT Fe	**Summary of bid for additional winter elective funding to NHSE (not as yet confirmed)**

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
CAMHS	Child and Adolescent Mental Health Services
CC	Continuing Care
CEP	Capped Expenditure Process
CGA	Comprehensive Geriatric Assessment
CHC	Continuing Healthcare
CMB	Contract Management Board
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (framework)
CRUK	Cancer Research UK
CT	Computerised Tomography Scan
CYC	City of York Council
DNA	Did not attend
DTOC	Delayed Transfer of Care
DEXA	Dual energy X-ray absorptiometry scan
DQIP	Data Quality Improvement Plan (in standard acute contract)
ED	Emergency Department
EDFD	Emergency Department Front Door
EMI	Elderly Mentally Infirm

Acronyms continued

ENT	Ears 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	Integrated Assurance Framework (NHS England)
IAPT	Improving Access to Psychological Therapies
IFR	Individual Funding Review (complex care)
IPT	Inter-provider transfer (Cancer)
IST	Intensive Support Team
LA	Local Authority
LD	Learning Disabilities
LDR	Local Digital Roadmap
MCP	Multi-Care Practitioner
MDT	Multi Disciplinary Team
MH	Mental health
MMT	Medicines Management Team

Acronyms continued

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

Acronyms continued

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

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Item Number: 11

Name of Presenter: Dr Shaun O'Connell

Meeting of the Governing Body

Date of meeting: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – Standard Operating Procedure for the approval of commissioning thresholds

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

Reason for Report

NHS Commissioning organisations can decide their specific commissioning policies for a wide variety of conditions, according to the evidence of cost effectiveness and appropriate prioritisation of use of NHS resources.

CCGs inherited many of their commissioning thresholds from predecessor Primary Care Trusts. As Sustainability and Transformation Partnerships (STP) were developed, an attempt to agree policy harmonisation across the six CCGs of the Humber Coast and Vale STP was initiated. Embarking on this STP harmonisation work has led Vale of York CCG to review their governance/sign off process with an aim to clearly document and define the process within the organisation.

It is proposed that once ratified, working in conjunction with other CCG colleagues we will start to review the CCGs threshold documents starting with the STP proposed policies and align where possible. If this is not possible on an STP level we will look to align at a local level with NHS Scarborough & Ryedale CCG (SRCCG). It is also worth noting that this process is integrated with SRCCG ensuring alignment across both CCGs thus helping reduce complexity with providers, in particular York Teaching Hospitals NHS Foundation Trust.

The process outlined in the attached document has been approved internally by the Clinical Executive and Governing Body Part II and it is now presented to the Governing Body for ratification.

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)

Clear governance processes are required for commissioning policy, without these the CCG is at risk of challenge.

Without the clear establishment of thresholds through the agreement of commissioning statements, the CCG is not able to monitor referrals into secondary care or activity within secondary care to establish if it is within CCG policy or not. This risks variation and by definition unnecessary use of resources.

Recommendations

The Governing Body is asked to consider

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

Responsible Executive Director and Title	Report Author and Title
Dr Shaun O'Connell Joint Medical Director	Dr Shaun O'Connell Joint Medical Director

Annexes (please list)

Annex 1 – Standard Operating Procedure for approval of Commissioning Thresholds

Standard Operating Procedure
Process for approval of CCG Commissioning Statements

The process below assumes VoY Governing Body has delegated authority to the Executive Committee.

1. **Initial draft documents** (version 1.x) will be created by the combined NHS Vale of York and Scarborough and Ryedale CCGs joint planned care team. The team will use each CCG's historical position, drafts from the STP process and from amendments and proposals suggested internally and with reference to other CCGs' policies.

2. **First final drafts** (v2.x) will be shared for consultation with the following stakeholders
   1) contracting colleagues
   2) local specialists (GPSI or Consultant)
   3) Vale of York and Scarborough and Ryedale Local Medical Committees
   4) Clinical Chair and Governing Body GP representatives
   5) the Clinical Executive (VoY Committee only)
   6) CCGs in the STP
   7) CCG Pharmacy colleagues (at both CCGs)

   A 2-4 week turnaround will be provided for all stakeholders to respond. Where stakeholders have not responded in this time they will be deemed to have no concerns about the first final draft.

   At the same time impact assessments will be undertaken if there is a material change to a policy. Where a policy is being reviewed and not changed impact assessments will not be carried out.

3. Following the outcome of the consultation, a **Near Final Draft** (v3.x) will be prepared and the impact assessments will be reviewed.

4. The **Near Final draft** (v3.x) and supporting impact assessments (where applicable) will be prepared for submission to the appropriate Committee for consideration and approval. For VoYCCG this will be done by the Executive Committee (VoY), and for SRCCG their Business Committee. However, where the Committees feel they are unable to make a decision, for example, where significant financial/political/public interest or reputational risk is a factor they may pass to the relevant CCG Governing Body for the decision to be made.

5. Once approved a **Final document** (FINAL) will be prepared and communicated as soon as possible to the following stakeholders:

- CCG Contracting colleagues –to submit to providers via CMB and formulate contract variation documents
- Primary and Secondary care colleagues
- Individual Funding Request team
- CCGs in the Humber Coast and Vale STP
- Published on the RSS pages of the CCGs websites

6. A summary of the decisions made at Executive Committee will be received by the Governing Body as required. SR CCG Governing Body will receive the minutes and outcome of the relevant Business Committee

Commissioning Statement Version Control Tracker

It is proposed that the CCG's system for policy documents will be adopted to ensure correct version control and approval tracking.

Item Number: 12

Name of Presenter: Michelle Carrington

Meeting of the Governing Body **Date of meeting: 1 March 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
Quality in Care Homes – work plan update

City of York Council withdrawal from the Infection Prevention and Control Service

Children in Care Update

Further information and assurance regarding York Teaching Hospital NHS Foundation Trusts Never Events

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
N/A

Responsible Chief Officer and Title	**Report Author and Title**
Michelle Carrington (Chief Nurse)	Quality Team

Vale of York
Clinical Commissioning Group

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

The General Practice Nursing Awards (GPN) Awards
To recognise the vital contribution that GPNs undertake the Yorkshire & the Humber General Practice Nursing Awards Committee are hosting an awards ceremony in February. The awards will be hosted in each STP and nominations are being encouraged widely. The Quality Lead for Primary Care is making further contact with all practices to encourage submission of more nominations.

Learning Disabilities & Screening
The Quality Lead for Primary Care continues to work collaboratively with other CCG staff and relevant stakeholders to promote improved screening rates for those with learning disabilities. There has been a good response to the LD questionnaire which was distributed across primary care and the outcomes will be shared across primary care and the Learning Disabilities and Screening Task Force Group.

The Quality Lead for Primary Care met with a local GP partner and LD lead for their practice to discuss provision and delivery of care related to LD. The aid GP subsequently invited the Quality Lead for Primary Care and a representative from TEWV to their joint review of the LD register. This will provide a broader understanding of how strategic management influences operational delivery.

A further meeting was held in January 2018 which was attended by all those associated with LD across the CCG and the resultant actions were identified.

1. LD Screening & Taskforce meeting; working across the STP footprint to improve health measures.
2. Ascertain base line figures across primary care to determine current cancer screening uptake for patients with a learning disability and ascertain the support GP Practices offer.
3. Development of central repository for easy read resources.
4. Development of a care pathway for preconception care planning.
5. Encourage uptake of screening

6. Quality assure easy read invite letters and aids to support care in practice e.g. body maps.
7. Improved communications with primary care. Draft copy of LD bulletin.
8. Improved communications within the CCG relating to LD.
9. Improve CCG staff knowledge relevant to LD and how the CCG support this
10. Continued engagement with the Learning Disability Forum.
11. Encourage primary care to identify patients with LD on computer records.
12. Ascertain the GP practices who have signed up for a QOF (LD register) and also those who have opted for a Designated Enhanced Service. CCG to assume responsibility for meeting the needs of the population for those surgeries without QOF/DES.

Safeguarding Children

Children in Care
Children in Care from out of area placed within a Private Provider home in North Yorkshire:

- The issue of access to Child and Adolescent Mental Health Service (CAMHS) provision was raised at the CCG/Tees Esk and Wear Valley (TEWV) NHS Trust Quality meeting in January. TEWV have agreed to review the trusts involvement with young people from the three homes identified and the impact on local resources.

- The Designated Nurse has very recently become aware that this private provider has requested that 'YorSexual Health' (NHS provider of Contraception and Sexual Health Services in York and North Yorkshire) assist staff within the homes to develop an information tool in order to support young people's understanding of their sexual health needs. It is of concern that, although this provider promotes these particular homes as a specialist therapeutic environment for young people thought to be at risk of child sexual exploitation, that such fundamental aspects of the young people's care is not available from within the organisation itself. This issue will be raised directly with senior managers within the provider.

- The Named Nurse for Looked After Children who is employed by Harrogate District Foundation Trust (HDFT) continues to provide expert health advice, support and training to the staff employed by the private provider homes in order to support the operational staff's ability to recognise and respond to safeguarding concerns and to be able to fully address the young people's health needs.

Timeliness of Health Assessments for Children in Care
The Designated Professionals are developing a more detailed reporting system regarding health assessments which would give the CCG improved information about the children for whom the CCG is responsible. Additionally this report will detail the performance of the local provider of health assessments. The first report will be presented at the next QPEC.

The latest Health Assessment Quality Assurance Audit, undertaken by the Designated Doctors, demonstrates some areas of improvement as well as areas for development. Training has been delivered across North Yorkshire and it is hoped that next quality audit will evidence some progress.

Infection Prevention & Control (IPC)

City of York Council (CYC) withdrawal from Community IPC service
CYC have served notice on their contribution to the shared Harrogate District Foundation Trust shared Community IPC service hosted by HARD CCG. This will take effect from 1st April 2018.
This carries significant risk to the on-going management and support of IPC outbreaks across Care Homes within the CYC boundary and has the potential to adversely affect patient outcomes as well as increased hospital admissions.
The service specification had already been revised before the CYC decision was known and therefore is now at risk of de-stabilising the shared contract.

York Teaching Hospital NHS Foundation Trust team update
YTHFT have undergone a review of their IPC team and revised their structure. A new role has been created with responsibility for IPC across community sites and staff in the community with an additional lead on Infection Prevention education. The new team structure is in place and the CCG leads including the CCG lead IPC nurse will meet the new IPC Lead Nurse to collaborate on ways of working together to progress the IPC agenda.

Norovirus
Whilst norovirus has remained a continued presence both in YTHFT and the community the number of community outbreaks across the Vale of York to date has been lower than last year.

The table below demonstrates this. This is thought to be due to alterations in the circulating strain of norovirus which alters in the same way cold and flu viruses do. Prompt identification and implementation of IPC measures reduces the spread so the work of the community IPC team with the homes is essential. Norovirus has been present intermittently in YTHFT but to date less so than previous years-probably due to the reduction in community cases.

Dates	Number of care homes affected in NYY CCG's	Number of care homes affected in VoY CCG only
September 2017 - January 2018	38	23
September 2016 – January 2017	52	16

The Community Infection Prevention team support care homes and provide advice and education upon request. A detailed review of the shared service specification

hosted by Harrogate and Rural District CCG is underway to better describe the service and the team's contribution to Care Homes as an important component of this.

Influenza (flu)

An increased incidence of influenza was anticipated due to surveillance provided from the southern hemisphere and that incidence has been low over several preceding years. Whilst there has been an increased incidence it is not yet categorised as an outbreak or an epidemic by Public Health England.

The vaccination schedule has gone well with CCG data demonstrating uptake above the Yorkshire and Humber average. Uptake in all categories is in line with or above targets except for those under the age of 65 who are at risk. The vaccination of schoolchildren managed by the community immunisation team has gone well. However it is acknowledged that accumulated GP practice totals will disguise practices with low uptake data. This data is available and has been shared with GP practices. The Quality and Nursing team and Primary Care commissioning team will support improvements.

An update on whether the flu vaccination campaign will be extended past the end of January has yet to be received.

The uptake of the flu vaccination in healthcare workers is monitored. YTHFT had achieved a commendable uptake of 70% as of the end of December 2017. TEWV have reported an overall Trust staff uptake of 60%, an increase of 4.7%.

As previously reported Primary care reporting is not mandated; 14 out of 26 practices in the CCG are currently updating their data. Discussions on how to improve this will take place with the screening and immunisations team and the Primary Care commission team.

Influenza has been an issue in both Care Homes and YTHFT this year with different strains providing real challenge to the isolation of affected patients. Data relating to the number of care home staff vaccinated is unknown however NHS England (NHSE) have funded the vaccination. The community IPC team have recently provided guidance to help prevent the spread of flu within Care Homes.

The uptake of flu vaccination in pregnancy has increased and the CCG have worked with maternity services and the Screening and Immunisations team to produce a video educating women on the benefits of vaccination in pregnancy. This is available on the CCG, Trust and Mumbler website. Mumbler is an online parenting community. To date the video has received over 17, 000 views. The antenatal clinic manager who is in the video explaining the benefits for women and their babies was approached by a pregnant woman at the Designer Outlet who said she had had the vaccination after seeing her in the video. http://www.valeofyorkccg.nhs.uk/winter/the-flu-vaccine/

Any learning and recommendations from this year's campaign will be incorporated into next year's flu plan.

Serious Incidents (SIs)

Definition
Serious Incidents are reported by NHS organisations in line with the NHSE Serious Incident framework. A Serious Incident acknowledges that the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is necessary.

The definition of what constitutes a Serious Incident as opposed to an adverse event or incident is, according to the SI Framework an incident, acts or omissions in care which result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm.

The process of correctly identifying, reporting and identifying learning from Serious Incidents provides valuable insight into the governance culture within an organisation. Although high levels of incident reporting can be indicative of a healthy culture in recognising the importance of learning when things go wrong, any failure to demonstrate learning by the recurrence of similar incidents raises concerns.

The table below illustrates the number of Serious Incidents raised by providers compared to the previous year. All providers, with the exception of Independent providers have reported a reduced number which collectively is a reassuring position. The increase in the number of serious Incidents reported by Independent providers is more apparent due to the small numbers with the variation being emphasised. To date 4 Serious incidents have been logged by Yorkshire Doctors Urgent Care, 1 by St Catherine's Hospice and 1 by About Health Referral Support in Harrogate.

	York Hospitals	Scarborough Hospitals	TEWV	YAS	HDFT	Independent Providers	All NY CCG SI's
Serious incidents reported during 2016/17	91	59	51	11	131	1	0
Serious incidents YTD	46	35	26	2	46	6	2

Never Events (NE)

Definition
NHSI guidance defines Never Events as Serious Incidents which are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

The list of Never Events has recently been updated and will be in place from February 2018. The new guidance includes the removal of the option for commissioners to impose financial sanctions on Trusts reporting Never Events and aligns the Never Events policy and framework with the Serious Incident framework to achieve consistency across the two documents. The revised Serious Incident framework is expected later in 2018.

Events which should never happen to patients in receipt of NHS care are:-

Surgical

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure

Medication

- Mis-selection of a strong potassium solution
- Administration of medication by the wrong route
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation

Mental health

- Failure to install functional collapsible shower or curtain rails

General

- Falls from poorly restricted windows
- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients
- Unintentional connection of a patient requiring oxygen to an air flowmeter
- Undetected oesophageal intubation

Key Issues from provider Trusts

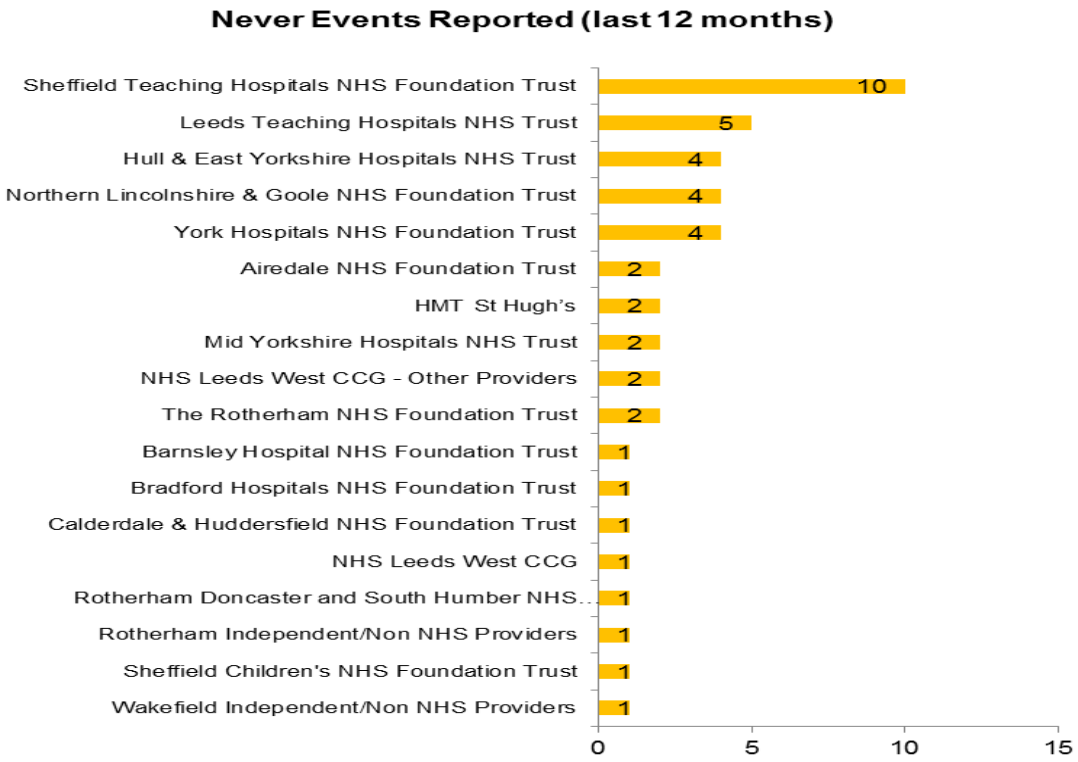
York Teaching Hospital Foundation Trust

Never Events

The CCG have significant concerns about the number and similar type of Never Events reported by YTHFT. There have been 4 Never Events declared by YTHFT to date all related to wrong site surgery; 1 at Scarborough Hospital site, 2 at the York hospital site and 1 at Bridlington Hospital. The CCG, Scarborough and Ryedale CCG (SRCCG) and East Riding CCG (ERCCG) have written to the YTHFT's Medical Director and Chief Nurse describing these significant concerns and a meeting is scheduled in February. Alongside the outcomes of this meeting quality assurance visits are planned to gain additional assurance. They will be take place across all 3

hospital sites and include all 3 CCGs. A detailed update will be provided at the next QPEC.

The tables below demonstrate the number of Serious Incidents and Never Events reported by other organisations across Yorkshire and Humber (Y&H) in the last year with the total for 2017/18 so far 36.



Serious Incidents:

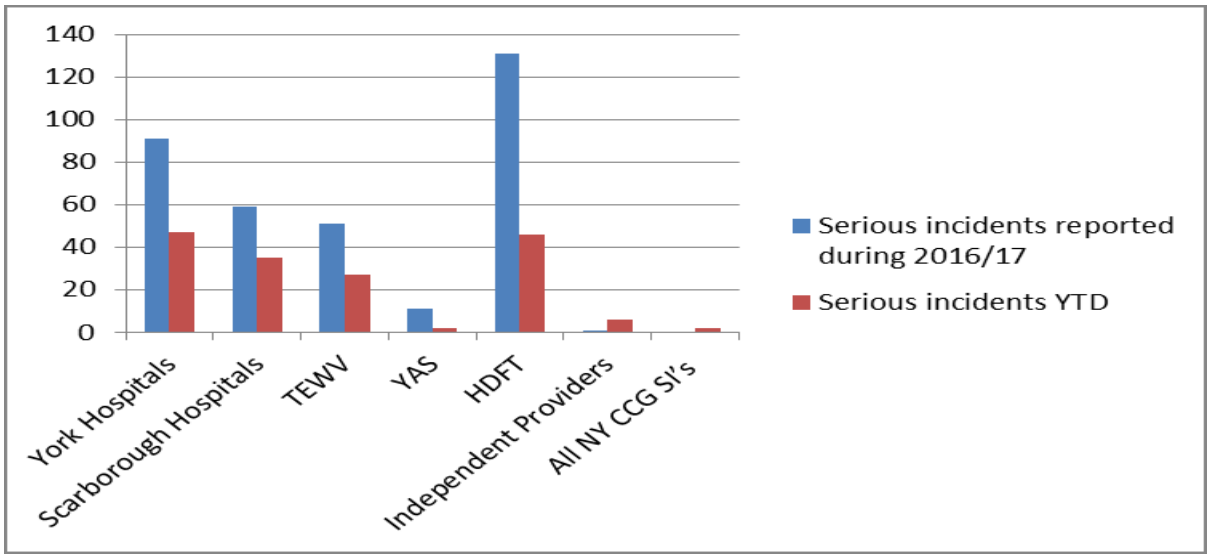
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Other Serious Incidents	126	127	120	133	115	125	149	114	110	129	129	155
Never Events	2	5	4	0	3	11	2	3	4	2	5	6
Never Event Types												
Wrong site surgery	1	2	3	0	0	3	1	2	3	1	2	2
Wrong implant/prosthesis	0	1	0	0	2	2	0	0	1	1	2	3
Retained foreign object	1	2	0	0	1	3	1	0	0	0	1	0
Strong potassium	0	0	0	0	0	0	0	0	0	0	0	0
Wrong route administration	0	0	0	0	0	0	0	0	0	0	0	1
Overdose of Insulin	0	0	1	0	0	0	0	0	0	0	0	0
Overdose of methotrexate	0	0	0	0	0	1	0	0	0	0	0	0
Midazolam	0	0	0	0	0	0	0	0	0	0	0	0
Collapsible shower/curtain rails	0	0	0	0	0	0	0	0	0	0	0	0
Fall from windows	0	0	0	0	0	0	0	0	0	0	0	0
Entrapment in bed rails	0	0	0	0	0	0	0	0	0	0	0	0
Transfusion or transplantation	0	0	0	0	0	0	0	0	0	0	0	0
Misplaced naso/oro-gastric tubes	0	0	0	0	0	2	0	0	0	0	0	0
Scalding of patients	0	0	0	0	0	0	0	1	0	0	0	0

The number of incidents reported to StEIS between October (134) and November (161) has increased by 27, bringing the year to date total to 1062. The Never Event total for 2017/18 so far is 36, of which 6 occurred in November. Wrong implant/prosthesis (3) was the highest reported never event in November.

The tables above demonstrate that surgical cases account for the highest number of Never Events across Y&H. The CCGs have asked NHSE to consider mechanisms to robustly share learning from these and the regional insight in a timely way.

Serious Incidents

The number of SI's reported continues to fall with 17 SIs being declared at York Hospital sites during Q3



Falls and Pressure Ulcers

The number of falls with harm which fit the Serious Incident framework continues to decrease with 5 meeting the SI criteria being reported during Q3. The year to date total is currently 8 compared with 29 reported in the same time period for 2016/17.

However, similar themes and issues continue to be evident in the cases reviewed. A meeting took place with the Deputy Director of Patient Safety before she left the post to review progress against the Trust pressure ulcer and falls reduction action plans. A meeting to discuss these further will be arranged once the new post holder is in place.

There is evidence of a sustained reduction in the number of pressure ulcers being reported which meet the SI framework. In Q3 5 pressure ulcer SIs were reported, compared to 20 SIs in the same time period for 2016/17. Of the 5 reported cases 2 were Category 4, 4 were acute hospital acquired and 1 community services acquired. However there is recognition that further learning needs to be embedded.

CCG attendance at the falls and pressure ulcer panel continues with positive effect. Themes and trends are captured as well as any cases relating to care homes being raised with the CCG's Senior Quality Lead to support on-going quality assurance and surveillance. Neighbouring CCGs and providers are scheduled to attend the panels in January and February to observe the process.

SI Framework Compliance
Adherence to the scope of the current NHS SI Framework contributes to the number of Serious Incidents reported which has been higher than neighbouring acute trusts.

The number of requests for de-logs continues; from April 2017 to date 29 CCG cases and 16 SRCCG delogs have been made which is an increase of 6 since last reported.

Duty of Candour
Evidence of YTHFT's compliance with the duty of candour standards demonstrates improving compliance and embedding of understanding.

Tees, Esk and Wear Valleys (TEWV)

Key Issues
Following significant concerns regarding the lack of responsiveness to queries about SI reports, outstanding action plans and extension requests the CCG has discussed this with both the Director of Quality and Governance and Head of Patient Safety. The response from TEWV is that the Patient Safety team capacity has improved and this will result in a reduction of requests for SI report extensions.

CCG involvement in both service level SI panels and Directors panels should lead to fewer outstanding queries allowing increased focus on embedding of learning and gaining assurance through other means. Progress has been made against closure of old cases.

A quarterly Quality sub group, reporting to the TEWV Contract Management Board (CMB) has also been established. Increased information on quality including evidence from learning will form part of the meeting.

12 Hour Trolley Waits
Since October, 2 trolley waits have been reported at the York site, affecting 3 patients. Scarborough site have reported 5 incidences affecting 13 patients. No patient harm has been identified. Therefore, all of these cases have been de-logged.

60 Minute Ambulance Delays
The need to declare all ambulance waits of over 60 minutes as an SI was communicated by NHSI in December. Resultant discussions have taken place to clarify the value of this and agreement has been reached that the SI Framework should be enacted for those ambulance waits over 60 minutes that have resulted in patient harm.

The CCG continues to receive the numbers of all 60 minute ambulance delays as part of YTHFT's Performance Reporting. The CCG has seen increased numbers of delays across both York and Scarborough Hospitals throughout the winter period. It is proposed to invite the CCG's Head of Transformation and Delivery to the April

QPEC to highlight the impact of winter on Urgent and Emergency Care Services and include any additional information in the next report.

Hull & East Yorkshire NHS Trust
HEY reported 2 SIs during Q3 relating to CCG patients, both relating to suboptimal care of a deteriorating patient.

Clinical Quality Visits
Two quality visits to TEWV services have taken place. The CCG visited Huntington House in December and Lime Trees and the CAMHS service in early January. Information on performance, themes from Serious incidents and information from staff about any changes they are aware of as a result of incidents and complaints were scoped before the meeting.

The visits were hugely positive. The services were welcoming and appreciative of the visits and there was evidence of positive aspects of patient care and service delivery. Actions were agreed for the CCG and the provider and summarised in feedback letters. The action plan will be reviewed at both the Quality and Performance sub groups of CMB.

Maternity

Regional Dashboard
The Quarter 2 Y&H regional dashboard has recently been produced which shows an encouraging profile for YTHFT. The Head of Quality Assurance and Maternity meets the Head of Midwifery to discuss the dashboard data on a regular basis. February's meeting will be highlighting bookings completed by 13 weeks as YTHFT appears as an outlier. The number of assisted vaginal deliveries is slightly lower than the Y&H average, as is the percentage of all normal births out of all deliveries. Unsurprisingly with this profile the total caesarean section rate is higher than the Y&H average. However, YTHFT continue to do well against the stillbirth reduction plans.

STP Local Maternity system
Work progresses across the STP Local Maternity System (LMS). An interim project manager has been recruited to and work is underway to ensure that the LMS plan is ready for re-submission at the end of January. This includes identification of resources required to implement the bid as funds are being released by NHSE.

Maternal Smoking Rates at the Time of Birth
The submission of Smoking at Time of Delivery figures for Q3 2017-18 shows that YTHFT have improved on both recording of smoking status over Q2 and overall performance appears to have improved with rates falling from 12% to 8% of deliveries still recorded as smoking when they deliver. The Y&H average is 13.4%.

The number of women where the data is not captured has also improved this quarter

Perinatal Mental Health
The NHSE funding for the development of perinatal mental health services is still anticipated. Funding requests are being included in the LMS bid submission as explained above.

Patient Experience Update

Vale of York CCG Complaints
8 complaints were registered in the CCG during November and December 2017:

- 3 complaints related to communication and information regarding the BMI/smoking threshold policy.
- 3 complaints related to communication/delays in CHC assessments.
- 1 patient was experiencing a long delay in accessing medication for ADHD following diagnosis.
- 1 patient was unhappy at orthopaedic surgery being cancelled at short notice.

78 concerns/enquiries were managed by the CCG, including:

- 12 contacts related to the proposal to replace gluten free foods prescribing with a top up visa card scheme and make this available to those that are in receipt of specific benefits. The consultation period has ended and feedback is currently being evaluated.
- 10 contacts were from patients who were unhappy with or seeking clarification on the BMI/smoking criteria for elective surgery.
- 16 contacts were from a persistent contactor which required no further action.
- Contact is continuing from patients with diabetes wanting to know if and when the CCG will be approving the prescribing of a new glucose monitoring system – Freestyle Libre. This is currently under consideration by the CCG and a decision will be made by the end of January. A number of contacts are using a standard template email provided by Diabetes UK to send to CCGs in support of their campaign for all patients to be able to access the new technology.

The table below shows CCG activity for all types of contact during the two month period of November and December (the primary issue headings are intended to help categorise and identify the main issue of the complaint or concern):

Service/area	Primary Issue	Contacts
BMI/smoking thresholds	Commissioning decision	3
	Communication/information	6
	Referral	1
Gluten Free Prescribing	Communication/information	1
	Commissioning proposal	11
CHC	Communication/information	4
	Assessment	6
	Funding decision	2
Pain Service	Commissioning decision	1
Podiatry	Referral	2
Referral Support Service	Communication/information re	4

	appointment/referral	
	Commissioning decision	1
CCG	Communication/information re services/providers/policies	9
Medicines Management	Prescribing policy	5
Gynaecology/Fertility services	Commissioning decision	1
York Hospital	Standard hospital contract breach notifications from GPs	4
Persistent contacts	N/A	16
Individual Funding Requests	Funding decision	1

Examples of actions arising from complaints and concerns:
Over the last few months, we have received feedback from a number of complainants/contacts who tell us that when they are referred to secondary care, their GPs have not had a discussion with them about the potential delay to surgery caused by their BMI and/or smoking status. As a result they have not been signposted to appropriate support to lose weight and/or stop smoking.

The CCGs Head of Commissioning and Delivery send reminders to all GP practices to ensure that health optimisation is discussed at the point of referral.

Other Organisation Complaints / Concerns
16 complaints/concerns were signposted to other organisations and these are detailed in the table below:

Provider/Service	Primary Issue	Contacts
GP	Clinical care	
	Communication/information	2
Other CCG		
GP	Care & treatment	1
CHC	Communication	1
Clifton Park Hospital		
Orthopaedics	Appointment cancellation	1
	Communication/information	1
TEWV		
Mental Health adult services	Communication/information	3
YTHFT		
Discharge information	Communication/information	1
Oncology	Care & treatment	1
Allied Health Professionals	Staff attitude	1
Website	Communication	1
Cardiology	Waiting time	1
Community	Services available	1

Yorkshire Health Solutions		
Ultrasound service	Complaints procedure	1

Other Sources of Patient Feedback
These include Healthwatch, Care Opinion and NHS Choices. Postings left about our providers are reviewed regularly (by the providers also) so that any themes, trends or potential issues 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	213
Scarborough	4	95
Selby War Memorial	5	21
Malton	4.5	32
St Helen's	3	2

Friends & Family Test Update
NHS England is in the early stages of a project to improve some areas of the way the Friends and Family Test (FFT) works across the country. The aim is to work through options with relevant partners and stakeholders over the next few months and to refresh the FFT Guidance by April 2019.

Outline proposals for the work were agreed by NHS Chief Executive Simon Stevens in the autumn and also supported by the Department of Health. The ambition is to embed the value of feedback from patients as a driver for service improvement locally.

It is almost three years since the two-year rollout of the FFT across NHS-funded services was completed. Since it began, more than 43 million pieces of feedback have been given by patients and this grows by about 1.2 million every month, demonstrating the appetite of members of the public to tell staff what they are doing well and where improvements can be made, particularly where they give comments on their experience in addition to their rating. Nationally, on average, nine out of ten people say they would recommend the service to their friends and family.

Patient Engagement

Patient stories
Patient stories are now a regular item at the Quality and Patient Experience Committee (QPEC). The first patient story featuring a parent carer was shown at the December 2017 QPEC. As part of the guidance we established we are following up with the patient carer on 1 February to provide feedback and discuss next steps. We

have identified a number of themes and a variety of methods of sharing patient stories for the next few meetings.

- February 2018 – The theme will be the young person's voice, linking to safeguarding children
- April 2018 – The theme will be Continuing Health Care (CHC)

The team is looking at how we share these stories wider (internally and externally) to ensure that the patient and the public remain the focus of our work.

Engagement events and activities

Building on the feedback we received from over 40 face-to-face events between July and October of last year, these comments have provided the foundations for the formulation of our commissioning intentions – our strategic direction over the next two years. We have listened to what our population has told us, such as the need to improve access to GPs, place more focus on mental health, provide more joined-up services and to help people to stay healthy and well, and these themes are reflected in our priorities for the coming year. The CCG's commissioning intentions were presented at Governing Body on 4 January 2018 and will be shared more widely as part a larger piece of engagement work during February and March 2018.

We have been out and about in our community over the last couple of months providing updates and asking for feedback on services. Some of the highlights include: Dr Kev Smith (Executive Director for Primary Care and Population Health) presented at the Healthwatch Assembly, Susan De Val (Commissioning Specialist) talked to the York Youth Council and the Parent Carers' Forum to gather feedback on mental health plans for children's services, and Victoria Hirst (Head of Engagement) attended the Carer's Advisory Group and South Milford Patient Participation Group. All these sessions are collated in a central repository, the engagement database.

Working with our LD community

In September Emma Broughton, Sarah Goode and Debbie Winder attended a Learning Difficulties (LD) Forum. Attendees discussed the potential barriers of attending screening and accessing primary health care. These focused on the length of GP appointments not always being long enough to communicate issues, the need for more accessible information for patients and health professionals, and for easy read invite letters to encourage the uptake of screening.

In response to the feedback Sarah Goode and CCG colleagues are working on an action plan to address these potential barriers. Sarah has since provided an update at the LD forum on 6 December 2017 and to an advocacy group member on 10 January 2018.

Some of the key areas include:

- Design of a guide/template for a patient to complete prior to seeing their GP/nurse including a list of their concerns, accompanied by an easy read body map and visual pain score

- Work on a central repository for links to leaflets, patient information and guidance for health professionals utilising the CCG website and RSS

- Survey to establish baseline figures across primary care to determine current cancer screening uptake for patients with a learning disability and to ascertain the support surgeries offer

- Improving communications with primary care and raising awareness of LD support available for healthcare professionals

Patient and public engagement IAF indicator for 2016/17
In April 2017, NHS England published revised statutory guidance for CCGs and NHS England commissioners on Patient and Public Participation in Commissioning Health and Care. The document sets out 10 key actions and links to annual reporting on the legal duty to involve patients and the public in commissioning.

We are in the process of appealing the outcome of the initial rating of 'requires improvement'. The appeal process deadline is 16 February.

We continue to measure ourselves against the 10 indicators, and improve processes where appropriate.

Meeting our legal duty to involve the patient and public in our commissioning arrangements
As commissioners we have a legal duty to make arrangements to involve the public in commissioning. We also have a duty to promote equality under the Equality Act 2010 and seek to reduce health inequalities under legal challenge. the NHS Act 2006.

We have been looking at our processes within each work stream and a new set of guidance has been developed, based on NHSE guidelines, and shared to help staff identify whether there is a need for patient and public participation in their commissioning activity.

Patient and participation form

- This tool helps identify whether there is a need for patient and public participation in the commissioning activity. It enables staff to plan for a level of participation which is 'fair and proportionate' to the circumstances.
- Staff are encouraged to complete the form at the start of the planning process for any commissioning activity and before operational decisions are taken

which may impact on the range of commissioned services and/or the way in which they are provided.

Guidance for staff:
A range of forms as part of the toolkit can be accessed via these links below:

- Patient and public engagement planning form
- Guidance for the legal requirement to involve the public
- NHSE public and patient engagement guidance
- Equality Impact Assessment prompt chart

Regulatory Inspection Assurance

Care Homes and Adult Safeguarding Update

The Retreat – York – Independent Mental Health Hospital – CQC report published service rated good across all domains. This is a huge achievement for this organisation which was rated inadequate last year.

The CQC have now rated a home in Stamford Bridge as inadequate and there are a number of homes across the Vale of York where a number of significant quality concerns that have been raised by the CQC. These include a number of safeguarding alerts as a result of poor care planning, poor documentation and risk management. A piece of work is also being undertaken to understand the response of those already involved in the care of residents in raising quality and safety concerns.

Both the CCG's Designated Professional Safeguarding team and Senior Quality Lead continue to respond to issues as they arise as well as proactively engaging with Care Homes with the aim of positively impacting on quality of care for residents

Quality in Care Homes

The CCGs Care Homes Work Plan is included as an appendix this month and therefore only progress updates will be identified in the section below.

Care Home engagement: The Head of Engagement and Senior Quality Lead continue to work together to plan a number of engagement events for care home staff and residents.

React to Red and Safety Huddles: To date six care homes are currently undergoing training for React to Red. This includes 260 eligible staff, 151have completed training (58.07%) and 146 of those assessed as competent (56.15%). Two homes have achieved full sign off with all staff trained and competent. There are a further four homes engaged with training dates identified.

Ten homes have been recruited for the next cohort starting in March. Following successful recruitment a Project Nurse for React to Red has been appointed and will join the team to work alongside the React to Red Practitioner and lead further spread.

Post training evaluation has been positive with care staff reporting the training as easy to understand, improving baseline knowledge of pressure prevention, recognition and actions to take. Some homes involved in the training package have also made pressure ulcer prevention training mandatory for care workers as an annual refresher.

Focussed support with reducing falls has started with a care home to include education and Safety Huddles. A number of other homes have expressed an interest in becoming involved in this work and the quality team are working with them.

An abstract has been submitted for a poster presentation 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.

Supporting Care Homes: The Senior Quality Lead aims to play an active role in the initiatives to support care organisations in providing care in the resident's home, in particular around the prevention of non-elective admissions.

Plans for a pilot continue to develop which would see a specialist multi-disciplinary team led by a GP supporting selected homes initially, in the central locality to primarily enhance the care residents receive. It will aim to prevent non-elective admissions and facilitate smoother, timely discharge.

A pilot to support care homes not to dip stick urine is being planned and 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 explore the early identification and communication of deterioration in care home residents with the use of a softer signs tool combined with NEWS scores and SBAR is being planned. This work is supported by the Improvement Academy and is anticipated to build on work published by Wessex Academic Health Science Networks and include sepsis awareness.

A conference is planned for May in collaboration with the Improvement Academy which will be entitled "Recognising and Responding to Deterioration in Care Home Residents". This will aim to bring together health and social care staff from around the region who are delivering front line care, to share ideas and good practice around recognition and response to deterioration, to showcase best practice, discuss, innovative ideas & form the basis of a network to drive improvement. The event will be hosted in York with key Note speeches by the CCG Chief Nurse and Medical Director.

Preparations for the roll out of the Red Bag initiative is planned to commence in summer 2018.

NHS Digital has approached a care home and the Quality Team to progress the use of IT to facilitate better communication with care homes on discharge from hospital. A colleague from NHS digital will attend the next partners in care meeting in February to discuss the Information governance tool kit and the offer of NHS mail for care homes.

Supporting Carers: The CCG's Senior Quality Lead has supported the Partnership Development Officer within the Carers Centre to structure a 'wellbeing adult carer hub programme'. This is to support unpaid carers of all ages in York. The sessions are now being advertised and will provide training around a variety of issues important to carers including sessions delivered by the React to Red Team. The Quality team have attended carers drop in sessions to promote React to Red which has been well received by the informal carers.

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 NHSE North region, aimed primarily at reducing delayed transfers of care. The tool has been procured by NHS England and is free. It aims to enable care homes to share 'real time' bed availability with NHS providers and Local Authority. The tool is now planned to go live in February in line with colleagues from the East Riding. The CCG is leading on this initiative with support from colleagues in North Yorkshire County Council (CC), City of York Council (CYC), East Riding of Yorkshire CC and YTHFT.

The Partners in Care forum The February meeting is planned with a full agenda and feedback will be included in the next QPEC report. The first draft of the Partners in Care monthly Lessons Learned bulletin was well received and will continue with contributions from stakeholders.

Health and social care joint working: The Senior Quality Lead continues to accompany CYC colleagues on assurance visits to care homes, when visits are required for action/ improvement plans or where concerns are raised. This is proving both supportive to the care homes and is a real example of joint working between health and social care in action, ensuring appropriate interventions can be facilitated.

The Quality team have been invited to participate in work with NYCC who are conducting a feasibility study for nursing and residential care. The opportunity to contribute to this important piece of work is valued and allows a joint response to the issues experienced in the NYCC area.

Verification of Expected Death (VOED) in Care Homes: British Medical Association guidance states that a GP is not required to attend a care home to verify an expected death and can be undertaken by a 'competent adult'. The CCG has led a response to issues raised at the Partners in Care meeting in relation to this to aid clarity and support guidance for care home organisations. In response, the following statement has been agreed;

“In light of the GP OOHs service not providing a service to support verification of expected death in Care Homes, the VOY CCG will continue to support staff in accessing training to be competent in the verification of expected death. For those Care Homes that do not have staff that are deemed competent with the verification of expected death, care homes can access their community nursing teams or Urgent Care Practitioners for support.”

Equipment Selection in Community: Guidance is under review to support staff in decision making and ease the ordering process when selecting a mattress for patients with pressure ulcers or those at risk of pressure ulcer development in community. This work continues in collaboration with Tissue Viability Specialists and community nursing colleagues. The process for selection has been streamlined to simplify and standardise best practice whilst also realising significant financial savings. This work is also extending to include the use of pressure relieving cushions and overlays during March.

A wider piece of work to ensure the quality perspective is integral to commissioning agreements is progressing. Quality Leads from the CCGS have agreed to meet and share quality issues relating to the equipment contract and to ensure contracting arrangements reflect the needs of all service users.

A case study into 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. This is a pioneering trial and its aim is to inform best practice.

R**esearch Agenda:** The CCG continues to support the research agenda and is currently awaiting an outcome to an application for a bid by the AHSN for a study into nutrition.

Mental Health

Children and Young People

CAMHS

At the clinical quality visits to TEWVs CAHMS the CCG were given an update by clinical staff about the impact of waiting times both on the service users experience and those of the staff. Despite demand and capacity pressures the CCG observed numerous innovations in an attempt to improve both patient care and safety.

The Single Point of Access service was particularly impressive and they were able to demonstrate how triage and risk assessment was working to process the high number of cases they are receiving; noting that 40 percent of referrals do not require a CAMHS services. These referrals are signposted elsewhere. The CCG agreed to support the team in communicating and educating primary care about the service, the referral processes and the option to self-referral. Additionally, Selby CAMHS team were able to describe the value of being collocated with the Local Authority prevention team which enabled the CAHMS team to work closely with the 0-19 service.

Current performance against KPIs (Q3) is as follows:

KPI	To Q3	Comment
85% 17 ½ year olds with transition plan	61.6%	Underlying trend is down. TEWV provide a breach report with monthly Q&P report. Included in Recovery Plan for further action
90% with second appointment (full assessment) within 9 weeks of referral	71.3%	Underlying trend is steadily upwards: December was 83%. Issue now is waiting time for treatment, which is not currently monitored but to be discussed with TEWV to add to activity data.

Autism Waiting Lists

Autism waiting lists continue to be challenging. In response TEWV are funding 36 additional assessments, which will temporarily reduce average waiting times. Referrals continue to increase; nearly doubling from 2015 (88) when TEWV took over the service to 143 in 2016/17.

The clinical pathways, with both YTHFT (0-5 pathway) and TEWV (5-18 pathway) remain under surveillance. This specifically relates to access of sufficiently qualified staff to enable a NICE complaint diagnostic pathway. The CCG Executive Committee is sighted on this with a second report due in February 2018.

These issues are included in the CAMHS recovery plan.

Community Eating Disorders (CEDS)

Performance against national waiting time standards should be achieved by 2020. The CCG position as of Q3 is indicating that 10 percent of routine cases and 40 percent of urgent cases commence treatment within national waiting time standards. Interim standards are being agreed which includes a level of data cleansing so that performance can be accurately presented. The CCG has assurance from TEWV that patients are receiving appropriate treatment. The number of referrals remains high and above the estimated projections when the service was planned. Approximately 30 percent of referrals are signposted to other services when assessed, but the demand remains high. The CCG is sighted on the clinical risk associated with these patients waiting for treatment and will continue to monitor through the CMB and newly formed quality sub CMB.

Children's acute care

The CCG have received the results of the National Children's Inpatient Survey for 2016/17. The survey is structured around a number of aspects of patient experience including ward environment, undertaking procedures and advice about medication. YTHFT's score comparable with other similar organisations, but some elements are noticeably low, including play therapy with patients on wards, unacceptable noise levels on the wards at night and varying levels of involvement in decisions about care. However, YTHFT scored highly on matters such as friendliness of staff and maintaining dignity. Any subsequent actions will be monitored via the quality and performance sub CMB.

Special Educational Needs and Disabilities (SEND)

Transition from child services to adult services continues to present challenges for families and young people which was highlighted at the QPEC through the patient story. A recent focus group with families revealed shortcomings in transition arrangements for some with lack of communication and empathy from services causing anxiety. An additional focus group is being held in January and recruitment to a transition nurse at the YTHFT to support families is a positive step and aligns them to this national requirement.

Research Group

The CCG Quality team have re focused the Terms of Reference and membership for this group. There is now representation from both York Universities as well as the National Institute for Health Research (NIHR) and the Local Research Network. YTHFT and Public Health colleagues from the City of York Council are also represented. The purpose of the group is to raise awareness of Research and generate opportunities for primary research across organisations, focusing on population health and priorities defined in the Joint Strategic Needs Assessment (JSNA).

Currently there is very little information on the CCG website about Research and Development. This is being addressed so that both the public and staff can access information as well as being signposted to relevant organisations to support research study participation.

Risk Report

A new Risk and Assurance Report was presented at QPEC on 8 February 2018. The Quality team are aiming to review the report and identify which risks require escalation to Governing Body, those that are reported to QPEC as well as a review of the Operational leads for each risk identified.

Appendix 1

Vale of York CCG Care Homes Work Plan 2018/9

Vale of York CCG Care Homes Work Plan 2018/9

"The Vale of York CCG (VOY CCG) in partnership with stakeholders from Health, Social Care and the third sector, will support Care Homes to provide high quality, cost effective care for all residents within the Vale of York."

This paper aims to identify and describe the key care homes work streams identified for 2018/9 by the VOY CCG Quality Team.
Rationale for the identified work streams is based on a number of factors which have contributed towards this overall plan. These include

- engagement with care homes, listening to residents and staff feedback
- understanding local health and social care needs in conjunction with the national context
- consideration of the strategic developments at CCG, STP and national level

In the UK 405,000 older people (aged 65 plus) currently live in care homes. This represents 16% of older people over the age of 85. The term care home includes homes both with and without nursing provision. Data from population and cohort studies suggest that older people living in care homes have complex healthcare needs. The average care home resident has multiple long term conditions, functional dependency and frailty. 75-80% of those people living in care homes have cognitive impairment. Residents are more likely to have better health outcomes if health services reflect these needs, with attention to comprehensive, multi-disciplinary assessment, case management and input from appropriately trained specialists in care of complex medical problems in later life. (British Geriatric Society, 2016).

Across the Vale of York CCG there are 83 care homes with a bed base of 2683. Care homes across the footprint rate higher than the national average CQC ratings. In line with the national picture care home beds are reducing which poses challenges for the support of older people in the home setting when care is required.

The NHS Five Year Forward View has recognised the need for better integration between GP, community health, mental health and hospital services alongside care homes and domiciliary care. It is recognised that there is a need to improve collaborative working to support frail, older people to remain healthy and independent and avoid admission to hospital. The paper identifies the need to focus on the prevention of illness and to support a sustainable NHS. Work within geographical areas known as 'Vanguards' have

demonstrated lower admission rates to hospital and reduced length of stay alongside improvements in health and wellbeing (The Kings Fund, 2015)

The 'Framework for Enhanced Health in Care Homes' (NHS England, 2016), describes how commissioners and providers including the NHS, Local authorities, the voluntary sector, carers and families worked together in a coordinated approach to overcome challenges. These challenges were identified as care, financial and organisational barriers which affect the care of those living in care homes. Six designated areas supported by NHS England, known as vanguards demonstrated changes could be implemented that have had a system wide approach, resulting in improvements for residents well-being. The enhanced health in Care home framework identifies key principles for successful care models;

- Person centred change
- Co-production
- Quality
- Leadership

These principles apply both to those living in a care home setting, those requiring support in the community and those at risk of losing their independence.

Learning from work within the vanguards and the principles of the Enhanced Health in Care Homes framework has informed this work plan for 2018/9.

It should be noted that there is much learning from work developed outside of the vanguard areas that can be shared and indeed exists within the Vale of York currently. This includes examples such as the React to Red programme, improving discharge flow by the implementation of the care home bed state tool, safety huddles for the identification of high risk residents.

This work plan aims to build on successes and share learning and different ways of working to develop sustainable high quality care. Residents of care homes within the Vale of York are to be supported with their health needs in the most appropriate way with safety and dignity as a priority.

The Kings Fund (2017) advocate that enhanced health in care homes is realistically achievable across England and significant results can be achieved within months in some cases. Skilled leadership supported by communities of practice are identified as key to support and share learning. It is recognised that Local Authorities and Commissioning Groups (CCGS) can provide essential leadership in challenging obstacles and considering how working practices can transcend organisational boundaries.

This work plan covers 2018/9 however it is acknowledged that for sustainability and change to be embedded time is often required particularly when working across organisations. Some of the work streams identified will require longer term planning. There may also be

programmes of work identified during the period which may be incorporated as necessary. Monthly reports on the progress of the work will be submitted to the QPEC Committee.

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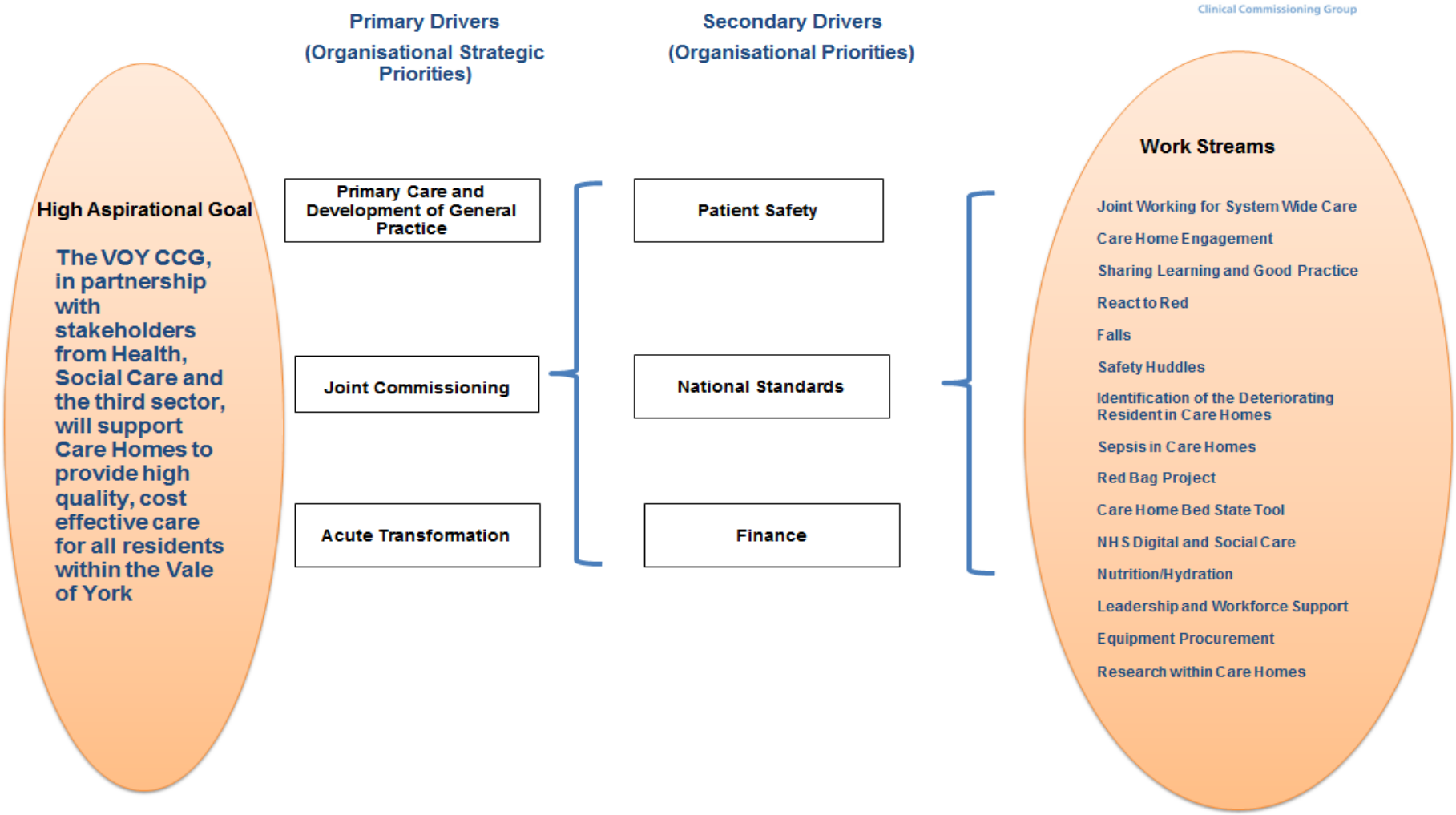
1. VOY CCG Care Homes Work Plan



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2. Joint Working for System Wide care

The CCG Quality team and CYC colleagues will perform assurance visits to care homes together, when visits are required for action/ improvement plans or where concerns are raised. This aims to support care homes with a proactive approach and demonstrates joint working between health and social care in action, ensuring appropriate interventions can be facilitated in a timely manner, preventing homes entering special measures. It is hoped this practice may be extended where appropriate with NYCC and East Riding for care homes across the VOY CCG footprint. It should be recognised that VOY CCG safeguarding colleagues accompany visits to CYC, East Riding and NYCC care homes where concerns exist and work closely with local authority colleagues. Participation in assurance visits and offers of support would complement this. Work with stakeholders across health and social care including local authority, CQC, CCG to identify care homes where there are concerns and share joint plans for support to prevent special measures and the loss of beds currently exists and will continue. Links with Health Watch and the local Carers organisations will continue to be developed.

Plans for a pilot are currently under negotiation which would see a specialist multi-disciplinary team led by a GP supporting selected homes initially, in the central locality to primarily enhance the care residents receive. It will aim to prevent non-elective admissions and facilitate smoother, timely discharge. This work is concerned with focussing on sustainable models of care for those residents in care homes. This links with the frailty agenda.

The CCG work regarding frailty and dementia is integral to many of the identified programmes of work identified within this work plan. A system wide approach linking with colleagues working on these work streams will be important to ensure maximise impact.

The Senior Quality Lead will link with the Acute Trust to explore and support opportunities for maximising pathways of care for residents from care homes and those receiving domiciliary care.

Ensuring a joint approach between health and social care to any emerging work streams will be vital for sustainability fitting with the wider context of evolving care systems.

3. Care Home Engagement

A number of focussed engagement events for care home staff and residents are planned to inform on the Care homes work across 2018/9. In addition to this bimonthly 'Partner's in Care' meetings will be held. These are forums for information sharing and discussion to bring stakeholders together in achieving the delivery of high quality care to residents.

4. Sharing learning and good practice

A 'Partners in Care Lessons Learned' (PICLL) bulletin specifically aimed at sharing learning from health and social care incidents within the VOY CCG is under development and aims to be issued quarterly. This will also include any relevant safety alerts to share with home managers.

A conference supported by the Improvement Academy is planned for May 2018. This aims to bring together those in the care home and domiciliary care sector with a purpose of sharing good practice and recognising achievements. This conference will show case improvement programmes and development opportunities for staff in their place of work. This will be a regional event hosted in York with the support of the Chief Nurse and Medical Director for the VOY CCG. This conference will raise the profile for the sector and encourage engagement in the quality improvement work within health and social care.

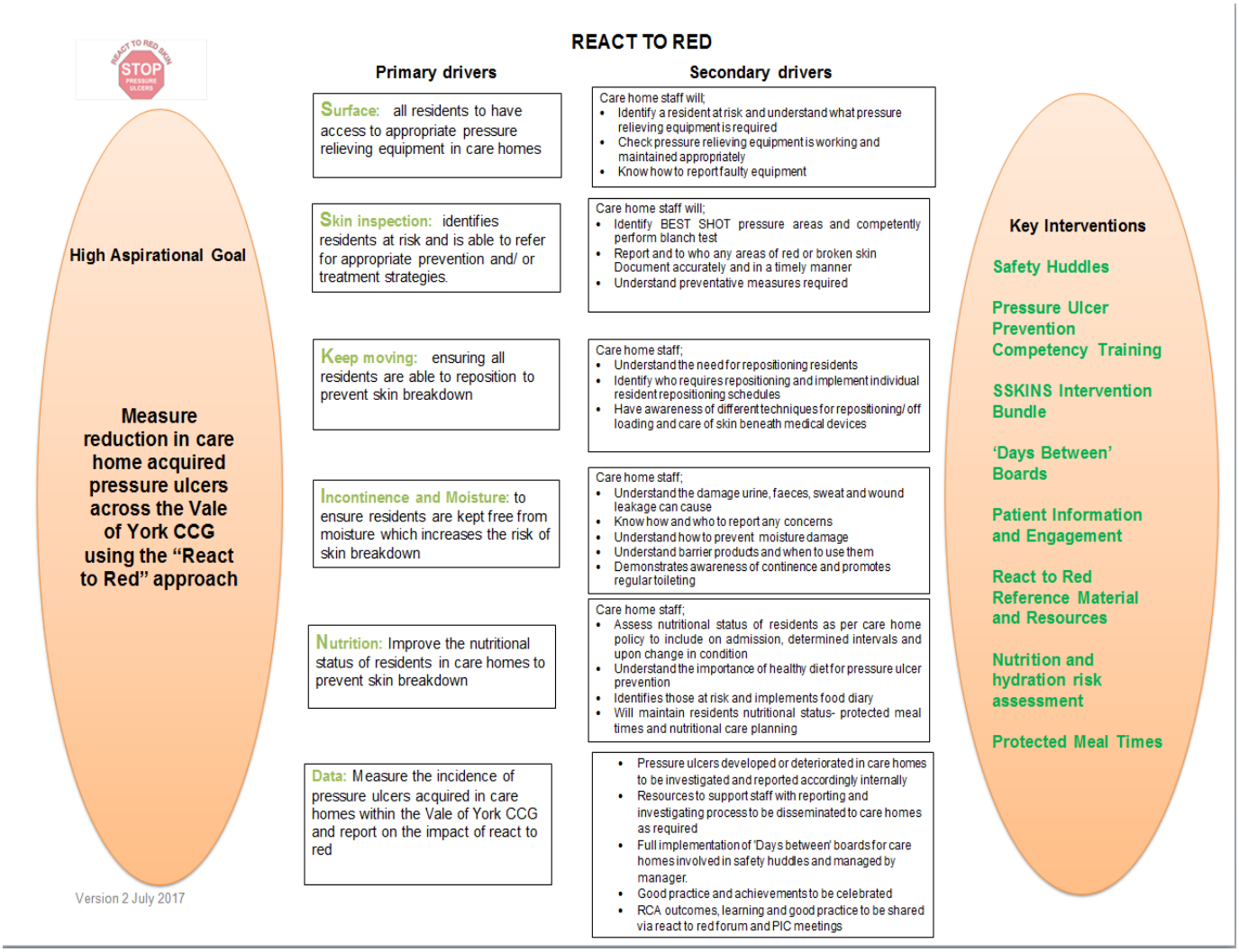
5. React to Red

React to Red Skin is a pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

The prevention of avoidable pressure ulcers in the community is one of the biggest challenges that care organisations face - a challenge which currently costs the NHS and care organisations in the UK around £6.5 billion per year. Pressure ulcers affect around 700,000 people in the UK every year and many of these will develop whilst an individual is being cared for in a formal care setting (hospital, nursing home or care home). Most pressure ulcers are avoidable if simple knowledge is provided and preventative best practice is followed (NHS England 2017)

The Vale of York CCG is committed to participating in the NHS England work to roll out of the 'React to Red' initiative. This includes an education package and the use of a simple, yet effective framework which supports carers in recognising when an individual may be at increased risk of pressure ulcer development. The framework, known as SSKIN prompts carers to consider key areas important in maintaining skin integrity. In order to facilitate the implementation of the 'React to Red' programme and to help embed and sustain change Safety Huddles will be introduced, supported by the Improvement Academy (IA).

React to Red Driver Diagram

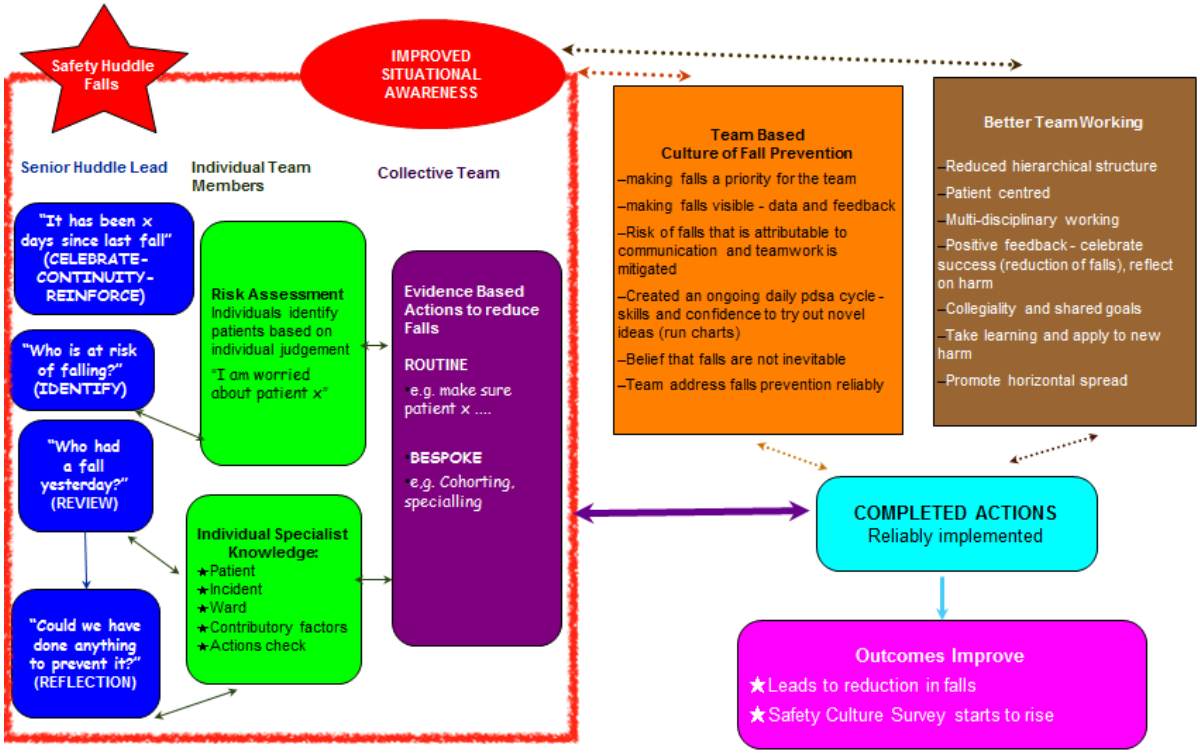


Through React to Red opportunities relating to standard dressing stocks, homely remedies and mechanisms for prescribing and dispensing across care homes have been identified. Work to support care homes in accessing the right dressing at the right time for the right resident will be progressed.

6. Safety Huddles

The Safety Huddles aim to motivate staff and promote a safer care environment through recognition of achievement and the sharing of learning from incidents and good practice. It is hoped the Safety Huddle will help in establishing a structure for further improvement work with care homes. A number of care homes involved in Safety Huddle work have incorporated a focus on falls alongside pressure ulcers or their own choice of harm. This is important work particularly as falls are known to currently account for the majority of reported patient incidents reported by care homes resulting in resident harm.

Safety Huddle Logic Model



7. Falls

This is work currently supported by Improvement Academy (IA) via the safety huddle programme. The CCG will analyse data from care homes and identify areas for focussed work with those who are engaged. It is recognised that falls account for a high number of conveyances to the Emergency department (ED) and there is a need for preventative action. This should be recognised as a priority for the prevention of avoidable harm. The CCG will explore opportunities available for training with care homes and how falls prevention may also be incorporated into the safety huddle work and safety prompts. This will be an area

explored for opportunities for research also data identifies a high number of falls within the older adult population of York who live independently.

8. Identification of the Deteriorating Resident in Care Homes

A Quality Improvement project to trial the use of softer signs of identifying resident deterioration alongside the use of SBAR and NEWS scores where appropriate in care homes will be explored. Anticipated to build on work published by Wessex AHSN it will focus on earlier identification of the physically deteriorating resident and the use of SBAR to improve communication and safety. It is aimed that appropriate communication and escalation will assist in earlier detection of the deteriorating resident, resulting in earlier intervention to prevent admissions to hospital and support care at home.

9. Sepsis in Care Homes

Early intervention to identify and treat sepsis is vital. Escalation protocols and sepsis pathways to support care home staff will be developed for the early detection of a resident with potential diagnosis of sepsis and actions to take. This work will run in conjunction with the identification of deteriorating residents and communication programme to ensure action is taken at the earliest opportunity when deterioration is recognised.

10. Red Bag Project

This project aims to improve communication from admission through to discharge. Work in the Sutton Vanguard (NHS, 2016) has shown improvements in individualised care and reduction in length of stay for residents from care homes when the red bag is used. The CCG will work with stakeholders across the VOY to engage and plan implementation of this intervention by summer 2018. This programme may require longer term planning as a system wide approach is required for success.

11. 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 NHSE North region, aimed primarily at reducing delayed transfers of care. The tool enables care homes to share 'real time' bed availability with NHS providers/ LA's. Following initial meetings with stakeholders from across health and social care, implementation was agreed in December. An implementation plan is in situ and roll out anticipated to commence in February 2018.

12. NHS Digital

NHS Digital is offering opportunities for collaboration and support in developing digital connection between health and social care. There are currently minimal social care providers linked on NHS Mail and developing the infrastructure for expansion would offer many benefits to the health and social care economy across the Vale of York. The possibility of how NHS Mail for social care providers might be achieved across the VOY CCG will be explored. One care home who have use of NHS Mail following successful completion of the Information Governance Toolkit can also access to System 1, will be used to run a proof of concept type trial to test how electronic discharge summaries may be received and communication direct with the GP surgery could benefit residents. This will allow a focussed trial to explore the benefits and challenges for the system.

13. Nutrition and Hydration

The VoY CCG were invited by the Academic Health Sciences Network (AHSN) to participate in a scoping exercise with colleagues across the region for a programme of work concerned with nutrition and hydration. The scoping exercise is being used to inform on a bid for funding which would allow a nutrition and hydration project to be undertaken within the VOY CCG and regionally. This would be wider than care homes and work to avoid the concept of 'undernutrition', the malnutrition cycle that susceptible individuals succumb to once they experience ill health. This is a programme of work which would include primary care and public health.

Tool kits currently exist for VOY CCG care homes, validated by the AHSN community. For those homes who would like to engage with these resources they are available for use and can be implemented independently or supported by the IA as part of the safety huddle work.

14. Leadership and workforce support

The VOY CCG recognises the importance in supporting staff from the care home sector at all levels in development. Workforce development will be a priority, working alongside providers for education in supporting care home staff to acquire the relevant skills to equip them in their roles. It has been recognised that developing leadership skills are vital particularly for those in senior positions within care homes to ensure care homes are well led and effective. From engagement with care home providers it is identified as important that care home managers are supported with the challenges they face and feel able to engage with the CCG to access support.

It is important that the Quality team engage in strategic work at regional level which links with and informs on national workforce development. The Senior Quality Lead alongside colleagues will engage in work to ensure that the health and social care workforce are supported in the appropriate education and role development. This is to provide a

sustainable solution suitable for local need in accordance with the national context and evolving requirements of emerging roles across the sector.

On a regional level the IA aims to support the growth in capacity of staff with Quality Improvement skills and knowledge. The Senior Quality Lead has recently completed training to allow 'Silver QI Training' and mentorship of projects endorsed by the IA to be provided in house. Opportunity to apply this will be explored throughout 2018/9. The opportunity to develop roles such as improvement fellows will be explored. Sustainability of the care home sector is recognised as a priority and engagement in strategic work to ensure this for the area is underway.

It is important to note that the VoY CCG have recognised the importance of the Care Homes Work Plan and have committed to funding two posts with an initial focus to support the Senior Quality Lead in successful delivery of the React to Red programme. To allow capacity for delivering on further opportunities following completion of this work a case will be submitted for the team to further become embedded.

15. Equipment Procurement

The Quality Team will contribute towards the process of equipment procurement to ensure reviews have a focus on quality and clinical perspective alongside the necessary financial considerations. Guidance has been updated to support staff in decision making and ease the ordering process when selecting a mattress for patients with pressure ulcers or those at risk of pressure ulcer development in community. The process for selection has been streamlined to simplify and standardise best practice whilst also realising significant financial savings. Training and support will be offered to clinical teams to help support them in selecting appropriate surfaces for patients. Further cost saving opportunities will be explored to include how staff order and particular categories of equipment where a review would be beneficial for example specialist equipment.

16. Research and Audit within Care Homes

A case study into the benefits of using the Mercury Hybrid mattress within a Nursing Home is currently underway with evaluation expected by the summer of 2018. This is a novel case study and eagerly awaited. A care home setting has not published a trial like this as yet and it is hoped this will contribute towards informing on best practice.

The VoY CCG will continue to support the University of York to look at how the research agenda within the Nursing Department can collaborate with care homes. Bids are in progress to secure research funding and formalise links between the University of York and the VoY CCG. This work is supported within the CCG Research Group where opportunities and priorities for research are identified and facilitated.

The Quality team will continue to horizon scan for potential collaboration with academic institutions for appropriate research studies within the care home settings.

Item Number: 13

Name of Presenter: Denise Nightingale

Meeting of the Governing Body

Date of meeting: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – NHS Vale of York CCG Personal Health Budgets Policy

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

Reason for Report

To approve the adoption of a Personal Health Budgets Policy which supports the CCG's Commissioning Intentions for 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

JC.22 Personal Health Budgets (PHB) Risk of ineffective PHB systems and processes to support delivery of national standard relating to increased take up of PHBs

Emerging Risks (not yet on Covalent)

N/A

Recommendations

To note the updates and approve the Policy.

Responsible Executive Director and Title	Report Author and Title
Denise Nightingale Executive Director of Transformation, Complex Care and Mental Health	Sarah Kocinski Commissioning and Transformation Manager

NHS Vale of York CCG Personal Health Budgets Policy:
Update to Governing Body

1. Background

The provision of Personal Health Budgets (PHBs) aligns with NHS England's commitment to provide patients with choice and control to enable them to lives their lives as independently as possible in line with NHS England's Integrated Personal Commissioning agenda.

The decision to implement PHBs and increase the number of people holding a PHB reflects NHS England's commitment to increase the numbers nationally and is reflected in the CCG's Commissioning Intentions for 2018/19 to "Optimise the potential for Personal Budgets and Personal Health Budgets to align systems and processes, joining up around the individual; simplifying the arrangements and minimising bureaucracy".

2. Current Position

Since the Partnership Commissioning Unit was dissolved, the responsibility for PHBs has transferred to the CCG. As a result of this change, it was recognised that there were opportunities to rationalise and streamline the systems and processes to make offering a PHB as simple as possible for healthcare professionals.

In December 2017, the CCG Executive agreed the development of a PHB Policy and streamlined processes for the identification and payment of PHBs with an initial review period of 3 months.

Since December, the Policy has been reviewed and adapted and reflects discussions that have taken place over the past couple of months with Continuing Healthcare, finance and Local Authority colleagues. CCG Executives approved the proposed Policy on 21 February 2017 with a further review date in 6 months to allow for Continuing Healthcare systems and processes to be consolidated into the CCG.

3. Action Required

Governing Body are asked to approve the attached PHB Policy.

Sarah Kocinski
Commissioning & Transformation Manager
21 February 2018

NHS
Vale of York
Clinical Commissioning Group

Personal Health Budgets (PHB) Policy
(Adults and Children)

Document Control

Document Name	Personal Health Budgets Policy
Document Reference Number	TBC
Document version	7
Committee/Group **Document ratified by and date of Ratification**	CCG Executive Committee 20/12/17 Updated Policy approved at CCG Executive Committee 21/02/18 Governing Body 01/03/18
Frequency of Review	Annually
Review Date	6m review 1 September 2018
Date of EIA	27/12/17
Date of PIA	08/02/18
Date of QIA	Draft 15/02/18
Date of SIA	27/12/17

POLICY VALIDITY STATEMENT This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document.

This policy has been developed following advice from NHS Bassetlaw CCG

Contents **Page number**

1. Background

1.1 The initiative for Personal Health Budgets (PHBs) originated from social care and organisations of disabled people pressing for the right for autonomy in their lives and for control over the assistance they needed in order to live independently.

1.2 This Policy applies to all those who may benefit from a Personal Health Budget – both Adults and Children.

1.3 NHS Vale of York Clinical Commissioning Group (the CCG) is committed to promote Patient choice, while supporting patients to manage risk positively, proportionately and realistically. Good practice must support Patient choice. Supporting people to take informed decisions with an awareness of risks in their daily lives enables them to achieve their full potential and to do the things that most people take for granted and this can be achieved via accessing Personal Health Budgets for some Patients.

1.4 The term "Patient" is used throughout, to reflect the language used in the NHS in funding healthcare through a Personal Health Budget.

2. Definition of a Personal Health Budget

2.1 NHS England defines a Personal Health Budget as follows:

An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their Nominee / Representative, and the local CCG. At the centre of a Personal Health Budget is the Support Plan. This Support Plan helps people to identify their health and wellbeing goals and together with their care co-ordinator, sets out how the budget will be spent to enable them to reach those goals and keep healthy and safe.

2.2 There are five essential components of a Personal Health Budget.

The Patient with the Personal Health Budget (or their Representative) must:

- Be able to choose the goals (outcomes) they want to achieve.
- Know how much money they have for their health care and support.
- Be enabled to create their own Support Plan, with support if they want it.
- Be able to choose how their budget is held and managed.
- Be able to spend the money in ways and at times that make sense to them, as agreed in their Support Plan.

3. Scope

3.1 Who can have a Personal Health Budget?

3.1.1 Apart from exclusions by statute, a Personal Health Budget can be offered to anyone who is likely to benefit. This includes:

- People receiving NHS Continuing Healthcare or children's continuing care, who already have a right to have a Personal Health Budget;
- People who have high levels of need but are not NHS Continuing Healthcare, but who have health needs which would be suitable;
- Parents, and children over age 16 with Education, Health and Care Plans, who could benefit from a joint budget including money from the NHS;

This is an indicative list not an exclusive list. There is no automatic exclusion by diagnosis or by virtue of mental incapacity.

3.2 What a Personal Health Budget can and cannot be used for

3.2.1 Apart from those specified below, there are no hard and fast rules for what a Personal Health Budget can be used for, the main determinant being whether a particular expenditure will meet the desired outcomes set out in the health Support Plan.

3.2.2 Personal Health Budgets cannot be used to buy:

- Alcohol, tobacco, fund gambling or debt repayment, or anything that is illegal
- Emergency or urgent care
- Primary medical services such as GP care, dental treatment
- Medication
- Inpatient care
- Long-term residential or nursing care – however, elements of long-term care in a care or nursing home can be purchased

It should be noted that this list is not exhaustive. The CCG is responsible for agreeing that all intended expenditure is legal as part of the Personal Health Budget governance.

3.2.3 The CCG provides Personal Health Budgets so that Patients may use them to meet their holistic, including health and well-being, needs. The use of such funding does not extend to deliver goods or services that would normally be the responsibility of other bodies (e.g. local authority social services, housing authorities) or are covered by other existing contracts held by the CCG (e.g. community equipment via the Medequip contract; district nursing via the Adult Community Health Services contract) unless under exceptional circumstances.

3.3 Types of Budget

- Notional budget – No money changes hands. The Patient finds out how much money is available and talks to their Health Professional or CHC Nurse/Case Manager about the different ways to spend the money on meeting their needs. The CCG pays the provider directly e.g. care home/agency.
- Third Party – Held by a Third Party (Brokerage). A different organisation or trust holds the money for the Patient, helps them decide what they need, and then together, they buy the services they have chosen. The third party takes on the employer responsibilities.
- Direct payment – The Patient receives the funds into a dedicated bank account or via a payment card to buy services they and their Health Professional or CHC Nurse/Case Manager decide they need. This could be via a Support Service. Patients take on employer responsibilities and will be expected to produce evidence and rationale for spending.

A combination of the above may also be appropriate.

3.4 People who access their Personal Health Budgets through Direct Payments or Direct Payments to a Representative/Nominee are required to maintain sufficient records to be able to demonstrate, if required, that any money provided to them as a Personal Health Budget has been used in accordance with achieving the outcomes agreed in their Support Plan. A framework for this will be provided to them.

3.5 Where the CCG manages a Patient's Personal Health Budget on their behalf in a Notional Budget, there is no requirement for the Patient to maintain financial records.

4. Principles of a Personal Health Budget

4.1 Our underpinning principles for providing Personal Health Budgets are:

- Patients and their carers will be central to all processes
- Services will be personalised regardless of who pays and whether they are delivered by the statutory or private sector
- The delivery of Personal Health Budgets will be managed within the agreed budgetary provision affordable to the CCG as part of its annual financial plan (see section 9.1)

4.2 The CCG acknowledges that people have the right to ask for a Personal Health Budget, but the capacity, resources and skills to meet all requests is likely to result in the need to prioritise individuals in the local process.

4.3 Following a clinical assessment, the Patient will begin to develop an individual Support Plan to meet their holistic needs including health and well-being. This Support Plan must be legal, effective, affordable and meet a range of agreed outcomes. This will then help formulate a final Personal Health Budget. The freedom to prioritise what is important in their lives is a fundamental shift in roles and responsibilities for both the Patient and the Health Professional.

4.4 Patients, supported by their Representatives where appropriate, in close liaison with Health Professionals, will identify their desired outcomes and plan their support within the proposed allocation of money.

5. Process

5.1 Making Patients aware of their right to a Personal Health Budget

The CCG will make individuals aware of their right to have a Personal Health Budget in a variety of ways:

- Information published on the CCG website
- As part of the NHS Continuing Health Care process
- As part of health and social care discussions as appropriate

Information will be provided to the Patient verbally and/or in writing using accessible language. The CCG will also offer Patients the opportunity to access independent advice in relation to their options if required.

5.2 The CHC Nurse/Case Manager

For each person choosing to receive a Personal Health Budget for care and support the Patient will have a CHC Nurse/Case Manager. They are responsible for:

- Managing the assessment of the health needs of the person receiving care, for the Support Plan
- Ensuring that both the individual, Representative or Nominee and the CCG have agreed the Support Plan
- Undertaking or arranging for the monitoring and review of the Personal Health Budget, the Support Plan and the health of the person
- Liaising between the CCG and the Patient receiving the Personal Health Budget
- Signposting to employment law for any employment issues regarding carers.

The CHC Nurse/Case Manager will normally be someone who has regular contact with the Patient, and a Representative or Nominee if they have one. Whilst they may not have CHC

Nurse/Case Manager in their job title, the important thing is that they are fulfilling the responsibilities above, while also being able to arrange with others to undertake actions, such as monitoring or review.

5.3. Nominees and Representatives

Patients with capacity may wish to appoint a Nominee to act on their behalf. Where a Patient is assessed as having no capacity to manage a Direct Payment, the CCG should consider whether a Representative can act on the Patient's behalf. It is important to note that for Patients in receipt of a Direct Payment, both Nominees and Representatives take on all the responsibilities for managing the Direct Payment that the Patient themselves would have if they were in receipt of the payment. Nominees and Representatives therefore sign the Direct Payment Agreement on behalf of the Patients for whom they have been appointed. Representatives can appoint Nominees.

All advice, information and support that would be provided by the CCG to a Patient in receipt of Direct Payments will be offered to their Nominee or Representative. See also section 7 for more information on safeguarding and Disclosure and Barring Service checks (DBS) requirements in relation to Nominees and Representatives.

5.4. Representatives for Patients without Capacity

Representatives can be:

- A person with parental responsibility for a child under 16 or a child over 16 who lacks capacity
- Someone given powers as an attorney or a deputy by a court to make decisions in specified areas on the person's behalf. Not all attorneys and deputies will have suitable powers and these individuals cannot act as Representatives

If there are no Representatives or Nominees it may be difficult for the CCG to support a Personal Health Budget.

5.5 Risk Assessment and Management

At the start of the Support Planning process, the CHC Nurse/Case Manager will complete a referral form and care assessment in partnership with the Patient, Representative or Nominee about potential care needs, and how these can be managed. This should be reviewed regularly throughout the process and as part of the three month and annual review process.

The Support Planning process should reflect the importance of seeing positive risk as a benefit to a patient's wellbeing when this is something important to them.

During the process of discussing care needs with Patients or their Nominees or Representatives, CHC Nurses/Case Managers should ensure that everyone has the opportunity to contribute. CHC Nurses/Case Managers should ensure the Individual or Representatives is always involved in these discussions, and if appropriate, their family or carers. It will also be important to gain the input of a range of Healthcare Professionals and the people involved in the Patient's care, for example social workers or care workers. CHC Nurses/Case Managers should consider how best to strike a balance between the views of patients and Healthcare Professionals, maximising choice and control as far as possible, while also ensuring clinical needs are met.

5.6 Setting an Indicative Budget

During the Support Planning process to develop a care plan, the CHC Nurse/Case Manager will arrange a process to identify an indicative budget.

The indicative budget predicts the amount of money allocated to the Patient following an assessment of their needs as part of the CHC eligibility assessment and Support Planning process.

It is the responsibility of the CHC Nurse/Case Manager to inform the Patient or their Representative that the budget at this point is indicative and discuss the options for how the Personal Health Budget payment will be made. The Patient should be made aware that there is an approvals process before the final budget and form of payment can be agreed.

5.7 Completion of a Support Plan

5.7.1 The CHC Nurse/Case Manager will develop, in partnership with the Patient or their Nominee or Representative, a Support Plan. This must set out:

- The health and wellbeing needs and outcomes to be met by the services in the Support Plan
- A suggested timetable outlining how the care and support will be delivered
- The services that the Personal Health Budget will be used to purchase – tied to the discussion around outcomes, there must be a discussion about the goods and services the Patient wants to purchase. As far as possible, the Patient, with support from Health Professionals, carers and others, should make these choices. It may also be helpful to involve advocates at this stage and the Mental Health Support Association – York Mind can provide this
- The amount of the Personal Health Budget, and how often it will be paid – Personal Health Budgets must be set at a level sufficient to cover the cost of each of the services agreed in the Support Plan

5.7.2 The financial arrangements and requirements are contained in the agreement between the CCG and Patient (or their Nominated Representative), which will be signed by both parties.

5.7.3 All new Personal Health Budgets will be reviewed at three months to ensure that budget estimates and plan are meeting the Patient's needs. Revisions to budgets will be agreed with Patients as required based on this monitoring and will help inform the budget setting for future Personal Health Budgets.

5.7.4 The following costs will normally be paid as part of the Personal Health Budget:

- The direct cost of providing the service, including support service costs
- Start-up costs such as initial staff training
- Refresher training
- Equipment costs
- Contingency planning
- Equipment contingency (e.g. hire fee to cover breakdown not covered by insurance or by the CCG's community equipment contract)
- DBS checks where appropriate

5.7.5 Additional elements may be required to be funded within the Personal Health Budget such as the following:

- Redundancy costs when a service provided by Personal Assistants ceases, if the Personal Assistant is entitled
- Maternity pay, if the Personal Assistant is entitled
- Long term sickness – sickness normally paid as statutory sick
- Training to support newly employed staff
- Pension
- Annual leave entitlement

5.7.6 The CCG has agreed some financial management processes and documentation to ensure robust management of individual Personal Health Budget payments. These include Personal Health Budget agreements whereby:

- The Patient and CHC Nurse/Case Manager have to sign their understanding of the Personal Health Budget purpose and funding arrangements and restrictions
- The Patient must provide evidence to the CCG of expenditure through bank statements, receipts etc
- Overpayments will be reclaimed if representing more than 8 weeks payment unless by prior agreement subject to planned saving to fund specific high value care/support
- Records are retained by the Patient and made available for inspection by the CCG or their agents (e.g. the Local Counter Fraud Service)

5.7.7 It is the responsibility of the CHC Nurse/Case Manager to inform the CCG as soon as they become aware of factors which may affect the cost to the CCG. Patients must be made aware that the CCG will not automatically fund increased costs which have not been pre-approved through the Support Plan Review process. Other benefits should also be taken into account to ensure that the Personal Health Budget does not duplicate other sources of funding (e.g. Winter Fuel Allowance, Motability Allowance, Universal Credit etc).

5.7.8 Risk of fraud will be a risk maintained on the Personal Health Budget risk register and advice or proactive reviews will be provided by the Local Counter Fraud Service.

5.7.9 Monitoring and Review of Individual Personal Health Budgets

The Support Plan should be open to review and revision as necessary, and should be reviewed at clinically appropriate intervals. The CHC Nurse/Case Manager will ensure that the Support Plan is initially reviewed within the first three months, and then at least annually. In case of a change in a Patient's condition or other changes required in the Personal Health Budget, it is important that the Support Plan is reviewed, adapted to meet those changing needs and agreed as soon as possible including; as required changes to the Patients Personal Health Budget. It is the responsibility of the CHC Nurse/Case Manager to inform the CCG Lead for Personal Health Budgets if services are not working.

5.8 Complaints

As part of the discussion around the Support Plan, there should be a discussion around how Patients can make complaints. The NHS complaints procedure will continue to apply.

6. Governance

6.1 Personal Health Budget Approval

The CHC Nurse/Case Manager will be responsible for presenting a request for a Personal Health Budget to the CHC Panel for clinical consideration and approval.

As a minimum the CHC Nurse/Case Manager will need to submit the relevant paperwork to the CHC Panel to enable them to make a decision, including:

- Indicative Budget
- Completed Support Plan documentation
- Completed Risk Assessment

6.2 Personal Health Budget approvals and sign off

Where there has been a request made for a Direct Payment or where the package of care is considered high risk (e.g. workforce sustainability) or high cost, then the CHC Nurse/Case Manager will be required to present this to the CCG Director of Transformation and Delivery in the first instance for approval to proceed to CHC Panel.

Once the CHC Panel agree the Personal Health Budget is appropriate, the final Personal Health Budget value and rationale will be submitted to the CCG Executive Team for ratification.

6.3. To sign off a Personal Health Budget request, the CCG Executive Team will approve:

- The Indicative Budget
- The Support rationale

The CCG will constitute an appeals panel to consider appeals in the following situations:

- A request for a Personal Health Budget that was not approved
- The type of Personal Health Budget requested was not approved, and the type of Personal Health Budget offered is not acceptable to the Patient
- The final funding allocation is challenged by the Patient, or
- The decision making process is challenged by the Patient

6.4 Young People – Transition to Adult services

There will be some instances where a young person's family is in receipt of a Personal Health Budget and where the Patient will be transitioning to adulthood. As part of the transition process the CHC Nurse/Case Manager for the family will also be responsible for discussing Personal Health Budgets.

7. Safeguarding and Disclosure and Barring Service (DBS)

The CCG has a duty of care to ensure that Patients are protected from harm. This is discharged through:

- Risk assessment forming part of the Personal Health Budget assessment and approval process
- Patients and their carers being helped to understand the importance of safeguarding, and their role, including what to do if they have concern
- Where a Personal Assistant is to be employed, a Support Service (this may include an agency, a broker or equivalent) is recommended, and Personal Assistants must be subject to DBS checks. If the Patient refuses, the CCG may not grant a Direct Payment, although other forms of Personal Health Budget will still be made available
- Where a Personal Assistant is already employed prior to the Personal Health Budget (normally through Local Authority funding), the provider must check whether DBS checks were carried out at the time. If not, these will be required, as for a new employee
- Where there are concerns about a change to a Patients' capacity to consent or manage their Personal Assistant, this must be assessed and appropriate steps taken by the NHS provider

- Loss of capacity or ability to manage should not mean the loss of a Personal Health Budget or Personal Assistant

8. Risks

8.1 Clinical Risk

8.1 The CCG is committed to promote Patient choice, while supporting them to manage risk positively, proportionately and realistically. Good practice must support Patient choice. Supporting people to take informed decisions with an awareness of risks in their daily lives enables them to achieve their full potential and to do the things that most people take for granted.

8.1.2 A Patient who has the mental capacity to make a decision, and chooses voluntarily to live with a level of risk, is entitled to do so. The CCG requires that providers document clearly any evidence of decision making and rationale in relation to the management and reduction of risk where appropriate or necessary. This will be considered as part of the Personal Health Budget approval process by the CCG. Empowering people to take control of their own health may generate a perception of increased risk and adverse consequences. However, in reality there is likely to be a reduced risk because Patients have been consulted about their choices, are actively involved in decision-making and take ownership of, and some pride in, the responsibility for achieving their outcomes.

8.1.3 The CCG encourages a tiered approach to risk when considering a request for a Personal Health Budget. In practice, because there are different ways to manage Personal Health Budgets, Patients deemed not suitable for a Direct Payment should be offered a budget held by a Third Party or a Notional Budget (which must be supported by an outcomes focussed Support Plan).

8.1.4 Risk is also a consideration when the Patient is deciding how they want to spend their money to meet their outcomes. Some choices made by Patients will be easy for the CHC Nurse/Case Manager to support – for example employing a Personal Assistant to visit at the times that suit the Patient's lifestyle, rather than a carer who attends at a time convenient to the service provider, or going swimming rather than attend physiotherapy.

8.1.5 Other choices may not be supported by NICE guidance, or be considered to be less orthodox, causing concern in Health Professionals trained to adhere to evidence based practice.

8.1.6 Ways of mitigating the risk should be explored with the Patient. Depending on the situation and the risk, it may be possible to agree a trial period with the Patient that includes frequent monitoring.

8.1.7 The CCG recognises that this is a very different way of working, and it may be a challenge for a Health Professional to balance the need to work alongside a Patient to deliver their choices, and a concern over whether a proposed activity or service will meet the need and deliver the outcomes.

8.1.8 To assist staff in delivering a consistent, evidence based approach to proportionate risk management, a Support Plan will be developed and will take into account other national assessment tools where appropriate.

8.2 Organisational Risk

8.2.1 Responsibility for approving Personal Health Budgets is the responsibility of the CCG.

8.2.2 The CCG has an obligation to ensure all Personal Health Budgets:

- Health and well-being needs are being met
- Safeguarding duties are fully met
- They are fulfilling their duty of care and broad statutory obligations
- They are fulfilling their responsibility to ensure that public funds are used to enable Patients to live independent and full lives ensuring value for money
- Patients expenditure is managed within the overall CCG budgetary allocation ensuring the CCG meets its statutory duty to breakeven on its resource limit,
- Public funds are used appropriately and value for money achieved
- The CCG's reputation is protected

8.2.3 The CCG is committed to shifting the balance of risk towards a positive approach of supported decision-making for Patients, the organisation, and its partners.

8.2.4 The CCG will work with partner organisations to promote a wider understanding of this approach to risk. It will also seek to secure from partners, a complementary approach to risk which is as light touch as is reasonable.

8.2.5 The CCG will work with the Local Authority as lead agency should any safeguarding concerns arise to ensure they are investigated accordingly.

9. Finance and Contracting

9.1 Role of Finance and Contracting Team

The Finance and Contracting Team will:

9.1.1 Support the CHC Nurse/Case Manager in developing a process to identify an Indicative Budget and the subsequent refinement into the Final Personal Health Budget.

9.1.2 Support the regular monitoring of the use of the Personal Health Budget, including the liaison with the CHC Nurse/Case Manager and Local Authorities who may undertake specific work on the agreements.

9.1.4 Ensure that all appropriate payments are made in a timely manner and that full records are maintained to support clear and understandable reporting of the financial position, including any under and over spends against the Personal Health Budget, taking account of timings set out in the Support Plan.

9.1.5 Ensure the Personal Health Budgets are managed within the overall financial limitations of the CCG and ensure they represent value for money by working with the CHC Nurse/Case Manager and the Budget Manager.

9.2 Deciding when not to offer a Personal Health Budget

The CCG may decide not to provide someone with a Personal Health Budget, if for example, the CCG considers:

- That the Patient (or their Representative/Nominee) would not be able to manage them
- That it is inappropriate for that Patient with their specific health need or the impact on that Patient of their health need
- That the benefit to that individual of having a Personal Health Budget for healthcare does not represent value for money
- That providing services in this way will not provide the same or improved outcomes
- That the Personal Health Budget will not be used for the agreed purposes

- There is an inappropriate conflict of interest between the recipient of the Personal Health Budget, the Care Provider and the Patient. This may be resolved through the use of a Third Party receiving the funds

In the event where the CCG decides not to give someone a Personal Health Budget, the Patient and any Nominee or Representative, will be informed in writing outlining the reasons for this decision in appropriate format for the Patient or their Representative to understand.

In cases where Personal Health Budgets have been refused, the CCG will, where possible, also consider whether other forms of Personal Health Budget, such as a Notional Budget or a Budget held by a Third Party, might be suitable for their needs, or how else their care could be personalised.

The Patient, their Nominee or Representative may request that a reconsideration of the reason for a decision not to give a Personal Health Budget. They may also provide additional evidence or relevant information to inform that decision. The CCG will reconsider their decision in the light of any new evidence, and then notify and explain the outcome of their deliberation in writing. The CCG will reconsider the decision not to give a Personal Health Budget only once in any six month period.

9.3 Value for Money

The CCG will ensure that Personal Health Budgets offer value for money for Patients and the CCG. This will be done through the way in which Personal Health Budgets are set up, through robust support planning and through effective monitoring or Direct Payments.

Whilst the CCG want to maximise flexibility, in the Support Planning process Patients and CHC Nurses/Case Managers should avoid using Personal Health Budgets to commission packages of care which are provided under existing NHS contracts as long as they can meet needs. The Personal Health Budget should be used to get maximum benefit for the Patient and also used in a way to ensure that the CCG is not paying twice for the same service. The CCG will always seek to ensure that packages of care are personalised as much as possible.

9.4 Agreement

Once the Personal Health Budget has been approved by the CCG, the CHC Nurse/Case Manager will then inform the Patient, Representatives or their family of the final budget and how the Personal Health Budget will be provided (i.e. Notional, Direct Payment or Third Party). This decision will also be recorded in the Patient's record. If it has been agreed for the Patient to receive a Direct Payment the Patient must also then agree to sign the CCG's Direct Payment agreement.

The CHC Nurse/Case Manager is responsible for then supporting the Patient in implementing the Personal Health Budget in order to meet the outcomes identified in their Support Plan.

9.5 Third Party Organisations and Independent Brokerage

The Patient or their Representative/Nominee may choose an external organisation to hold their Direct Payment and/or recruit staff for them.

The Patient or their Representative/Nominee may also choose to use an independent broker to support them in deciding how to use their Personal Health Budget in order to meet their health and well-being needs and outcomes as identified in their Support Plan. The broker may provide on-going assistance, where required, in supporting an individual in the management of their care.

Both Third Party organisations and those providing brokering functions will be financed to an appropriate level as part of the Patient's Personal Health Budget. The CCG may make reasonable checks on these organisations before agreeing to fund them as part of the Personal Health Budget. These checks may include but are not limited to:

- CQC reports where applicable
- Registration e.g. with the charity commission
- Financial checks

9.6 In line with NHS finance policy, a Patient cannot "top up" a Personal Health Budget to purchase an item of higher specification, or gain greater benefit, over and above that required to meet assessed need. For example, a Personal Health Budget may include an agreed sum for gym membership, based on the local market rate. This sum cannot be added to so that the Patient joins a more expensive gym offering facilities which are not required to meet their agreed health outcomes. If there are concerns then this needs escalating to the CCG Lead for Personal Health Budgets.

9.7 If equipment purchased through a Personal Health Budget is no longer required e.g. if it no longer meets assessed needs, or the Patient dies, the CCG would expect a discussion to take place with the CCG Lead for Personal Health Budgets about the disposal of that equipment.

9.8 Disposables which are provided through an NHS contract (such as continence products) are not funded through a Personal Health Budget to avoid double funding. However, if the local service is unable to supply to meet particular needs in either an appropriate or cost effective way, a Personal Health Budget may be considered in the best interests of the Patient.

9.9 There is no formal entitlement to holiday funding for Personal Assistants within a Personal Health Budget, but for those individuals who do not benefit from carers' respite, the CCG recognises that a holiday or short break is beneficial to health and well-being. The CCG acknowledges that there may be additional staffing and equipment costs to support someone away from their home in an environment which may not be suitably adapted. In some instances two carers may be needed for safe care. In addition, people who do not normally require 24 hour care may need to take their own carers and require them to work longer hours.

9.10 The CCG will consider funding up to 14 days extra support plus appropriate equipment hire per annum to enable the chosen holiday or breaks to take place. The Patient should discuss the implications of the break (including travel) for their clinical care Personal Health Budget support plan with their CHC Nurse/Case Manager. The additional costs must be calculated and approved by the CCG (through submission of the Personal Health Budget Holiday Funding proforma) before the holiday is booked. The CCG reserves the right to refuse to fund support or equipment over and above that required to meet assessed need. The Personal Health Budget will not cover Personal Assistant's travel, meals, accommodation, or anything not related to the agreed Support Plan.

9.11 Any other breaks or additional costs will need to be funded by the Patient, or by saving up underspend on their Personal Health Budget. Any savings made via the Personal Health Budget should not reduce the ability to meet agreed outcomes, or be made at the expense of health or well-being.

9.12 **Funding for Personal Assistants' pensions**. The Support Service is responsible for helping ensure that good practice is followed in Personal Assistants' employment, including a pension.

9.13 **Funding for Personal Assistants' redundancy**. Personal Assistants' (other than through an agency or broker) are employees of the Patient rather than self-employed and are entitled to redundancy pay as set out in employment legislation. Some Personal Assistant insurance cover includes Personal Assistants redundancy. It is an expectation of the CCG that all insurance includes redundancy provisions. In the absence of cover the CCG will fund redundancy, and will seek to recoup a pro rata element where the Personal Assistant was previously funded through LA Direct Payments. If there is evidence that the Personal Assistant has ignored advice from a Personal Health Budget funded support service provider the CCG reserves the right not to fund redundancy.

9.14 **Funding for Travel and Mileage**. A Personal Health Budget can cover travel costs such as bus fares to activities which are part of the Personal Health Budget. When appropriate, a Personal Health Budget can provide a contribution towards the mileage at the NHS standard rate (latest rates available here). However, if the Patient has a Motability Car or higher rate Mobility Allowance the CCG would not pay the full HMRC / NHS Mileage rate but only the reduced mileage rate. The standing costs for running a car should be met from the Mobility Allowance as these costs would need to be met regardless. If the Patient is not in receipt of Mobility Allowance at higher rate then the Personal Health Budget would meet the HMRC / NHS rates. Calculations are based on the average distance between the Patient's home and the activity using a nationally recognised online tool such as the AA Route Planner.

9.15 **Funding for Board and Lodgings for Live-in Carers.** The Personal Health Budget will include an element for "travel and subsistence" (including a food allowance), but not accommodation.

9.16 **Interface with Individual Funding Requests (IFR)**. On occasion a request may be received through IFR for an intervention which may be more appropriate for a Personal Health Budget, particularly if the request does not meet the criteria for IFR. The majority of these Patients would be in receipt of universal services (i.e. NHS funded), hence the principle of Personal Health Budget being a replacement for an existing service rather than a source of additional funding would still apply. In this situation, the IFR Lead will contact the CCG Lead for Personal Health Budgets, and work together to determine whether a Personal Health Budget can be offered.

10. Expanding Personal Health Budgets

The CCG will continue to develop Personal Health Budgets across all age groups and for all Patients who would benefit from a Personal Health Budget.

10.1 It is expected that individual Health Professionals will talk to Patients about Personal Health Budgets and develop the Support Plan, assessing risk, and identifying costs. They will be supported to undertake these tasks.

10.2 The funding for the expansion of Personal Health Budgets in the future in a number of instances is tied up in the block contracts. There is very limited additional funding available from the CCG. The expectation is that the majority of Patients are identified through risk stratification and are pro-actively offered a Personal Health Budget as being those most likely to benefit.

10.3 It is the responsibility of all agencies to work together to identify those who are most likely to have the greatest benefit and work with them to see how a Personal Health Budget could improve their health. For some people, this will involve working with their carers as well.

10.4 Requests for Personal Health Budgets will also be coming directly from Patients. It is important that the Health Professional receiving the request explores with the Patient:

- The reason for the request
- The outcomes which the Patient wishes to achieve
- Whether there are other ways these can be met within existing resources
- What kind of Personal Health Budget they want (i.e. Direct Payment, Third Party or Notional)
- Whether the service can become more responsive

This will ensure that Patient centred planning remains at the centre of discussions, and will enable the Health Professional to assess whether the request should be explored further or recommended to be supported.

11. Performance and Monitoring of Personal Health Budgets

11.1.1 The CCG will ensure that mechanisms are in place to collect and collate sufficient information to provide assurance that Patient outcomes can be measured against overall budget allocation, statutory and locally agreed performance measures.

11.1.2 Ongoing monitoring and evaluation will be undertaken by the CCG, and includes:

- Finance
- Breakdown of uptake of Personal Health Budgets
- Patient experience of Personal Health Budgets
- Improvements in quality of life (outcomes and benefits)
- Addressing any requirements from the Quality and Patient Safety Committee
- Receiving provider reports, to include activity data and a quality report
- Receiving reports relating to the audit of Personal Health Budget or proactive reviews by the Local Counter Fraud Service
- Provide detail of any serious incidents or concerns (including safeguarding)
- Reports via markers of progress to NHS England

12. Legislation and Guidance

Relevant documents include:

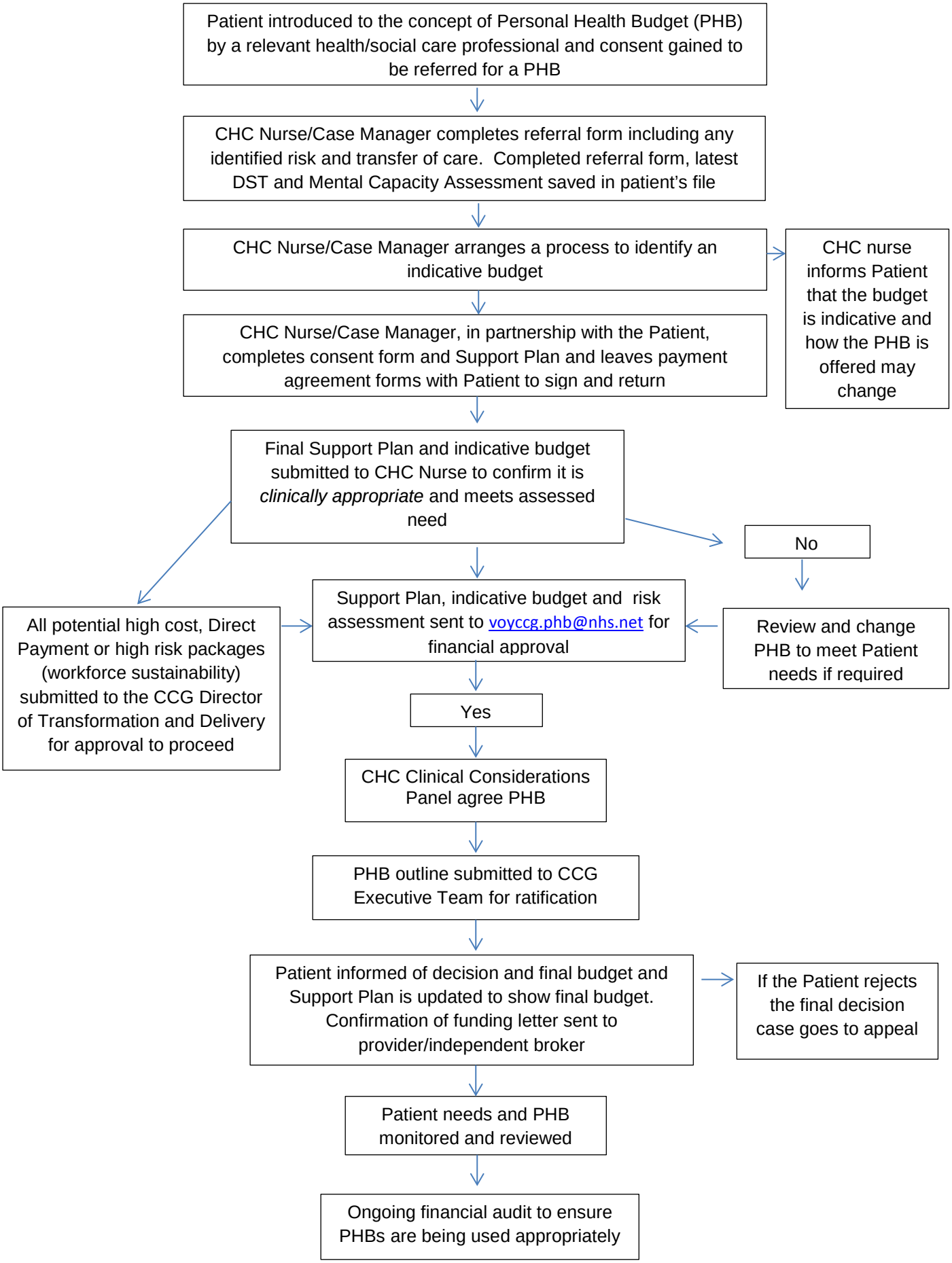
- Next Steps on the Five Year Forward View (NHSE, 2017) further promotes supporting disabled people and people with complex health needs through personal health budgets, with plans to reach in excess of 40,000 people by 2019
- Personalised health and care framework (NHSE, 2017) provides best practice advice for NHS and local government professionals delivering Integrated Personal Commissioning and implementing personal health budgets
- Forward View into action: Planning for 2015/16 (NHSE, 2014) required the expansion of Personal Health Budgets to all those who may benefit, and highlighted that by April 2016, NHS England expect that Personal Health Budgets or integrated Personal Health Budgets across health and social care should be an option for people with Learning Disabilities
- The Governments Mandate to NHS England 2016-17 (Department of Health, 2015)
- The Care Act 2014, which primarily applies to Local Authorities, places Personal Health Budgets into law for the first time, making them the norm for people with care and support needs
- The Children and Families Act 2014 which introduced Education, Health and Care Plans for children and young people with special educational needs and disabilities
- On 1 August 2013, the Direct Payment in Healthcare regulations came into force across England, meaning that the NHS can lawfully offer Direct Payments for healthcare
- Health Act (2009) Allowed selected Primary Care Trust sites to pilot Direct Payments

- The Operating Framework for the NHS in England 2009/10: High Quality Care for All (Department of Health, 2008) outlined NHS priorities such as better access, reduced inequalities, partnership working in delivering personalised care, and supporting Patient contributions to improvement and shaping high quality provision
- NHS Next Stage Review: High Quality Care for all (Department of Health, 2008) outlined plans for Personal Health Budgets

Other relevant legislation includes:

- Human Rights Act (1998) including Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination
- The Data Protection Act (2003)
- The Carers (Equal Opportunities) Act (2005) ensures that carers are able to take up opportunities that people without caring responsibilities often take for granted
- The Mental Capacity Act (2005). The need to apply the Mental Capacity Act features strongly in self-directed support where there may be concerns about a Patient who appears to lack the mental capacity to manage their own money and/or the ability to make decisions about their care
- The Equality Act 2010 Replaced previous anti-discrimination laws with a single Act
- Delivering the forward-view NHS Planning Guidance 2016/17 – 2020/21

Appendix 1 – Personal Health Budget Flowchart



Appendix 2

What Makes a Good Support Plan?

The plan must:
1) Show who the Patient is, with their strengths and skills, and their personal social context, as well as their health and well-being needs. If the Patient lacks capacity to make their own decisions the plan must show how this decision was reached and identify who will speak on their behalf.
2) Describe what is working and not working from their perspective.
3) Detail what is important to the Patient and what is important for their health and well-being.
4) Identify and address any risks and how they will be mitigated to an acceptable level, including a contingency plan for if things go wrong, and a point of contact in health services. State the health and well-being outcomes to be achieved and how it is proposed that those outcomes will be achieved.
6) Describe in broad terms how the money will be held and managed and show how it will be used to achieve the outcomes.
7) Have an action plan that details who will do what and when to ensure that the plan is carried out.
8) Include the name of the person's CHC Nurse/Case Manager.
9) State how and when the outcomes, and the money, will be monitored and reviewed. (This will include describing how Patients will know the plan is going well, and how Patients would know if things were going wrong.) (From "Implementing Effective Care Planning" toolkit guide).

The Individual Support Planning Process
The central focus of Personal Health Budget planning is on improving the dialogue between the Patient and Health Professionals to create a **synthesis** of **expert clinical knowledge with an individual's unique direct experience and capabilities, their preferences, creativity and motivation**. At the heart of a Personal Health Budget is a Support Plan developed in partnership.

The following section of this paper outlines how this process may best take place. Whilst it is written as a number of stages, this does not imply a series of consultations, nor will the process necessarily be linear. It is an iterative process, unique for each person. The stages do however, contain the essential steps towards building the finished plan.

Importantly, the stages mirror the criteria for sign off described in the strategic framework. This is because the strategic framework within which Support Planning is implemented is a dynamic part of the process, informing and shaping each Patient's individual conversation with their health team, and underpinning each Health Professional's decision-making. As such, it does not remain separate from, but is interwoven with every Support Plan. The stages are as follows:

Stage One – Having the necessary information.
Stage Two – What is working and not working.
Stage Three – What is important to me and for my health, including risk enablement.
Stage Four – Outcomes and priorities.
Stage Five – Action planning.

Stage One: Having the necessary information
Before starting to plan, people will need to have been given clear accessible information about what a Personal Health Budget is, what its purpose is and what the "deal" is around the money and the other important parts of the framework. That is: all the elements of the

strategic framework will need to be outlined, including information on: how much money, choice of ways to hold the money; choice of and range of support for planning; information about what could be possible etc will each need to be discussed. Capacity issues will also be addressed at this stage.

This is a lot of information for someone to take in, and this first stage needs to be given sufficient time. Staff need to explore people's understanding, and give space for questions and clarification. Sending a leaflet or directing someone to a web site is unlikely to be sufficient, though can be a helpful part of a broader approach. Linking people with others who have a Personal Health Budget can be particularly helpful, both in person and through virtual links.

Stage Two: What is working and not working
Initially, the starting conversation seeks to build a trusting relationship and allow Patient's space to explore what is working and not working in their life, related to their health. Patient may need to explore this with peers, to begin to move from a passive acceptance of everything the way it is, to a realisation that things could change. For example, if a parent carer has never been able to go out for the day with her child because the shift of agency staff who supports them happens every day at 2pm at home, they may not appreciate initially, that through using a Personal Health Budget they could organise their days and the days of their child, very differently.

For people with Long Term Health Conditions – their health needs are woven through their life: - they are not a separate thing and so there is little need to worry that patients will talk about random or irrelevant things when they identify what's working and not working well in their lives. This part of the Support Planning process, and each of the next stages, gradually starts to build a picture not only of health needs, but of who the Patient is and how they want to shape their life by making the decisions about their health and well-being which matter most to them.
"Previously, the vital question of how the individual would like to live their life was never asked. There was little planning around the individual and often the debate would be around generic symptom management, and too often on the professional assumption that any other way would be too costly, too risky or too onerous" (Personal Health Budget peer network member).

The stage at which a Health Professional's views are incorporated into the Support Planning process is really important. The Health Professional's view is not put in at the very beginning *nor* at the end. This second stage is exploratory discussion, active listening and respectful questioning and reflection – finding out the most important things which are working and not working.

Stage Three: What is important to me and important for my health, including risk enablement
The next stage is to consider together, with those things which are working and not working, what is important to the Patient in terms of what matters most to them, and also what matters for their health. The Patient themselves is the only one who can know what matters to them; and the Patient themselves, (unless newly diagnosed), will also have a good idea of what is important for their health, to which the Health Professional can add their expertise.

What matters most to someone in their life cannot be explained – it simply does matter. It is then useful to understand a little more about the essence of what matters, in order to be able to write a specific outcome and a Support Plan linked to that.

In thinking together about what is important to and important for someone, the Health

Professional can helpfully contribute their expert knowledge about the specific “important for” information. For example, the person may be aware that they need to keep their blood sugar or oxygen saturation at a certain level – the Health Professional can give specific detail and advice about how to monitor and maintain the correct level for their particular illness, age and context. Health Professionals also play a vital part in helping Patients explore really difficult issues around loss and adjustment to a different life after accidents or strokes, or following a life limiting diagnosis.

So it is at this third stage where the Health Professional can most usefully begin to input their knowledge, ideas and expertise.

A great planning process will lead to a Support Plan which integrates what matters most to someone with what matters most for their health, because it is that interaction and joining together of best clinical practice with someone’s own motivations and creativity which leads to Support Plans which are:

- Acted on not ignored
- A live participative process not a “prescription”
- and which make best use of both professional and individual knowledge and ideas

Risk enablement
It is also at this stage that any risks can be identified and addressed. When planning with a Personal Health Budget, risk and responsibility are openly discussed and can be shared. If a Patient wishes to have more power and control then there is an expectation that they will begin to share more responsibility for the management of their health condition. As stated before, it is a “deal”, or a new contract.

However, everyone has different views of how much risk and responsibility they may want to take at different times, and so there should never be any compulsion to do things differently. Personal Health Budgets can be used, for all, some, or none of someone’s treatment, depending on what that Patient wants.

If a Patient is feeling vulnerable, scared and unwell, they may wish for Health Professionals to determine what is in their best interest. Alternatively, over time when they may feel more confident, or if they feel that something vital to them is at risk of being lost or never achieved, they may want to take more control and more responsibility and they may view risk differently.

A more open, trusting and respectful dialogue can lead to better quality decision making and significant potential for improved outcomes, as someone commits to carrying out the personal plan they have written. This “adherence” is seen as key to safety. However, there are workforce development and cultural issues to be addressed: “Research in the UK suggests clinicians may take a “compliance approach” to self management and this is unlikely to be helpful” .... “The most promising way of supporting self management appears to involve approaches which empower and activate people so they feel more confident about managing their conditions and are more likely to alter their behaviours. There is strong evidence suggesting that improved self efficacy is associated with better clinical outcomes.” “Whilst evidence is emerging, there is still a long way to go before we understand the education support necessary to optimise clinician’s attitudes, skills and behaviours towards self management. This also calls for a fundamental shift of power dynamics and the way both Patients and Health Professionals view their roles”. (*Helping people help themselves, Health Foundation, 2011*).

Supporting staff and people using Personal Health Budgets to find personalised ways of managing risk
When developing the Support Planning process, it is helpful for both Patients with budgets and clinicians, commissioners and service providers to work together on how this part of the Support Plan will be discussed, agreed, and recorded. It can be helpful to have a separate sheet of the Support Plan specifically to address the issues of risk where the Patient and anyone supporting them to make their Support Plan, records what might go wrong with the Support Plan and how they plan to minimise the likelihood of this happening. On this sheet, it can be helpful to have a simple checklist of prompts such as:

- Is there is anything that the person or their clinician is worried about?
- Is there anything that has happened in the past that might arise again?
- Is there a possibility of harm or abuse?
- Is there adequate support in place if Patient wishes to use Direct Payments to employ their own Personal Assistant?

In their paper making the case for shared decision making in Health, Angel Coulter and Dr. Alf Collins argue that: there should be a formal process for documenting:

- The decision
- The agreed course of action
- The ongoing roles and responsibility of each party
- The risk-sharing agreement.

While all of the above is usually formalised in the process of consenting to a medical or surgical intervention, healthcare providers should ensure that they have documentation systems and processes in place when there has been a shared decision about any course of action, such as adhering to a medication regime or undertaking a lifestyle or behaviour change. As well as providing a useful record for Patients and other Health Professionals they may encounter during their care, this practice could provide protection from legal challenge if Clinicians can demonstrate that Patients were offered choices and provided with reliable information about the options (*Making Shared Decision Making A Reality, Angela Coulter and Alf Collins, Kings Fund, 2011*).

Stage Four: Priorities and outcomes
Having started with exploring what is working and not; and then going on to consider what is important to and for Patients; and how risks will be addressed; some clear priorities will begin to emerge. What needs to be ensured is that all of the priorities and the outcomes which flow from these, are the Patient's own outcomes. It is important not to add on Health Professionals' "health outcomes" at the end just as they cannot be imposed at the beginning.
"individual goals need to feel important to the Patient....action planning may feel uncomfortable to the Clinician where the Patient is not willing to agree to something which the Clinician sees as important....engaging with the process is essential to find out what the Patient is prepared to do...
"Patients and Clinicians have similar aims to improve long term outcomes by increasing length of life and reducing morbidity – also in short term improving quality of life; but they often prioritise differently, with Clinicians emphasising the former and Patients with Long Term Conditions the latter. .....Accepting a Patient's quality of life and their knowledge, skills and confidence to manage their own health and healthcare are important outcomes in their own right, poses newer and harder challenges..."
(*Care planning - improving the lives of Patients with Long Term Conditions, RCGP, 2011*).

If the outcomes are not recognised and owned by the Patient then it is not their Support Plan and something has gone wrong with the conversation. There needs to be further dialogue. The prioritising stage will pull together, from the conversation, what are the joint priorities agreed by the Patient and the Health Professional. There will have been a synthesis of ideas, and a clarification of top priorities for action, including risk enablement and contingency planning.

When developing outcomes, care needs to be taken against moving to thinking of services and therapies too soon. Outcomes are not services, treatments or therapy, nor attending places – unless for a specific purposeful outcome. Outcomes are, broadly, changes in or sustaining of physical behaviours, or mental states/emotions. The Support Plan needs to describe clearly what is being aimed for, in specific terms. What will be working better, be maintained or be avoided? This can include what is hoped for even in a deteriorating health condition, or at the end of life and should include resources available in the local community i.e. charities, voluntary services etc.

The health outcomes need to come from the Patient. The Health Professional's role is to help support the identification of the Patient's own outcomes and to contribute to making them as specific and individually relevant as possible. The actions which follow are then fully and clearly linked to the specific outcomes.

Stage Five: Action planning
The ideas about how to achieve the outcomes will be a bringing together of what someone has thought of as their own solution, is willing to commit to and is motivated to do; with the Health Professional's expertise about what might have proved useful for others and what research suggests too. The intention is that the Support Plan produced is the Patient's own Support Plan for their health outcomes, integrated with the other key parts of their day to day living. It is that personal ownership and control, together with the recognition of health as an interwoven part of someone's whole life, which enhances the Support Plan's effectiveness.

The actions in the Support Plan should be specific and linked to the outcomes. As shown above, there must also be clear identification of potential likely risks and ways to address these.

Health Professionals need to trust Patient's own solutions. This is at the heart of the shift in the relationship – Patients exploring what matters and finding their own ways to achieve change, actively and fully participating.

Appendix 3

Direct Payments
Direct Payments will be managed via a schedule of payments.

1) Patient requesting Direct Payment identified in Support Plan
2) Final Personal Health Budgets budget approved by CCG Executive Team
3) Patient agrees to the Support Plan and signs the CCG's Direct Payment agreement
4) The Patient is responsible for opening the bank account to receive their Personal Health Budget payment
5) The CCG will monitor payments made by Patients on a monthly basis. The Patient or their Representative will be required to submit to voyccg.phb@nhs.net details of their spend (through receipts / proof of payments) for the period against the agreed Personal Health Budget. Payments may be stopped if there is evidence of any irregular activities.

Third Party Management
Third Party payments will be managed in a similar way to the Direct Payments Process.

1) Third party trust fund identified in Support Plan and approved by CCG Executive Team
2) Third Party agrees and signs Third Party agreement
3) Third Party sets up a separate bank account for payment
4) The CCG will monitor payments made by Patients on a monthly basis. The Patient or their Representative will be required to submit to voyccg.phb@nhs.net details of their spend (through receipts / proof of payments) for the period against the agreed Personal Health Budget. Payments may be stopped if there is evidence of any irregular activities.

Financial Process for ending a Personal Health Budget
1) The CHC Nurse/Case Manager informs the CCG Finance and Contracting Team that a Personal Health Budget is no longer required
2) CCG Finance and Contracting Team to update SBS and ensure payments are stopped on system also

Ceasing Direct Payments
1) The CHC Nurse/Case Manager notifies the Patient or their Representative giving the reason for ceasing payments and giving 28 days' notice
2) CCG Finance and Contracting Team to amend the record on SBS

Finance Audit and Controls of Personal Health Budgets
The CCG Finance and Contracting Team will audit the delivery of Personal Health Budgets and manage any financial risk associated with Personal Health Budgets. This audit will involve:

1) Review of overall spend Personal Health Budgets as part of the Budget Management process
2) As part of the finance payment process the CCG will review on an ongoing basis Direct Payment and Third Party spends against their budget to ensure the money is being spent in accordance with their identified assessed needs.

Process for Recovering Personal Health Budget money
The CHC Nurse/Case Manager, supported by the CCG Finance and Contracting Team, as part of the ongoing review process, identifies unused funds in the individual's account.

Where appropriate the CCG Finance and Contracting team will effect a return of the money. The CCG Finance and Contracting Team will update SBS.

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Item Number: 14

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 1 March 2018

NHS
Vale of York
Clinical Commissioning Group

Report Title – North Yorkshire Safeguarding Adults Board Annual Report 2016/17

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

Reason for Report

This annual report provides details about the work completed and actions taken during the year of the North Yorkshire Safeguarding Adults Board with contributions from each of its member organisations.

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

N/A

Responsible Executive Director and Title	Report Author and Title
Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse	Welcome by Colin Morris, Independent Chair, and Councillor Michael Harrison, Executive Member for Health and Adult Services, with contributions from partner organisations

North Yorkshire Safeguarding Adults Board

Annual Report 2016-2017

Working in partnership to Safeguard Adults at risk of abuse or neglect

Are you concerned about an adult who is at risk of abuse or neglect?

Telephone North Yorkshire County Council's Customer Service Centre:

01609 780780 and speak to a representative to raise a concern.

nysab@northyorks.gov.uk

August 2017

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- **Craven District**
- **Hambleton District**
- **Harrogate Borough**
- **Richmondshire District**
- **Ryedale District**
- **Scarborough District**
- **Selby District**

12. **Independent Care Group (ICG)**
13. **North Yorkshire and York Forum**

Appendix 2: Membership of the Board and attendance.

Appendix 3: Contact Details of Partner Organisations

1. Introduction

About the Annual Report

This annual report reflects coordination and partner activities for the past year and includes contributions for statutory, independent, voluntary and other bodies who are involved in safeguarding adults in North Yorkshire. The Care Act (2014) places the duty on the Local Authority to lead safeguarding arrangements and one of its duties for the Safeguarding Adults Board is to publish its annual report.

This report is a public document and will be shared with Chief Executives of all agencies on the Safeguarding Adults Board who will be expected to disseminate the report across their organisations sharing it with stakeholders and scrutiny committees including.

2. Welcome

From Colin Morris the Independent Chair

It gives me enormous pleasure to introduce the Annual Report for North Yorkshire Safeguarding Adults Board for the year 2016/17.

By way of explanation, Safeguarding Adults Boards are a statutory requirement made upon each Local Authority area in England. They have specific duties and responsibilities to ensure that the plethora of partner agencies that meet under the auspices of the Board work together to provide safe, effective, and efficient safeguarding arrangements to those most vulnerable adults living in their areas. The Partnership is made up of a rich mix of both statutory and non-statutory bodies.

The provision of the Annual Report is a statutory requirement made upon the Chair of the Safeguarding Adults Board, to give full account of the workings of the Board and its activities over a 12 month period. This then becomes the evidence base by which the Safeguarding Adults Board can be held to account by describing its workings within this both technically and emotionally challenging area of work and providing coverage around performance, audit, training, assessment of risk, success and where lessons need to be learned.

Throughout 2016/17 the North Yorkshire Safeguarding Adults Board has demonstrated the great strength of its multi- agency commitment to protecting and safeguarding the interests of those who are most vulnerable living in the County, at the same time doing this in a way that encourages and maximises the individual rights and preferences of those with whom partner agencies are working. Living a life that is free from harm is a fundamental right and principle of every individual, but that is founded upon the principle that safeguarding is "Everybody's Business". This is a headline message that our Board needs to continually reinforce, which it does by utilising public awareness campaigns such as during Safeguarding Week, training on a multi-agency basis, and specific activities.

The Board has recently undertaken a range of governance reviews, including a membership review of the Board, its supporting Executive and sub-groups which, in turn, have witnessed important changes in the way the Board deploys its duties and responsibilities. A major focus has been on breaking down historical barriers between partner agencies, and reducing the bureaucracy that previously may have deterred people from accessing appropriate help at a time when they may have most

needed it. Crucial to this has been attempts to work with individuals as early as possible to minimise the potential for further harm in the future.

In terms of focus, this year has witnessed many additional changes and challenges to the safeguarding "agenda", many of which do not fit the traditional profile of work that the Board has previously addressed. What is clear is that these new areas of work specifically highlight how vulnerable people, be they adults, young people or children, are being targeted and making them increasingly "at risk". Modern day slavery, human trafficking, sexual exploitation, and forced marriage are all very real examples where an individual's vulnerabilities are taken advantage of and exploited. Advances in technology have brought about liberating opportunities for people, but at the same time opened up huge opportunities for exploitation - cyber bullying, on-line fraud, sexual exploitation and grooming are all examples of this.

Whilst we need to acknowledge these new challenges and develop ways to address them, we must at the same time ensure that previously identified priorities do not fall by the wayside. So, for example, our commitment to personalisation, with a strong emphasis of placing the individual at the heart of everything we do, and our commitment to " Making Safeguarding Personal " need to maintain priority focus and be fully owned by the whole Partnership and not just the Local Authority, Police, or health services. There has undoubtedly been great work in all of these areas which we need to keep on recognising and acknowledging. More information on these achievements can be found in the detail contained within the Annual Report - the message here is despite the obvious evidence of austerity cutting deep into everyone's resources, working together as one collective partnership, rather than a bundle of individual agencies, will bring about far greater impact, improvement, and efficiency.

In ending I would like to formally record my thanks to everyone who is involved in this most challenging yet highly rewarding area of work for making safeguarding "Everybody's Business".

Colin Morris
Independent Chair, North Yorkshire Safeguarding Adults Board

Having taken on the role of Lead Executive Member for Adult Social Care and Health Integration in May 2017 I would like to recognise the achievements presented in the Report, and am grateful for all the hard work and commitment demonstrated by the Partners of the North Yorkshire SAB.

Our partners continue to provide leadership focused upon specific safeguarding matters in North Yorkshire, and the ability to challenge, empower and support them has given greater emphasis and scope for development - particularly around learning from practice. I am confident that the skills, experience and knowledge embedded in the Board will continue to deliver tangible and real changes in North Yorkshire that helps protect the most vulnerable adults living in our communities.

Councillor Michael Harrison
Executive Member, Health and Adult Services

3. The Role and Achievements of the Sub-Groups

The Board has a number of Sub Groups to assist in its role:

Executive Group

The Executive Group, established this year, is responsible for overseeing the strategic management of safeguarding adults work in North Yorkshire by monitoring the work of the Sub Groups, and the Delivery Plan. This group is also responsible for ensuring processes carried out by the Board are done so effectively. Key recommendations are made by this Group for consideration by the Board.

Learning and Improvement Group (LIG)

This newly established group, which has met once, will promote a culture of continuous learning across the Board and the wider partnership, ensuring that there are lasting improvements to services. The role of the group includes overseeing the Safeguarding Adults Review (SAR) function on behalf of the Board. One SAR has been commissioned by the Board this year, which is still ongoing. The outcome will be reported in the 2017/18 Annual Report. The Group has begun to develop a work plan and a draft Learning and Improvement Framework for the Board to ensure that it has robust multi-agency arrangements in place to evaluate effectiveness of practice.

Practice Development and Training Group (PDTG)

The Practice Development and Training Group ensures the development of safeguarding practice and promoted improvements to practice across all partner organisations in North Yorkshire. The group ensures that each organisation is completing the right training, which in turn ensures the right outcome for adults at risk and disseminates good practice examples. This group has met four times this last year.

For the first half of the year, the group focused on planning for the first Safeguarding Week held in North Yorkshire. The North Yorkshire and City of York Children and Adult Safeguarding Boards, together with the Community Safety Partnerships and Independent Domestic Abuse Services (IDAS), held a series of events across North Yorkshire and the City of York between 17 and 21 October 2016. The theme for the week was Domestic Abuse. A core awareness session was designed by IDAS and the Domestic Abuse Coordinators (DACs) for professionals. These sessions were 1.5 hours in duration and delivered twice in each of the five locality areas.

Multi-agency market places were held involving representatives from local services. 318 professionals attended the training/awareness raising sessions. Across the five areas, engagement by agencies was generally positive.

Safeguarding Week had a positive impact on services and a wide range of agencies working together. IDAS has reported that Safeguarding Week enabled the service to connect with a wide range of agencies and has assisted IDAS in positioning

themselves in people's minds as the largest provider of domestic abuse and sexual violence services in North Yorkshire. The presentations gave IDAS the opportunity to demonstrate the varied work that is undertaken, both to prevent abuse and support those affected.

Practice Sessions have included focusing on Modern Slavery and domestic servitude across North Yorkshire including linking in to a working group with colleagues from the Police, Trading Standards, District Councils and Community Safety Partnerships; and Community Messaging System and how this can be used to share information across communities to reduce crime and help keep people safe.

Training Sub-Group

The Training Sub-Group ensures sufficiency and consistent standards of the North Yorkshire safeguarding adults training provision. The group facilitates networking opportunities and the sharing of lessons learnt and best practice to a range of partner organisations. This group has identified the need for a guidance tool to support raising a safeguarding concern to the local authority to ensure a proportionate response to safeguarding which will be developed in 2017. This group has met twice this last year.

Quality and Performance Group (QAP)

The Quality and Performance Group, which has met four times, develops safeguarding data for presentation at the Board. The group considers the scope of data required, and quality assures the information produced by partners.

A summary of some of the data is set out in Section 5 of this report.

Some of the areas of work considered by, or reported to, the QAP include the following:

- Analysis of cases that are No Further Action under safeguarding to understand if any other appropriate action could have been taken.
- Work with the Vulnerable Adults Team (VAT) North Yorkshire Police to understand their screening process to raise concerns to Health and Adult Services.
- NYCC training courses and take up of courses has been reviewed. Take up by North Yorkshire Police of NYCC courses is currently low. The in-house training offered to the police and other options available will be reviewed.
- Gathered data on the number of concerns by home, (including where no concerns have been raised) and shared this with the Quality and Monitoring Team within NYCC.
- Improving the data recording and collection around whether people's individual outcomes have been met.

Mental Capacity Act Forum

The role of the Forum has been reviewed, and new Terms of Reference agreed, taking account of feedback from a survey for Forum members. Changes agreed include themed meetings with all members being involved in the choice of themes and agenda

items. At each meeting one or two partners will share recent experiences or cases that they have come across, enabling other views and expertise to be shared. In tailoring future meetings, and enabling all partners to contribute to the agenda, it is hoped that attendance will increase.

A work plan for the Forum has been developed to enable the Forum to work collectively to achieve its strategic outcomes. A key priority for the Forum is to raise awareness and understanding across the partnership of issues around the MCA.

Local Safeguarding Adults Groups (LSAGs)

The lead safeguarding representative for each partner agency and within each organisation meets quarterly to ensure information is received from the Board on practice, delivery, lessons learned and active discussion takes place to resolve local issues and informs the Board of progress made locally to meet the strategic objectives.

LSAG meetings are convened quarterly across the county covering the four locality areas as follows; Craven and Harrogate; Hambleton and Richmondshire; Scarborough, Whitby Ryedale; Selby.

Members of the LSAGs across the county were asked to complete a survey saying what they found useful and what they would like to improve about the groups. The results were used to develop new Terms of Reference for the Groups, with an increased focus on promoting awareness and understanding of safeguarding in their local areas, including a key role in planning Safeguarding Week. The groups will use their local knowledge and experience of safeguarding information/data presented to the QAP to identify trends/issues.

The private and independent sector will be represented on the LSAG's across North Yorkshire, with volunteers from the Independent Care Group and the voluntary sector.

Case Study 1

The Financial Assessment Team received a revised Statement of Finances from someone with mental health problems. The worker noted that he had declared receiving a substantial inheritance which would require a financial reassessment as this would potentially lead to him becoming self-funding. She also noted the bank mini-statement which he had enclosed revealed he was withdrawing considerable amounts of money from the cashpoint on almost a daily basis. There has been recent safeguarding concerns raised and the safeguarding team had been involved in giving safeguarding advice. A safeguarding concern was raised.

Contact was made with the staff involved who were unaware of this inheritance or the pattern of cash withdrawal. The staff who knew him were concerned he may be at risk of exploitation as they were not aware of his spending and agreed to explore this further with him. They visited the man and established with him that there were no safeguarding concerns on this occasion, so no further action was needed under safeguarding.

4. What we have achieved this year

2016/17 has been a busy year for the SAB, and there continue to be many achievements to celebrate. The Board agreed that a key area of development should be the promotion of a culture of continuous learning. It therefore established a new Learning and Improvement Sub-Group, chaired by the Independent Chair to ensure that agencies reflect on the quality of their services internally and collaboratively, so that lessons learned are used to improve future practice and partnership working to safeguard adults at risk.

The Board has undertaken a review of the Strategic Plan with an increased focus on Making Safeguarding Personal and Prevention. As in previous years, the Board worked to meet four main outcomes of its Strategic Plan which are based on the six safeguarding principles of safeguarding.

Awareness and Empowerment - people feeling safe and in control, being more able to share concerns and manage risk of harm either to themselves or others.

Prevention – working on the basis that it is better to take action before harm happens.

Protection and proportionality - support and help for those adults who are vulnerable and most at risk of harm. Responding in line with the risks and the minimum necessary to protect from harm or manage risks.

Partnership effectiveness and accountability – working for local solutions in response to local needs and expectations, Focusing on outcomes for people and communities and being open about their delivery.

Key achievements of the Board include:

- A review of the Governance arrangements of the Board, and the introduction of the Learning and Improvement Group to promote and champion a culture of continuous learning around safeguarding.
- Working in partnership with representatives from West Yorkshire, and York to review the Multi-Agency Safeguarding Policy and Procedure.
- Joint working with North Yorkshire and York's Adults and Children's Safeguarding Boards and Community Safety Partnerships to deliver North Yorkshire and York's first Safeguarding Week.
- Local sessions as part of Safeguarding Week in October 2016 meant over 300 staff across the partnership were more aware of how to recognise domestic abuse, report it, and the services available.
- Partnership working with City of York Council to share good practice and look at where closer joint working is possible.
- Participation in initial multi-agency meetings to develop a partnership approach to Modern Slavery and Human Trafficking.
- Introduction of Safe Places Scheme within North Yorkshire with 65 members on the scheme. There are 155 registered safe places across the county. Safe

places are predominantly public buildings. Phase 2 includes working with private businesses and organisations.

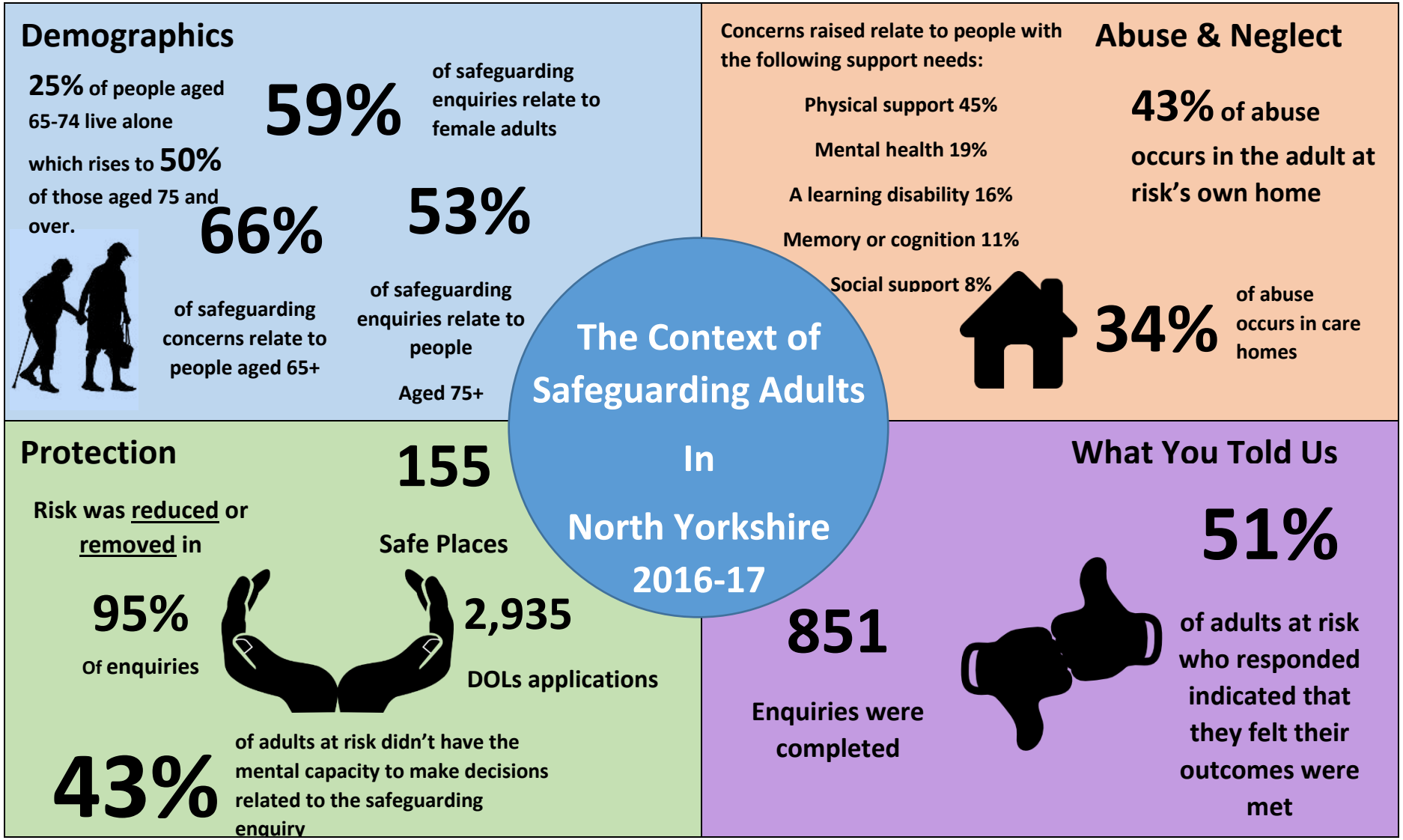
- Development of a work plan to address development needs identified through self-assessment by partners around Mental Capacity Act and Deprivation of Liberty Standards.
- Attendance at user-led forums to raise awareness of safeguarding, and incorporating feedback into new Safeguarding leaflets and other publicity.
- Review of role and membership of Local Safeguarding Adults Groups, improving links between them and the Board. The Board has strengthened the links with public engagement ensuring that Healthwatch attend all Local Safeguarding Adults Groups across North Yorkshire and by ensuring representation of health and social care providers through the Independent Care Group (ICG).
- Roll out of revised Levels 3 and 4 Safeguarding Training.
- Through the input of the Nurse Consultant, Primary Care, improved awareness by GPs of, and contribution to, Safeguarding.
- A half day Development session to update the Board's Strategic Outcomes to reflect a greater focus on prevention, to be more explicit about MSP and the importance of qualitative information about safeguarding in North Yorkshire.
- Completion of the annual self-assessment by partners of their safeguarding arrangements that showed an overall improvement from the previous year.

Case Study 2

A safeguarding concern was raised in respect of J, who has a mild learning disability as he had run up £36K of debt to mobile phone companies by using chat lines. He was neglecting himself and often had no money for food and heating. He was drinking excessive amounts of alcohol and was arrested for stealing a friend's phone, using chat lines and running up debt on it. He was asked what he wanted to have happen regarding the safeguarding concern and he said that he wanted agencies that were working with him to meet within a safeguarding meeting.

He felt he was in a situation he couldn't cope with and felt more vulnerable. He wanted help to manage his money as he had previously had an appointee as previously he lacked capacity to manage his finances. He was later reassessed as having capacity to manage his finances which is when he had started running up the debts, excessively drinking and neglecting himself. The Police, Health and Adult Services and his support workers met to assess risks and formulate a safeguarding plan with J who, as part of that, agreed to attend an agency to support with his alcohol issues. J was later reassessed as lacking capacity to manage his finances and an application was made to Court of Protection. Trading Standards Multi Agency Financial Investigation Team contacted the mobile phone companies and managed to reduce all the debt apart from £5k. J now has an appointee to assist with managing his money. Extra support was initially provided to assist J at his request to help him look at alternative ways to alleviate his isolation and loneliness and to try and prevent his use of chat lines in the future. J felt that the safeguarding meetings had helped him regain more control over his life.

5. Safeguarding Infographic



What does the data tell us?

The Board receives data via the Quality and Performance Sub-Group (QAP) which produces a quarterly report. The Board then identifies key issues and any actions required by Board members and feeds back to the QAP group.

The proportion of people aged 65 or over is higher than the national average in all North Yorkshire Districts and is highest in Ryedale (24.9%) and lowest in Selby and Richmondshire (18.4%). (ONS 2015 Mid-Year population estimates.)

25% of people aged 64-75 live alone which rises to 50% of those aged 75 and over. (Data taken from the ONS 2011 Census.)

The following is a summary of some of the data collected for 2016-17.

Following the format of the Board's strategic plan, the report has been split in to the following 3 sections:

What the data tells us about Awareness and Empowerment:

There has been a significant increase (36%) in safeguarding concerns in 2016/2017 from 2015/16

6,490 concerns were raised, 4,986 of which were not progressed to safeguarding. Other actions included Information and Advice, referral to a partner agency, or being linked to an existing referral.23% of concerns (1504) were progressed to safeguarding enquiries in 2016/17 compared with 28% for the whole of 2015/16. A key priority for the QAP has been to better understand the reasons why a concern doesn't progress to safeguarding.

Changes to the Yorkshire Ambulance Service and North Yorkshire Police referral forms have resulted in some reductions in the number of concerns in quarter 4. This will continue to be monitored in 2017/18.

What the data tells us about Prevention:

The majority of safeguarding concerns are raised for incidents that take place in the adult's own home or in residential and nursing homes 77%. (43% of abuse occurs in the adult at risks own home and 34% of abuse occurs in care homes).

In 2016-17, 2,935 Deprivation of Liberty Safeguards (DoLs), applications were received. These were recorded under a new recording system (from 25th July 2016). Of these, 923 were granted, 253 were not granted, 377 were withdrawn and 1,382 are still waiting to be assigned or signed off. (265 were received prior to 25th July 2016 and it is not possible to confirm their status). Future data will break down the number of cases assigned from those waiting to be signed off.

Whilst there are three new types of abuse which were introduced with the Care Act it has not been possible to report on these within this year's data on a quarterly basis, but will be included in the end of year national return.

What the data tells us about Protection and Proportionality:

- Concerns raised relate to people supported with physical support needs (45%), mental health needs (19%), people with a learning disability (16%), people supported with memory or cognition (11%), social support (8%) and people with sensory needs (1%).
- There are 155 Safe Places venues in North Yorkshire, there are 65 members currently and public buildings are being used.
- In North Yorkshire, there is an increase of concerns raised regarding safeguarding enquiries relating to female adults at risk. This increase is noted in National data.

In each quarter during 2016-17 the number of enquiries concluded with the risk remaining was reduced or removed in 95% of cases. For the remaining 5%, it was confirmed that people were supported to make their own decisions which included situations where the adult at risk chose to remain in situations or to accept risks that may others may believe to be unwise. Making Safeguarding Personal emphasises the right of the adult to choose and at times, safeguarding may reduce risk but recognise that risk remains. We will keep this area under review especially if any of these clients have repeat concerns.

Making Safeguarding Personal: 851 enquiries were concluded in 2016-17 and 51% of adults at risk or their representatives who responded, stated their outcomes were met. 33% didn't know whether their outcomes were met, 4% said that their outcomes were not met, and 12% of people had died before the enquiry concluded.

The Board will monitor the data going forward which will include ensuring that the adult at risk's outcomes are noted at the start of the enquiry and are checked throughout the safeguarding enquiry, before the enquiry is closed.

6. Overview of Safeguarding Training in North Yorkshire - Summary of Activity (2016/17)

Awareness and Empowerment:
NYCC continues to offer a comprehensive programme of Safeguarding training both internally and to the Private and Voluntary Sector on a free of charge basis. This includes multi-agency e-learning modules to support the workforce of North Yorkshire. The NYCC training strategy has been reviewed and updated so that it reflects the priorities and strategic outcomes of the SAB. All Safeguarding courses were updated in line with the West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures and the New Bournemouth competencies. We are also fully compliant with Care Act guidance. Two of our internal courses, the Level 3 Formal Enquires and Level 4 Chairing and Role of the Safeguarding Coordinator courses have now been fully revised to further promote best practice. Refreshers of these were rolled out to all relevant NYCC staff. In addition, the NYCC internal practical competency framework for these courses were updated and made mandatory for completion following attendance on this training. A new framework of MCA and DoLS competencies has also been developed and is in the process of being signed off. These will help underpin training provision and embed practice in both subjects. In addition a MCA intermediate course was developed and has commenced roll out to NYCC staff which will continue for the next year. After this we will look at offering this to the wider sector. A detailed evaluation of all Safeguarding courses began in January 2017. Survey results closed at the end of Q4 and these will be analysed during Q1 2017/18. This will inform future improvements to the courses.
Prevention:
Prevention has been embedded within all updated NYCC training courses. Prevent online/WRAP courses have been developed and commissioned up to April 2018. In addition extra detail on Prevent has been added into the level 3 and 4 Safeguarding courses to further embed the subject.
Protection and Proportionality:
As part of the updates to all safeguarding courses, we have ensured that details of Making Safeguarding Personal, the Mental Capacity Act and the new policies and procedures are included as a golden thread throughout.
Partnership Effectiveness and Accountability:
The updated NYCC Training Strategy was shared with partners to ensure that they are able to the SAB values into their own training plans. The SAB Training Task and Finish Group has been reconvened with refreshed multi agency membership. This includes various private providers, TEWV NHS Foundation Trust, Ryedale District Council, York Teaching Foundation NHS Trust, ICG, voluntary

agencies and NY Fire and Rescue. The group advise on various training related issues and gives a network within which to share and promote best practice to a wider audience.

The Alerter Champions programme continues to run for organisations of 50+ staff who wish to deliver their own in house Level 1 Alerter cascade using NYCC materials. We currently have 66 active champions in place who receive a yearly refresher and revised training materials. The recently held refreshers ensured that our updated materials noted above have been cascaded to all NYCC champions for delivery.

We have continued to respond to urgent needs for training in Private and Voluntary Sector as identified by commissioners.

Total for Safeguarding/MCA/DoIs Classroom courses year to date (2016/17):

	2014-15	2015-16	2016-17			
			Q1	Q2	Q3	Q4
Number of Courses Planned	170	160	27	56	77	82
Number of Courses Cancelled	17	22	2	4	8	22
Total Courses Run	153	138	51	52	69	60
Cancellation %	10%	14%	7%	7%	10%	27%
Delegates Attended/Booked on courses	1699	1752	593	764	1138	804
Total Capacity for Courses Run	2150	2363	735	1103	1463	988
% Capacity Filled (courses)	80%	74%	81%	69%	78%	81%

Total Online Course Completions 2016/17:

	2014-15	2015-16	2016-17							
			Q1		Q2		Q3		Q4	
Online learning completion			**NY CC**	**Ex**	**NY CC**	**Ex**	**NY CC**	**Ex**	**NYC C**	**Ex**
Kwango										
Safeguarding Awareness	1259	1112	90	181	90	298	73	218	110	229
Mental Capacity Act	859	708	89	102	59	159	15	151	24	132
Deprivation of Liberty Safeguards	1150	1056	60	144	100	279	49	284	54	223

Alerter Champions Completions:

Note: This course is cascaded within various other external organisations on our behalf.

	2014-15	2015-16	Q1/Q2	Q3/Q4	2016-17	Change to date from 2014-15	% Change to date from 2014-15
Alerter Champions Cascade (delivered by champions in their own organisations	878	517	205	503	708	+191	+37%

7. Prevent Statutory Duties

Within North Yorkshire Community Safety Partnership's delivery plan for 2016/17 the relevant priority areas linked to the SAB's strategic outcomes are related to the activity in supporting Vulnerable People, namely in the areas of Domestic Abuse and Prevent. **Domestic Abuse** Multi-agency work in relation to Domestic Abuse is led by the Domestic Abuse Joint Coordinating Group (DAJCG), which sits across North Yorkshire and City of York. It reports directly to North Yorkshire and Safer York Community Safety Partnerships. **Prevent** "Prevent work depends on effective partnership. To demonstrate effective compliance with the duty, specified authorities must demonstrate evidence of productive co-operation and co-ordination through existing multi-agency forums, for example Community Safety Partnerships." (Revised Prevent Duty Guidance- HM Government 2015)
Awareness and Empowerment:
Domestic Abuse As a sub group to the DAJCG, a commissioning group has been established to ensure that the right services are available to victims, perpetrators and those affected by DA at the right time. The task of aligning multi-agency commissioning framework to evidenced local needs is a large task, all partners (commissioners) are engaged and the group currently meets on a monthly basis. **Prevent** Multi-agency procedures "Working with Individuals Vulnerable to Extremism" agreed by NYCSP, NYLSCB, and NYSAB, implemented and launched at multi-agency conference June 2016. Extensive training programme internally, including on-line training, bespoke and face to face WRAP training available to partners. NYCC lead on the multi-agency train the trainer's network.
Prevention:
Domestic Abuse/ Prevent Area for development for NYCSP 2017/ 18 is around community engagement, particularly in relation to raising communities' awareness of DA services and Prevent and the sharing of relevant 'intelligence'. A number of community engagement events are being planned for 2017/18 across all Districts.
Protection and Proportionality:
Prevent Channel Panel established in North Yorkshire. Meets on a monthly basis. Appropriate cases are discussed; proportionate action plans are in place. When necessary Home Office approved intervention providers are used. Good, consistent multi-agency attendance.
Partnership Effectiveness and Accountability:
Domestic Abuse Strategically agreed key principles for the DAJCG Understanding the needs and expectations of adults, children and young people affected by Domestic Abuse and using this knowledge to shape the objectives of the Domestic Abuse strategy Working in partnership in a planned and coordinated way that will drive activities and deliver real outcomes

Communicating and educating our community on the causes and effects of Domestic Abuse.

The Community Safety Partnership initiates Domestic Homicide Reviews (DHR) when the criteria are met. DHR procedures for North Yorkshire and City of York have been updated in line with Home Office Guidance (December 2016). When reviews are initiated close liaison will be established with other statutory partnerships (SAB and LSCB) and processes to avoid duplication and ensure clarity of purpose.

8. North Yorkshire Safe Places

More information is available on the North Yorkshire County Council website:
www.northyorks.gov.uk/safeplaces

To join the scheme: Phone: 03307 260260 or Email: safeplaces@spsdoorguard.com

Safe Places is a nationally recognised community initiative for people who may need more help and support when they are out and about in the community. The scheme in North Yorkshire has been designed so that when a person attends a Safe Place they have a Safe Place's membership card and/ or wristband with a membership number. Currently in North Yorkshire (April 2017) there are 65 members and 155 registered safe places across the county. Safe Places are predominantly 'public' buildings; phase 2 includes working with private businesses and organisations.
Awareness and Empowerment:
This initiative supports the positive work of living well teams, stronger and safer communities, and provides people with the confidence to get out and about on their own without formal support.
Prevention:
During the phased approach Safe Places has been set up to help all people who may be vulnerable in their community, with the main target groups to register as members being: Learning disabilities Mental health issues Older people and those with the onset of dementia Young people in transitions Physical disabilities
Protection and Proportionality:
Dependent upon why the member has attended the Safe Place, the Safe Place can either provide the help and support for simple issues (e.g. give directions) or the Safe Place can make contact with a call centre who will contact the member's 'responder.
Partnership Effectiveness and Accountability:
The North Yorkshire Safe Places scheme began when the Learning Disability Partnership Board supported work on a project related to Hate Crime. A 'new' multi-agency project Board for Safe Places has been introduced, and a multi-agency action plan is currently being developed. Areas for development include working with the private sector and clear linkages with Dementia Friendly settings and North Yorkshire Police in relation to Hate Crime Reporting Centres.

9. Safeguarding Adult Review

This year the Board has commissioned one Safeguarding Adults Review, which is currently underway. Progress on the review is being monitored through the Learning and Improvement Group, and the outcome will be reported to the Board, and included in its Annual Report for 2017/18.

As part of its adoption of a Learning and Improvement Framework, in addition to any SARs, the Board will commission a range of audits and Lessons Learned, and the learning from these will used to improve practice.

Case Study 3

Over a three year period, 9 safeguarding concerns were raised for HW alleging domestic abuse from her partner, including neglect, physical, emotional and financial abuse. More than 15 safeguarding meetings were held and the risk was always assessed as high. The case was also heard at Multi-Agency Risk Assessment Conferences (MARAC) on several occasions.

HW was assessed as having the mental capacity to understand the risks regarding the concerns and the safeguarding process. She had care and support needs and was vulnerable as she was paralysed on her right side and had difficulties with speech following a stroke. She disclosed that she had been physically assaulted by her partner, AF, and was frightened of him and could not see how things could change. Bruising could be seen but she did not want to make a formal complaint to the police.

AF prevented HW from seeing professionals on her own despite many attempts being made so it was difficult to establish her views and wishes. Many safeguarding options were offered to her and professionals would offer her safety plans at every opportunity. The agencies involved were NYCC HAS, Police, IDAS, Horizons, GP and Housing.

NYCC START service provided weekly visits to assist her with a shower and build her confidence in household maintenance tasks such as laundry. START staff going in was also part of the safeguarding plan as it was another opportunity for risk to be checked.

There was more and more evidence of neglect and bruising and HW disclosed more incidents. At a case conference meeting a detailed plan of action was agreed. The police arranged for a Domestic Violence Protection Order (DVPO) to be issued by the magistrate's court, preventing AF from seeing HW for 28 days. This was valuable as it was something that could be put in place without HW's permission and it enabled her to have time apart from AF, so she could decide what she wanted and make an informed choice without being pressured, threatened and coerced by him.

HW agreed to try a residential home out of the area on a temporary basis and took her pet cat with her. AF was also arrested by the police on suspicion of assault. HW quickly settled into the residential home and started to recognise the risks from the domestic abuse she was experiencing. She joins in with all the activities, socialises really well with other residents and her independence and confidence continues to increase. She has made the decision that she does not want to return home and does not want to have any type of relationship with AF.

Appendix 1

What we have achieved – Partner Statements:

1. Health and Adult Services

Awareness and Empowerment:
Leading role in the delivery of Safeguarding Week resulting in improved awareness of staff of domestic abuse. Review of Safeguarding Leaflets and publicity in partnership with "experts by experience" Delivered training and awareness sessions to a range of staff and volunteers
Prevention:
Continued development of Safe Places Scheme to help adults who need additional support to lead independent lives and feel safe Worked with providers to promote prevention and early intervention in care settings Through the Living Well Team, and through support planning, reduced loneliness/isolation and helped people to strengthen or build their social and support networks.
Protection and Proportionality:
Redesign of the audit tool within the electronic recording system (Liquid Logic) to ensure that it reflects what outcomes people want to achieve and whether they feel safer.
Partnership Effectiveness and Accountability:
Secondment of a Safeguarding Officer to work with the multi-disciplinary team with Trading Standards to tackle and prevent financial abuse. Additional Resources have been provided to enable the Customer Resolution Team based at the Customer Service Centre to respond to new safeguarding concerns on cases that are not known to Health and Adult Services. This screening is enabling a more efficient response from locality teams. Joint working with officers from Safeguarding Boards in North Yorkshire and York around Safeguarding Week and sharing and development of good practice.

2. Nurse Consultant Primary Care and Clinical Commissioning Groups represented by the Partnership Commissioning Unit (PCU)

(*Commissioning services on behalf of NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Scarborough and Ryedale CCG and NHS Vale of York CCG)*

Awareness and Empowerment:
Safeguarding GP practice leads meetings are held quarterly in each of the CCG areas. During 2016/17 these meetings have particularly focused on raising awareness of adult safeguarding policy and processes. This has directly led to a three-fold increase in GP engagement calls made to specialist nurses to advise on the management of adult safeguarding concerns. The structure of named GPs with safeguarding leads in each Practice has become embedded and a recent survey undertaken with the GP leads acknowledges the value obtained by the quarterly meetings. The safeguarding story at the Safeguarding Adult Board in March 2017 was provided by one of the named GPs – this focused on the story of 'Robert' – a learning lessons review undertaken by North Yorkshire. The learning identified actions from a GP perspective and this learning will be taken forward in training 2017/18. Three team members attended the Making Safeguarding Personal (MSP) full-day workshop hosted by ADASS in Bradford in May 2016. The workshop examined the different elements of MSP and provided a theoretical example using a theatre performance group and a real example from practice hearing the experience of a service user. We have continued to embed 'making safeguarding personal' into enquiry work recording service user wishes. The intention for 2016/17 is to audit and improve this practice.
Prevention:
Training events for CCG staff and GP and primary care practitioners in 2016/17 have included WRAP (workshop raising awareness of prevent)/prevent awareness; domestic abuse; human trafficking and modern slavery. Embedding of changes made through the Care Act has continued. A total of 671 staff have received training in 2016/17. The Named GPs North Yorkshire and York CCG's, Nurse Consultant Safeguarding Primary Care and Designated Professionals Children and Adult hosted the first Northern Region Safeguarding Named GP Conference on the 11th November 2016 in York. The aim of the conference was to deliver safeguarding level 4 training for Named GP's, showcase and share local innovations in practice and to develop peer support networks for Named GP's within the Northern Region. The event was extremely successful and will as such be expanded across the Northern region later in 2017.
Protection and Proportionality:
The safeguarding officers have supported enquiry work into Independent Provider services responding to concerns that are raised with the quality of care provision.

In addition to enquiry work the safeguarding officers have also undertaken joint quality assurance visits often picking up areas of concern before they reach the threshold for safeguarding.

Recognition and management of domestic abuse has been a priority for 2016/17 – with the promotion and involvement of health agencies in safeguarding week, the embedding of MARAC (multi-agency risk assessment conferences) processes into GP practices. Learning from Domestic Homicide Reviews has been incorporated into training events. Following learning from a national Serious Case Review the team has begun to develop pathways and processes for managing MAPPA (multi-agency public protection arrangements) cases across the health economy.

Partnership Effectiveness and Accountability:

The CCG Designated Nurse and Nurse Consultant in Primary Care have consistently attended and contributed to the Safeguarding Board multi-agency meetings and groups. The CCG Designated Nurse also actively contributes to a quality engagement group with partners. The CCG Designated Nurse works closely with the North Yorkshire County Council Safeguarding Team Manager and North Yorkshire Police Vulnerable Adult Team to jointly manage safeguarding allegations made against people in a position of trust.

The CCGs provide safeguarding assurance to NHS England and in July 2016 an assessment of the CCG assurance framework was completed. This was followed by a two day assurance visit from the NHS England Designated Safeguarding team to examine evidence of compliance. The CCGs developed an action plan to address a small number of gaps noted namely in a training needs analysis and in guidance for staff.

All members of the safeguarding team have maintained their knowledge and skills completing training and attending development opportunities appropriate to their roles and level of responsibility.

3. Airedale Wharfedale and Craven CCG

Awareness and Empowerment:
In 2016/17, AWCs Continuing Health Care Team supported a significantly increased number of people to take advantage of Personal Health Budgets and arrange their own healthcare support. This helps people remain in their own homes with care tailored to meet their individual needs. The CCGs has engaged with a range of networks and groups, listening to patient stories and feedback, in order to inform health needs assessments and local service developments. One example is the development of a 5-year mental wellbeing strategy for Bradford District and Craven, which focuses on maintaining good mental health and supporting those living with and recovering from mental illnesses.
Prevention:
The Named GP for Safeguarding Adults has continued to support GP Practice Safeguarding Leads, disseminating learning from Safeguarding Adults Reviews and Domestic Homicide Reviews and providing updates on the broad range of safeguarding issues affecting adults across Craven. This helps Primary care practitioners to identify and enquire about signs of potential abuse at the earliest possible time.
Protection and Proportionality:
The CCG quality and safeguarding teams have worked closely with the local authority, regularly contributing to multiagency safeguarding processes where there have been concerns of abuse or neglect. The CCGs safeguarding team continues to have oversight of Serious Incidents within NHS funded services, identifying potential safeguarding issues and advising on proportionate and timely responses to any safeguarding concerns. We have worked closely with the Local authority to support and monitor quality within care homes, helping to organise access to specialist services including e.g. medicines management, tissue viability and the care homes support team.
Partnership Effectiveness and Accountability:
The CCG has continued to be an active member of the SAB, with regular attendance at Board meetings and the Local Safeguarding Adults Group. The CCG has engaged in a number of safeguarding related assurance activities during the year. In July 2016, the CCG received an assurance visit from NHS England, using key lines of enquiry from NHS England's CCG Assurance Framework 2015/16. In September 2016, NHS Audit Yorkshire conducted an internal safeguarding audit on behalf of the CCG, providing significant assurance. The CCG also provided assurance to the Safeguarding Adults Board using the Yorkshire and The Humber Safeguarding Adults Self-Assessment Framework. The CCG plays a key role in holding NHS providers to account, monitoring quality of services and safeguarding performance. The CCG safeguarding team received and reviewed safeguarding reports and updates from our local NHS Trusts, larger independent providers and care homes on the NHS contract.

4. NHS England

Awareness and Empowerment:

To access and acquire leadership training for Designated Professionals and Named GPs in the North region.

To ensure health professionals in Yorkshire and the Humber are well informed about the Female Genital Mutilation (FGM) mandatory reporting requirements.

To ensure trusts including Mental Health trusts and in addition GP practices were registered with NHS Digital and able to report any FGM cases identified.

Provide an updated Adult safeguarding Pocket Book for health professionals in Yorkshire and the Humber.

Launch a safeguarding repository and App for all front line health professionals.

Prevention:

Pressure Ulcers – "React to Red"

React to Red was launched on 01 February 2016 at the Pressure Ulcer Summit in Leeds. It is a bespoke training package for pressure ulcer prevention which is competency based and designed specifically for care home staff and care providers. Since its launch in February 2016, there has been significant interest in this resource from CCGs: private organisations; secondary care; hospices; domiciliary care providers; tissue viability nurses and care homes. During 2017/18 this work will continue to be a priority across NHS England North.

Prevent

Across NHS England North there are a number of priority areas which are designated by the Home Office, who fund two Regional
Prevent Coordinator posts. These posts support the implementation of the Prevent Duty and ensure that Health embeds the requirements of the Contest strategy and specifically Prevent into normal safeguarding processes. Funding to support this work was secured from the North Region Safeguarding budget which has facilitated a number of projects including supporting partnership working with the North East Counter Terrorism Unit , delivering a conference in October on 'Exploitation, grooming and Radicalisation 'and an Audit of referrals to Prevent /Channel where Mental Health concerns are understood to be a contributing factor. A research project to scope the current, attitudes, awareness and practice amongst GP colleagues has also been commissioned in the Region.

Protection and Proportionality:

Learning Disabilities Mortality Review (LeDeR) Programme

Over the last 2 years a focus on improving the lives of people with a with learning disabilities and/or autism (Transforming Care) has been led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. In November 2016 the national LeDeR Programme has been established following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD).

All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

"Improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism.
LeDeR involves:
Reviewing the deaths of all people aged over 4 years
Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
Identify variation in practice.
Identify best practice.
Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.
A national database has been developed and anonymised reports will be submitted. This will allow, for the first time, a national picture of the care and treatment that people with learning disabilities receive.
The LeDeR Programme is not a formal investigation or a complaints process and will work alongside any statutory review processes that may be required.

The LeDeR Programme recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Good practice examples will be written up and shared nationally.

Partnership Effectiveness and Accountability:

Yorkshire and the Humber has an established Safeguarding Network that promotes an expert, collaborative safeguarding system, which strengthens accountability and assurance within NHS commissioning and adds value to existing NHS safeguarding work across Yorkshire and the Humber.
Representatives from this network attend each of the national Sub Groups, which include priorities around Female Genital Mutilation (FGM), Mental Capacity Act (MCA), and Prevent.
The Independent Inquiry into Child Sexual Abuse (IICSA) team attended the meeting in January 2017 to provide an overview of progress. Learning around safeguarding practice has also been shared across GP practices via quarterly safeguarding newsletters; in addition a safeguarding newsletter for pharmacists has been circulated across Yorkshire and the Humber and one for optometrists and dental practices has recently been shared.
NHS England Yorkshire and the Humber works in collaboration with colleagues across the north region on the safeguarding agenda and during 2016/17 a Clinical Commissioning Group (CCG) peer review assurance process was undertaken. Themes from this process have influenced the commissioning of leadership training for safeguarding professionals and there are future plans for a national assurance tool for CCG's.

5. North Yorkshire Police (NYP)

Awareness and Empowerment:
The Police and Crime Commissioner – Crime plan 2017-2021 prioritises '' Caring about the Vulnerable'' The police are now having to respond to more public welfare calls, including missing persons, individuals in mental health crisis, older people with complex needs, and people with alcohol and drug issues. Protecting the public from harm is the purpose of policing and in North Yorkshire this is already done well. But these challenges demand more of the police, beyond traditional protection. By combining response with compassion, the police can embed a more caring service for vulnerable people, which will help families and individuals feel better served. This requires a deeper understanding of vulnerability, as well as finding new ways to work with partners and charities who are better placed to provide support. During 2017/18 North Yorkshire Police are committed to working with partners in developing and delivering additional training to those officers that can make a difference and deliver outcomes outside traditional Policing.
Prevention:
In January 2016 the police team formally known as the Safeguarding Team / CRU team / MASH team became the Vulnerability Assessment Team 'VAT'. The Multi Agency team, based across two locations in York and North Yorkshire is developing further to become a MAST (Multi Agency Screening Team). The team is designed to provide a single point of contact for safeguarding and screening across York and North Yorkshire to ensure the most appropriate response is agreed with agencies in order to protect children and vulnerable adults. The overall objective having an improved response to reduce serious harm. In 2016/17 MARAC development with Police and Health improving lines of communication with GP's This work continues to grow. This is a cultural shift for a predominantly reactive service the Police offer and is evidence of commitment from the Police to Safeguarding the Counties most vulnerable people in a proactive way.
Protection and Proportionality:
The PCC has outlined in the Crime plan 2017- 2021 the priority of 'Ambitious collaboration' with the objective 'maximising collaboration with partners' There will be deeper collaboration with our 'Blue light' partners in ensuring we tackle Serious, organised crime, human slavery & trafficking and other serious emerging threats. In 2017/17 North Yorkshire Police responded to 20,901 Public Safety Welfare incidents within this category there are 49 subtypes. These particular incidents are often as a PSW Concern for Safety. This would prompt further action of varying types, some of which are highlighted below: A referral for Safeguarding (without consent) A referral for a care and support needs assessment (with consent) Completion of a Herbert protocol Completion of a Vulnerable Risk Assessment Completion of a Domestic Incident form Missing / Trigger plan

Strategy meeting
Referral to MAPPA
Referral to MARAC
Street Triage
Crisis team intervention
The Police continue to use and develop THRIVE (Threat Harm Risk Investigation, Victim, Engagement) to protect the public/ client from further harm. This model is now used across all aspects of Policing.

Partnership Effectiveness and Accountability:

North Yorkshire Police continue to work effectively, developing and implementing best practice with partners. In 2016 problem profiles were completed for Modern Day Slavery and Human Trafficking and Missing. Recommendations based on the 4 'P's Prevent, Protect, Pursue and Protect. These recommendation are shared with partners to ensure national, regional and local needs are met.

The Police Control Strategy for 2017/18 includes the key headline:

REDUCING VICTIM HARM

Safeguarding Vulnerable and/or Exploited People

Cyber-enabled sexual crime
Fraud (Personal)
PREVENT
Modern Slavery and Human Trafficking
Child Abuse and Neglect including CSE
Domestic Abuse
Missing People
Stalking and Harassment

6. National Probation Service

Awareness and Empowerment:
Safeguarding Adults has continued to be a priority for the National Probation Service (NPS), reflected in our 2016-17 Business Delivery Plan. In carrying out its functions, the NPS is committed to protecting an adult's right to live in safety, free from abuse and neglect. In recognition of this the NPS issued in 2016 a Policy statement setting out NPS responsibilities for promoting the welfare of adults at risk. The NPS has a national and NPS North East Divisional lead for Safeguarding Adults, as well as a local York & North Yorkshire SPOC, to support and promote best practice. NPS Safeguarding Adult ELearning training has been undertaken by the majority of staff (all grades) during 2016-17 NPS Safeguarding Adults at Risk Policy Statement circulated to all staff NPS Safeguarding Adults at Risk - Offenders in the Community with Care and Support Needs – Practice Guidance issued in 2016-17 Safeguarding E Briefing shared with all staff, which includes link to local procedures EQuiP – NPS National electronic process mapping system in place and available to all staff to provide access to all relevant guidance and ensure the processes in relation to Safeguarding Adults are consistently applied. Senior Managers Briefing on Modern slavery and human trafficking undertaken
Prevention:
Through their work NPS staff come into contact with offenders who pose a risk to known adults at risk; pose a risk of harm to adults at risk in general; are adults at risk; have care and support needs and/or are carers in need of support. During 2016-17 a range of professional training to support risk assessments and risk management, as well as safeguarding Adults training has continued to strengthen practice and reinforce the key role of NPS staff in relation to prevention. Recording practices have been reviewed nationally to improve the flagging on the NPS database of relevant cases who are considered a vulnerable adult, as well as those at risk to others. This will also support monitoring and analysis going forward. A NPS Suicide prevention plan has been launched nationally and shared with staff, and York and North Yorkshire Safeguarding Adult Boards.
Protection and Proportionality:
NPS is a responsible authority under MAPPA (Multi Agency Public Protection Procedures) and continues to work to safeguard adults and victims through our multi agency risk assessments and risk management plans. An HMIP Quality & Impact Inspection completed in NPS York & North Yorkshire 2016 evidenced strong practice in relation to assessment and MAPPA/public protection. NPS staff are engaged with Domestic Abuse Partnerships as well as Prevent and Extremism Boards. Regular supervision and management oversight is provided to all staff which provides opportunities to discuss and review adult safeguarding cases and the actions required to manage the risk posed by or to an offender. The Partnership Framework and Policy and guidance issued to staff sets out clear roles and responsibilities in relation to safeguarding adults, including routes for escalation.

Partnership Effectiveness and Accountability:
NPS Safeguarding Adults Partnership Framework issued and implemented NPS has continued to support the work of and contribute to, the work of the NY Safeguarding Adult Board. NPS is actively engaged with a range of related partnerships across North Yorkshire including Safeguarding Children, Community Safely Partnership and MAPPA Senior Management Board. NPS has continued to support multi agency training through MAPPA and the launch of the MAPPA eLearning for Duty to cooperate agencies. In relation to offenders appearing in court, work has been undertaken with North Yorkshire Police and Children's Social Care to improve processes supporting 'on the day checks' for domestic abuse and safeguarding concerns, to inform assessments and reports.

7. Healthwatch

Awareness and Empowerment:
Throughout the year 12 of our volunteers and 2 members of staff undertook Safeguarding Level 2 responder course. All staff have received safeguarding training and all volunteers who lead on Enter and View visits have received training.
Prevention:
Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they will inform their lead who will inform the service manager, ending the visit.
Protection and Proportionality:
If any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.
Partnership Effectiveness and Accountability:
Our Delivery Manager maintains a seat on the Adult Safeguarding Board providing a two way dialogue on safeguarding matters.

8. Tees Esk and Wear Valley NHS Foundation Trust

Awareness and Empowerment:
TEWV completes an annual audit of compliance with the safeguarding protocol to ensure that staff are acting in a manner that is in line with the principles of making safeguarding personal, this looks at the empowerment and choice people were given prior to a concern was raised and the outcomes expected.
Prevention:
The Trust has a commitment to providing safeguarding training to all its staff appropriate to the role they carry out. This training is in line with the SAB principles and the principles of making safeguarding personal, with a result that 92% of staff have received basic awareness training.
Protection and Proportionality:
The trust work with advocacy services, provide PALs and mental capacity act training, the safeguarding adult level 2 training promotes proportionality and risk management as a way of protecting individuals.
Partnership Effectiveness and Accountability:
The Trust Safeguarding Adults team participate and engage in the SAB and SAB subgroups, the team actively participated in the safeguarding week in 2017 and are actively participating in preparation with the plans for the next safeguarding week. The Trust provide statistics to the SAB as part of the data request and actively participate in strategy meeting and enquiry's as requested by the local safeguarding teams. The Trust Safeguarding Adults team have committed to attend the local safeguarding adults groups and work with other agencies to ensure the best outcomes for individuals who are at risk of abuse of neglect.

9. Acute Provider Trusts:

- Airedale
- Harrogate District Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- York Teaching Hospital Foundation Trust

Awareness and Empowerment:
Airedale NHS Foundation Trust Bespoke training sessions complement mandatory training and are undertaken with clinical teams using case studies with a focus on identifying the outcome/s that the person at risk wishes. We have built upon lessons learned from investigations and enquiries. We work within an annual audit programme related to safeguarding adults in 2016/17. Findings are received at the Trust's Strategic Safeguarding Group.
Harrogate District Foundation Trust An Adult Safeguarding Strategy has been developed based on the safeguarding principles. This is available for all staff on the Safeguarding page of the intranet. Work is ongoing jointly by the Trust Adults and Children's safeguarding teams to review our Domestic abuse guidance and training. An audit of safeguarding concerns raised by Trust staff is being undertaken to examine issues around gaining consent.
South Tees Hospitals NHS Foundation Trust Alerts into the local authority are made with consent of the person or following a best interest decision. The importance of this is included in safeguarding adults training which is mandatory for all staff. Mental Capacity Act Training is mandatory for all clinical staff.
York Teaching Hospital Foundation Trust Patients in our care who have capacity are encouraged to be fully involved in any safeguarding concerns raised by Trust Staff. They are asked for consent to take any concerns into the Safeguarding Process. Where a patient in our care lacks capacity, key people in their life are consulted (if it is safe to do so). Where a patient lacking capacity does not have any key people in their life consideration is given to appointing an advocate. The patient and their views will be central to the process and any safeguarding enquiry. Policy, training and staff guidance direct staff to fully involve a patient where there are concerns. The Trust safeguarding Adults Team are available to advise staff on how to involve the patient in their concerns An Intranet Resource is also available to Staff to support staff involve a patient for whom they have concerns. Mental capacity Act Policy/training and staff guidance direct staff to involve key people in the safeguarding Adults Process Trust Leaflets give guidance to patients involved in the safeguarding adult's process.

Prevention:
Airedale NHS Foundation Trust The Safeguarding Team are highly visible within the Trust and they work closely with clinical and non-clinical teams to ensure that staff support the patient in making decisions. Bespoke training session's takes place within clinical teams to increase knowledge and awareness related to recognising and responding to abuse. This supplements formal teaching and learning. We now have a Clinical Supervision framework for Safeguarding Adults. There is a bi-annual audit related to DoLS within clinical settings together with a review of the assessment of Mental Capacity and best interests' decision-making tool that is used. The findings were received by the MCA Working Group
Harrogate District Foundation Trust A review of WRAP training is being undertaken, and extra sessions are being made available for staff who require this. Bespoke safeguarding training for all areas is available as required. An enhanced admission proforma has been introduced to help staff understand the needs of people with learning disabilities. Safeguarding link workers have agreed to also be learning disability link workers. A task and finish group has been evaluating policies and processes for MCA/DOLS and a training review is underway.
South Tees Hospitals NHS Foundation Trust Information on safeguarding adults is available on the trust website for patients and relatives. Staff training contributes to this outcome promoting the early identification of concerns in relation to both trust practice and the practice of others.

York Teaching Hospital Foundation Trust
Staff are encouraged to be supportive where they identify the risk of abuse from colleagues internally and as part of other care provisions.

Staff commit to communicating care requirements from the onset of an admission to discharge.

Policy, training and staff guidance direct staff to identify potential risk of abuse.
The Trust safeguarding Adults Team are available to advise staff on how to support staff to identify potential risk of abuse.
An Intranet Resource is also available to Staff to support staff identify potential risk of abuse.
Community Teams are supported by the Safeguarding Adults team to support patients who decline treatment and potentially pose a risk to themselves in doing so.
Commitment to PREVENT Duty with embedded Policy Guidance and training
Trust Safeguarding Adults Processes link with other key policies within the Trust that manage concerns. (Did Not Attend Policy, Pressure Ulcer Prevention).

Protection and Proportionality:

Airedale NHS Foundation Trust
We have increased the capacity within the safeguarding team to cope with the ever increasing safeguarding agenda. The additional post supports the team and provides further support for colleagues in clinical areas.

Harrogate District Foundation Trust
An Acute Liaison Nurse for Learning Disabilities has been recruited; this person also supports the Senior Nurse Adult Safeguarding.
From April 1st 2017 after consultation there was a change to the process for sending safeguarding concerns for some pressure ulcers. This has resulted in a more proportionate response. New Trust MAPPA arrangements are being developed, and links have been strengthened with the Children's safeguarding ream re MARAC. Staff have been made aware of the reporting mechanism for soft intelligence, and have used this process to report lower level concerns.

South Tees Hospitals NHS Foundation Trust
The trust has robust policies and procedures for identifying and alerting safeguarding concerns. Concerns are identified through a number of routes including incident reporting system, patient comments (PALS) and complaints, and significant incidents. Safeguarding issues are monitored via quarterly governance arrangements and where necessary escalated to Board of Directors (BD). The BD receives an annual safeguarding report.

York Teaching Hospital Foundation Trust
Staff are supported by the Trust Safeguarding Adults team to ensure concerns are managed in the most effective yet proportionate manner based on the patient's views and consent to involvement.

The Trust Safeguarding Adults team have continued liaison with Local Authority Safeguarding Adult teams regarding concerns.

The views of the patient is central, bearing in mind one of the Mental Capacity Act Principles that “a perceived unwise decision does not mean the patient lacks capacity”.

Trust Safeguarding Adults processes are in line with Local Authority Guidelines and Thresholds.
Trust Safeguarding Adults Processes link with other key policies within the Trust that manage concerns. (Serious Incident, Complaints, Root Cause Analysis, Pressure Ulcer Prevention).

Proportionality
The Trust Safeguarding Adults Team is committed to supporting both internal and external actions plans which protect patients in our care.
Compliance with safeguarding actions plans from Case Conferences.
Safeguarding Action Plans reviewed and monitored for completion.
Investigations reports shared routinely with Departmental managers, Matrons and A D Ns for awareness and progression of identified learning.
Themes reported quarterly to the Safeguarding Adults Governance Group.

Partnership Effectiveness and Accountability:

Airedale NHS Foundation Trust
We have reviewed the Terms of reference for our safeguarding governance structures:

Strategic Safeguarding Group (Adults and Children) is chaired by the Director of Nursing. The purpose of this group is to oversee and monitor the trust statutory responsibilities in relation to the safeguarding agenda. Membership of this group includes the Designated Professional Safeguarding Adults Airedale Wharfedale and Craven CCG.

The Operational Group for Vulnerable Adults is chaired by the Consultant Geriatrician and co-chaired by Senior Nurse Safeguarding Adults and reports to the Strategic Group. The purpose of this group is to oversee and monitor operational safeguarding practice across the trust with senior colleague representation from each clinical group.
Safeguarding level 1 training is a 3 yearly mandatory requirement for all staff and volunteers who deliver trust services. This is delivered either face-to face, or via a work book. .

At the end of 2016/17, Trust staff were compliant with

- Dementia Awareness (inc Privacy & Dignity standards) 91.94%
- Mental Capacity Act 89.91%
- Safeguarding Adults 91.53%

Harrogate District Foundation Trust
We continue to meet regularly with HAS to provide assurance re lessons learnt. The Trust provides representation at Channel and other Prevent meetings; LSAG, HPG and SAB sub groups. Representatives also attend individual strategy and case conference meetings as required and support investigations on an ongoing basis.

Governance structures have been reviewed and Adult Safeguarding now reports to the Supporting Vulnerable People Steering Group.
South Tees Hospitals NHS Foundation Trust The trust has a range of information governance policies which dictate how personal sensitive information is used and information sharing protocols to ensure information can be shared proportionately and securely with adults consent or in their best interests where they are not able to consent. Interagency working to safeguard and promote the wellbeing of the adult is central to good clinical practice as well as to trust policies and procedures in relation to safeguarding. All staff who have contact with adults are required to introduce themselves and their role to patients and their relatives and the organisation has championed the 'Hello my name is …' campaign. http://hellomynameis.org.uk/
York Teaching Hospital Foundation Trust The Trust continues to work with multi-agency and partners to safeguarding adults in our care and in the community. The Trust recognises its duty under Section 6 of the Care Act to co-operate to work together to safeguard adults who are experiencing or at risk of abuse and neglect Senior Commitment and representation at the three Local Authority Safeguarding Adults Boards Representation at Local Authority Safeguarding Adult Board task and Finish Groups and sub groups. Routine involvement in local Authority Led safeguarding adult strategy and case conference meetings Shared Annual reporting Compliance with the safeguarding Adults Self-Assessment submissions and responsive to local authority challenge panels The Trust remain accountable for care delivery and addressing any gaps in care delivery and listen in order to improve. Commitment and representation at Local Authority Lessons Learned Processes Continued Open and honest liaison with adults in our care involved in safeguarding concerns Identified gaps have accompanying regularly monitored action plans Continued safeguarding referrals where concerns arise on Trust practices On-going operational links to with internal systems such as complaints and incidents. Strategic links with Quality Safety Committee The Trust is represented on Safeguarding Adults Boards and has commitments to Board sub-groups. The Trust complies with SAB Safeguarding Adults Self-assessment processes and assurance is supplied to all SABs in our region along with commissioners and quality monitoring organisations (such as CQC and Monitor).

There is currently representation at two of our regions SABs (CYC and ERYC). Under Care Act re-organisation of membership York Teaching Hospital NHS Foundation Trust no longer sits on the NYCC Board. It is understood that there is acute representation by a nominated Chief Nurse with a view to feedback to other Trusts. Whereas the principle of this is understood it has been identified that NYCC SAB information is not always received. As such the Trust welcome involvement in any projects which may improve this.

10. Yorkshire Ambulance Service

YAS serves a population of more than five million people and covers 6,000 square miles of varied terrain from the isolated Yorkshire Dales and North York Moors to urban areas including Bradford, Hull, Leeds, Sheffield, Wakefield and York.

We are commissioned by 23 clinical commissioning groups (CCGs) and, as the only regional healthcare provider, we are ideally placed to support joined-up care for patients and provide the gateway into urgent and emergency services.

We employ over 5,000 staff and have over 1,200 volunteers and provide 24-hour emergency care to the region.

For everyone working at YAS, providing high quality patient care is our key priority. This applies to our ambulance clinicians responding to emergency calls, to our Patient Transport Service (PTS) crews taking patients to and from their planned hospital appointments, our call handlers handling 999 and 111 calls, to our managers developing new care pathways or ways of working, and to our Trust Board making decisions about the future of our Trust.

In 2016-17:

- We received 895,700 emergency calls;
- We responded to a total of 723,935 emergency calls;
- We undertook 1,020,621 non-emergency journeys.

A key priority during 2016-17 has been the establishment of the Critical Friends Network (CFN) within YAS. This network is made up of patients and members of the public who have an interest in the ambulance service and recent experience of using one of the services; the newly formed CFN, along with Staff Forum Members, are now consulted prior to new service developments and improvement projects.

The profile of safeguarding children and adults at risk continues to grow and change and is a key priority across YAS. Both policy and practice have been reviewed to ensure compliance with legislation and good practice guidance. The Safeguarding Team continues to engage and support staff within all departments including The Emergency Operations Centre, Operations, Patient Transport Service and NHS 111 to identify safeguarding priorities to ensure quality patient care.

The Safeguarding Team continues to work Trust-wide, with partner agencies, including commissioners, social care and health partners, to review and improve the quality of the safeguarding service provided by YAS staff. Ensuring YAS employees including, secondees, volunteers, students, trainees, contractors, temporary or bank workers and NHS 111, have the appropriate knowledge and skills to carry out their safeguarding children and adult duties.

Safeguarding processes and practice are being continually reviewed and strengthened; especially with regard to the quality of Safeguarding referrals to Adult and Children Social Care, the education and training of staff and the safeguarding clinical audit processes.

Within the year, safeguarding practice has been enhanced by the introduction of a safeguarding module within Datix. This ensures accurate monitoring of activity, reporting and the availability of trend analysis of current safeguarding processes and work streams.

Ongoing priorities are to review the current Safeguarding Children and Adult Referral Process, to ensure concerns are effectively shared with local authorities, and to review and develop the Mandatory Safeguarding Training Plan, for all YAS staff, inclusive of NHS 111, volunteers and Community First Responders (CFRs).

Extracts from YAS Quality Account 2016/17

11. North Yorkshire Borough/District Councils:

- **Craven**
- **Hambleton**
- **Harrogate**
- **Richmondshire**
- **Ryedale**
- **Scarborough**
- **Selby**

Awareness and Empowerment:
Craven CDC Children and Adults at Risk Safeguarding Policy and Procedures 2015 available to all staff. Staff Safeguarding leaflet updated in June 2016 and circulated to all staff with wage slips. Councillor safeguarding training session held. 4 staff safeguarding training sessions were held during 2016/17. For all staff a reminder to check on whether safeguarding training is adequate and up to date is included Annual Performance Review, where a need is identified this information is included in the individuals personal development plan and passed to HR to be incorporated into the Annual Training Plan.
Hambleton HDC has adopted a safeguarding training plan and in 2016/17 trained 150 people. Safeguarding is now a standard item on the council's corporate induction programme. An internal safeguarding information leaflet continues to be issued to all new starters.
Harrogate We have taken steps to ensure a proactive lead for safeguarding adults and children exists within the district. This includes helping to identify when a concern is not a safeguarding issue but still requires social care attention. There are two new nominated officers who provide leadership to the district on safeguarding matters for staff and residents. We have reviewed, amended and updated the Council's safeguarding policy providing details of emergency contacts for information and referrals. We are in the process of updating our internal training offer for safeguarding, as well as actively promoting the use of NYCC resources.
Richmondshire • Appropriate training has been provided to staff and Members on an ongoing basis to recognise abuse and know how to raise a concern • Awareness provided for local businesses and community partners • Effective range of partnerships with other agencies • Continue to work with the NYSAB and LSAG • Continue to work with NYCC Safeguarding staff

- Continue to work with the York and NY Prevent Strategic Board
- Continue to work with the North Yorkshire Community Safety Partnership
- Presented the NYSAB Annual Report 2015-2016 to Overview and Scrutiny Committee's 1 and 2

Ryedale

We held the DV awareness event delivered by IDAS at Ryedale House on 12/10/16
We have a display of safeguarding posters in reception on a permanent basis
We promoted safeguarding week in October on our website
RDC was involved in the planning of and was part of the safeguarding week in October 2016

Scarborough

SBC was involved in the planning of and was part of the safeguarding week in October 2016.

Awareness on safeguarding remains a priority for SBC with sessions running for staff and members on a regular basis. Awareness sessions are also provided to taxi drivers, hotels, guest houses, pubs and door staff, holiday parks to ensure they understand their responsibility to safeguard vulnerable people and equip them with the skills to do so.

Selby

Selby District Council has undergone a whole organisation review which has resulted in new structures and systems for meeting the strategic outcomes. The Community, Partnership and Customers Service area now leads on the strategic delivery of safeguarding to ensure a council wide approach to effective safeguarding awareness. The review and subsequent recruitment is still under way. A wholescale workforce development plan will be deliver as part of this review and will include ensuring staff are aware and confident in identifying abuse, raising concern for vulnerable people.

Prevention:

Craven

Awareness was raised with the wider public via public information events in Skipton, Settle and Bentham. Information about the events and where to get further information about safeguarding was circulated to local community groups, District Councillors and local Parish and Town Councils.

Hambleton

HDC has reviewed its Recruitment and Selection Policy and Procedures in 2016 including safer recruitment requirements. Alongside this HDC has produced a stand-alone DBS Policy and Procedure.
HDC has a comprehensive training matrix which it is rolling out to all staff. This includes bespoke sessions for leisure staff and waste and street scene staff.

Harrogate
We have provided safeguarding training to all our taxi drivers, including a course on recognition of Child Sexual Exploitation. We have actively participated in safeguarding week, as well as attending and contributing to the Local Safeguarding Adults Board.

Richmondshire

- Training has equipped staff and Members to recognise and report issues
- Awareness raising campaigns for staff, Members and customers
- Safer recruitment policy and process in place including DBS prior to appointment and reviewed every 3 years
- Safeguarding Training Matrix in place
- Supported local museums in safeguarding awareness

Ryedale
Training for staff is ongoing in RDC and for those activities we license
RDC have a proactive multi agency arrangement working together to identify and support those vulnerable that are living in our community.

Scarborough

- Training for staff is ongoing in SBC and for those activities we license
- SBC have a proactive multi agency arrangement working together to identify and support those vulnerable that are living in our community.
- A Notice, Check and Share event was coordinated by SBC, NYP and NYCC to raise awareness at a local level on Prevent this will now be rolled out across county.
- A training package developed by SBC for taxi drivers has now been adopted at a county level.

Protection and Proportionality:

Craven
Strategic Managers were circulated with information re how the Mental Capacity Act and Deprivation of Liberty Safeguards relate to District Council functions.
For all staff a reminder to check on whether safeguarding training is adequate and up to date is included in Managers Performance Review Preparation Notes, where a need is identified this information is included in the individuals personal development plan and passed to HR to be incorporated into the Annual Training Plan.

Hambleton
HDC is currently working on a safeguarding improvement plan for clubs/organisations that hire leisure facilities. The new procedure make the booking system more robust and will ensure that all clubs/organisations that are delivering regulated activities are accountable and that HDC has carried out a series of checks that will evidence their understanding of accountability.
HDC has set up an internal Tactical Group to consider cases of anti-social behaviour – this group will also discuss particular safeguarding concerns. The group is attended by North Yorkshire Police and Broadacres to provide a partnership approach to this work.

Harrogate
We have developed a proactive community hub with partners including the police, where we actively discuss a range of issues including safeguarding matters. We have followed up on referrals to ensure matters have been addressed.

Richmondshire
Designated Officers in place for staff to refer to and deal with staff issues.
Up to date staff training inc TMCA, DoL, CSE and Dementia
Revised Policy and Procedures (April 2017)

Ryedale
We are improving staff knowledge of Mental Capacity Act and DOLS to meet the protection and proportionality goal – this work will be ongoing.
We carry out regular staff training sessions in-house which are given a high priority and include the Mental Capacity Act and safeguarding policies and procedures.
We carried out taxi driver safeguarding training and have amended our taxi licensing policy to make this mandatory.

Scarborough

SBC coordinates a multi-agency team that are co-located within the Town Hall. This team identifies, supports and makes appropriate referrals for those that are vulnerable and at risk living in the community.

Selby
The Community, Partnership and Customer Service chairs the Selby Safer Hub weekly meetings which include problem solving crime and ASB issues related to either victims, offenders or vulnerable locations. This includes identifying where vulnerable adults require additional support to prevent ASB and crime. For example, this involved including adult health and social care representatives in local problem solving meetings to reduce issues around neglect, mental health and housing.

Partnership effectiveness and Accountability:

Craven
CDC has signed up to the Multi Agency Overarching Information Sharing Protocol and Safeguarding Adults West and North Yorkshire & York Multi Agency Policy and Procedures.
CDC participates in Local Safeguarding Adults Meetings, Multi Agency Problem Solving Group (MAPS) and the North Yorkshire District Safeguarding Lead Officers Group. During Safeguarding Week 2016 staff from Craven DC, Police, Children and Families' Service, Adult Social Care and local charities such as Independent Domestic Abuse Services, Age UK North Craven and Hand in Hand, used the Mobile Police Unit to hold three pop up public information events in Skipton, Settle and Bentham, information about the events was circulated to local community groups, District Councillors and local Parish and Town Councils.
Key safeguarding issues are reported to the CDC Corporate Leadership Team and appropriate action plans agreed.

Hambleton
HDC has established an internal Safeguarding Panel to oversee the council's safeguarding policy and procedures to ensure that they are adhered to. The Panel

also monitors the delivery of the training plan and corporate safeguarding improvement plan.
Harrogate The Chief Executive represents all NYCC districts on the Strategic Safeguarding Adults Board, emphasizing the importance of safeguarding to our council and the districts. We are working with colleagues across the districts and with NYCC to improve communications on safeguarding and other social care matters, to ensure we provide a joint response to service needs, and that appropriate referrals are being made and followed up. We also look to share good practices with colleagues to help improve our response to incidents, as well as improving our preventative support services. For example our CSE course information was shared with colleagues throughout the area.
Richmondshire We are active members of local safeguarding groups including: - • Hambleton/Richmondshire Local Safeguarding Adults Group • North Yorkshire Safeguarding Adults Board • North Yorkshire Community Safety Partnership • York and North Yorkshire Prevent Strategic Board • Safer Richmondshire sub groups including: Domestic Abuse forum, VPI, VEMT, Local Prevent Group and MAPS
Ryedale Representatives from the district councils meet to share good practice and tackle challenges collectively on a regular basis Referral pathway has been developed for reporting modern slavery A safeguarding panel ensures that any county or national legislation is implemented at a local level and ensures good practice is adhered to through the council.
Scarborough Representatives from all the district councils meet to share good practice and tackle challenges collectively on a regular basis A safeguarding panel ensures that any county or national legislation is implemented at a local level and ensures good practice is adhered to throughout the council. An internal audit was undertaken in 2016 to ensure SBC was adhering to its responsibility to safeguarding. An update report and any recommendations are provided to cabinet on an annual basis
Selby The Community, Partnership and Customer Service now has full representation on local safeguarding groups to ensure that the district is appropriately represented in safeguarding forums. Selby District Council in partnership with North Yorkshire County Council Stronger Communities have funded a pilot programme – the Community Navigators

Scheme which aims to support people to gain the right information, advice and guidance in their local area. The scheme commenced in August 2016 and within the 9 month period has dealt with 2000 referrals for advice and support, particularly from individuals aged 65+years. Issues usually relate to financial difficulty as well as ensuring the right support for adaptations to increase independence and tackle concerns such as falls prevention. The scheme is set to run until August 2017.

12. Independent Care Group (ICG)

Tell us what your organisation has done during 2016/17 to meet the SAB's strategic outcomes The Independent Care Group (ICG) represents independent care providers across North Yorkshire. ICG is a member of the Safeguarding Adults Board. It communicates safeguarding priorities to its members through weekly updates and a quarterly newsletter, and raises issues from the independent care sector.
Awareness and Empowerment:
We use every opportunity to promote the importance of Safeguarding and putting the individual at the centre of an enquiry, in line with the Care Act. We make our members aware of any changes to policy and procedures.
Prevention:
We promote Safeguarding Training through direct communications and on our website.

13. North Yorkshire and York Forum

Tell us what your organisation has done during 2016/17 to meet the SAB's strategic outcomes **Note:** North Yorkshire and York Forum merged with Rural Action Yorkshire in April 2017 to form Community First Yorkshire. Community First Yorkshire continues the work of its two predecessors and will continue the representation role at the SAB and two-way communication with the voluntary and community sector.
Awareness and Empowerment:
Meeting minutes and the website are checked for updates on events and awareness of activities. Events and awareness activities around the county were cascaded to the database of over 1,800 VCS organisations, in advance of activities taking place. Safeguarding training has been regularly promoted to the sector and discussions have been had regarding the performance data which could be provided on VCS take-up, in order to gauge the success of communication and awareness of training provision and level of interest. Messages from the meetings, taken from the minutes, were part of the representation round-up input into the VCSE Strategic Leaders' Group which meets quarterly, and provides a route for conversations to push for greater awareness via their contacts and discuss emerging issues in relation to safeguarding matters. Safeguarding is one of the areas of questioning in the sector-wide training needs survey, issued in spring 2017.
Prevention:
Safeguarding issues and topics are raised as part of the quarterly NYYF facilitated Equality and Diversity Strategic Partnership Group, which brings together public and VCS representatives to address and develop plans for addressing all aspects of equality and diversity in relation to service access and take-up. The prevention conversations led to a request for a specific agenda item on Prevention Partnerships at the early 2017 meeting.
Protection and Proportionality:
Promoting and providing an efficient Disclosure and Barring (DBS) checking service to organisations especially those within the VCS community. Over the year the number of organisations using the service increased to 250. The service provides training on DBS, these sessions cover the legislation which underpins DBS, outlines when it is applicable for someone to have a DBS check before taking up a role and how to complete forms for employees and volunteers. DBS news update information is reviewed and as relevant cascaded to DBS current and past clients, and the wider network of VCS organisations.
Partnership Effectiveness and Accountability:
The Annual Client survey is used to monitor and look to improve representation and partnership working of the Forum. The latest findings show the majority of respondents agreed that the Forum had made a difference for the sector in its representational role and is able to speak for the sector because it understands the views of a wide range of organizations. Feedback from discussions and representation at groups has been an important part of work with the sector,

including messages from the Safeguarding Board, overall around 90% of survey respondents feel the Forum feeds back effectively.

NYYF is accountability of our effectiveness of representation to NYCC and CCGs which fund this activity and support for others providing representation. Representation will continue as part of the new Capacity Building and Support to Voluntary and Community Sector Organisations and Volunteering Grant Agreement which came into effect from 1 April 2017. The Agreement is held by Community First Yorkshire, which is a new organisation created by the merger of North Yorkshire and York Forum and Rural Action Yorkshire (which merged as from 3 April 2017). Accountability to NYCC and CCGs will continue through quarterly monitoring reports and review meetings.

Accountability of the DBS Service is measured through regular client surveys and DBS national team undertaking short notice audit checks. The survey monitors delivery of the checking service and information out to the sector. These surveys are consistently at the 95% level against criteria which explores the service they had received, very good value for money judgements and the timely provision of the service. The level of repeat custom from clients is high which reflects the effectiveness of the service provided.

Appendix 2

North Yorkshire Safeguarding Adults Board Membership and Attendance 2016/17

Organisation	Designation	May 2016	September 2016	December 2016	March 2017	Nominated representative or substitute
	Independent Chair	Y	Y	Y	Y	100%
North Yorkshire County Council	Corporate Director of Health and Adult Services	Y	N	Y	Y	75%
	Assistant Director, Care and Support	Y	N	Y	Y	75%
	Assistant Director, Quality & Engagement	Y	Y	Y	N	75%
	Director of Public Health	Y	Y	Y	Y	100%
North Yorkshire Police	Deputy Chief Constable	Y	Y	Y	Y	100%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	Y	Y	N	100%
	Designated Professional for Adult Safeguarding	Y	Y	Y	Y	100%
Airedale, Wharfedale, Craven CCG		Y	Y	Y	Y	100%
NHS England		Y	Y	Y	N	75%
Tees, Esk and Wear Valley NHS FT		Y	Y	Y	Y	100%
Harrogate District Foundation Trust (on behalf of		Y	Y	Y	Y	100%

Foundations Trusts)						
Harrogate Borough Council (on behalf of Borough/District Councils)		Y	N	Y	Y	75%
Independent Care Group		Y	Y	Y	Y	100%
Healthwatch		Y	Y	Y	Y	100%
North Yorkshire and York Forum for Voluntary Organisations		N	N	N	N	0%
Legal Advisor to the Board		Y	Y	Y	Y	100%

Appendix 3

Contact Details of partner organisations in North Yorkshire

Organisation	Telephone	Email or Website
Airedale Wharfedale and Craven Safeguarding Team and wider CCG	01274 237324	Awccg.quality@nhs.net
Care Quality Commission General enquiries	03000 616 161	www.cqc.org.uk/content/conact-us
Craven District Council Customer services	01756 700 600	contactus@cravendc.gov.uk
Hambleton District Council Customer Services	01609 779977	info@hambleton.gov.uk
Hambleton Richmondshire and Whitby CCG General Enquiries	01609 767 600	Hrwccg.hrwccgenquiries@nhs.net
Harrogate Borough Council Customer Services	01423 500 600	CustomerServices@harrogate.gov.uk
Healthwatch North Yorkshire General enquiries	01904 621 631	healthwatchny@nbforum.org.uk
Independent Care Group Information Line	01423 816582	Keren.wilson@indcaregroup.plus.com
NHS England North Yorkshire and Humber Office	0113 825 1986	www.england.nhs.uk/north/contact-us
North Yorkshire & York Forum	01765 640 552	info@nyforum.org.uk

General Information		
North Yorkshire County Council Customer Service Centre	01609 780 780	Customer.Services@northyorks.gov.uk
North Yorkshire Police Enquiry Line	101 or 999 in emergencies	General.enquiries@northyorkshire.pnn.police.uk
Richmondshire CCG Customer Services	020 8734 3000	RICCG.richmondpals@nhs.net
Richmondshire District Council Customer Enquiries	01748 829 100	enquiries@richmondshire.gov.uk
Ryedale District Council Customer Enquiries	01653 600 666	enquiries@ryedale.gov.uk
Scarborough & Ryedale CCG General Enquiries	01723 343 660	SCRCCG.enquiries@nhs.net
Scarborough Borough Council Customer First Centre	01723 232 323	www.scarborough.gov.uk
Selby District Council Customer Contact Centre	01757705 101	info@selby.gov.uk
Tees, Esk & Wear Valley NHS Foundation Trust – involvement and engagement team	01325 552 314	Tewv.ftmembership@nhs.net
Vale of York, CCG General enquiries	01904 555 870	Valeofyork.contactus@nhs.net

Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Executive Committee

Date of Meeting	6 and 20 December 2017
Chair	Phil Mettam

Areas of note from the Committee Discussion

1. Plans to reform acute provision continue to be developed to align with the anticipated funding position for 2018/19 and beyond.

2. The consequences for services in Malton (For Vale of York patients) of the Scarborough and Ryedale CCG Multispeciality continue to be reviewed to ensure continuity of service.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

Minutes of the Executive Committee, meeting held on

6 December 2017 at West Offices, York

Present

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

In Attendance

Dharminder Khosa (DK)	Director of Turnaround & Delivery
Caroline Alexander (CA) for items 1 -5	Assistant Director of Delivery and Performance
Simon Cox (SC) for items 1-5	Chief Officer, Scarborough and Ryedale CCG
Fiona Bell (FB) for items 1-5	Deputy Director of Transformation and Delivery

The agenda was discussed in the following order:

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

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 15 November were deferred to the next meeting.

4. **York and Scarborough Acute System Review**

   SC updated the committee on the strategic programme paper and the feedback received from NHS England & NHS Improvement. The feedback had been positive, recognising the proposal was a good start. More detailed information would be included in the final paper to be submitted to the regulators.

   It was agreed that the following would be included:

   - Financial and activity figures where possible to quantify over three years

- Impact on health and population outcomes to be clear and specific where possible
- A supporting overarching engagement document for launching with partners
- A supporting system programme plan with key deliverables and milestones

It was noted that the proposal for the system to move to Aligned Incentives Contract (AIC) had not yet been agreed and therefore the system plan was being developed within the current context of PbR and system working as organisations.

It was also noted the link to the two acute hospital reviews within the STP (Yorkshire and Humber) and that an initial meeting had been held with the S&RCCG Ambitions for Health programme teams to refresh that local plan as part of the Yorkshire acute service review. The paper from the Humber acute service review had been shared with the committee.

The committee discussed the acute system programme being led through a joint committee and it was agreed to request approval from the Governing Body to develop the proposal for this joint committee, PM would take this forward.

The committee also agreed for the programme to become a standing item on the Executive Committee agenda.

Home first and Malton Hospital

FB provided an update on the paper received from the Trust outlining a communications and engagement plan for the coming months on 'home first'. System leaders were being asked to sign up to the approach to holding conversations with the public, helping patients, relatives and carers to understand the concept of Home First and discuss how this would work in relation to their care. A discussion was held on additional areas execs would like including for any communications plan, with recognition that messages need to be firmly grounded in the wider system issue of delivering high quality care within finite resources, and building on previous CCG events around changing models of service delivery. AP and SC were attending the follow up meeting with system leaders on 7th December – to feed back.

Malton issues: Following notice given by York trust in September on the inpatient beds at Malton, the committee discussed the next steps to secure in-patient provision. As Scarborough Ryedale CCG had announced Humber FT as the winning bid for their MCP model of community provision, it was agreed that further work was required to understand any potential impact on community services for Vale of York patients in the Ryedale locality. FB to draft letter to Humber FT asking if they may be prepared to provide clinical cover for the beds pending a longer term review of Malton hospital and service provided. Additional

letter to be sent to York FT to ask for an update on remaining services provided through the community contract in Ryedale. Agreed that longer term issues re bed provision form part of the system transformation work being led by SC; core community contract issues and provision to remain within CCG.

5. Finance

5.1 Latest Financial Position

Month 8 financial info not yet available but early month 7 flex activity on York FT indicates further deterioration, mainly in non-elective. Detailed work is underway to better understand this.

TP reported that the prescribing NCSO was nationally a big issue with the NHS figure in the region of £300-400m nationally. NHSE will issue guidance for month 8 reporting (£2m for us) and will be including in our risk figures.

TP also reported that the outstanding rehab bed day's challenge remained unresolved and was likely to go to formal arbitration following extensive discussions with the Trust and NHSE colleagues.

TP also reported that CHC and mental health out of contract expenditure were still a concern.

5.2 Turnaround Headlines

Dharminder presented his recommendations from his turnaround work to date and summarised the key steps to achieve improved efficiency/QIPP delivery and governance. These would be presented to S&R CCG and key actions agreed would be implemented in January 2018.

There was a request for the CCG Board to review progress with financial recovery in mid-January in order to review all key projects.

The presentation had been shared with the committee.

5.3 ENT Microsuction Procedure Not Routinely Commissioned (PNRC) proposal

CA outlined the paper which had been brought to the Committee to discuss the introduction of a PNRC policy and to decommission the secondary care micro- suction service. Due to timings of planned care and CCG Clinical Executive meetings the paper had not yet been to the Clinical Executive, but it was felt helpful to get an Executive steer on this proposal asap to support the fortnightly planned care meetings.

The committee agreed with the initial proposal and felt a Quality Impact Assessment was needed to understand the impact the change in process would generate.

The proposal would be brought back to the meeting for approval in due course.

CA/SC/FB left the meeting

6. Performance & Delivery

6.1 NHS Property Services Vacant Space policy

TP presented the paper to the committee. The paper detailed the NHS property services vacant space policy and the impact on the CCG. A realisation list was prepared listing all the CCG properties categorising the properties as currently surplus, likely to be surplus in the near future or long term hold. The realisation list was agreed by the committee.

There were a number of properties identified as currently surplus or likely to be surplus in the near future. It was agreed that property vacation notices would be submitted to NHS Property Services for these properties.

6.2 Thresholds Update

MC provided an update on the STP Thresholds work. The committee noted that:

- An STP process had been established to try to align thresholds across the six STP CCGs. In considering the first tranche of those thresholds the Vale of York CCG recognised the need to consider each individual threshold and consider whether a QIA was needed or whether there was already a satisfactory QIA in place. If a QIA was completed this would advise on whether or not full public consultation was required on the change to the threshold. There should also be an EIA completed at the early stages of considering changes to the threshold. Once the CCG is content that clinically the threshold is appropriate and that the necessary Impact Assessments have been completed, it can move to approving the new thresholds in Executive Committee / Governing Body.
- A discussion had taken place with the STP Lead Alex Seale who had agreed to undertake a review of the STP process and terms of reference and membership and this would come to CCGs to approve.
- The contract variation with YHFT had been deferred until 1st January however all 22 thresholds may not have been approved by then.

- It was apparent that no other CCGs had undertaken QIAs for the agreed thresholds and Vale of York was sharing their process and example to support.

The committee agreed:

- That it did not support the cataract threshold and that SOC should progress the policy with Peter Billingsley from S&R CCG.
- The CCG needs to agree a governance process SOC/MC/AC to action
- The Executive decided to inform Alex Seale that the Vale of York CCG did not agree with the proposed Cataract threshold and that the CCG's participation in the STP process would be reviewed, pending the STP's review of the whole process.

6.3 Winter Planning Mobilisation

A number of the winter planning elements discussed at the last meeting had moved forward and AP provided the following update:

- Expansion to the Community Response Team – The Trust had agreed to fund this
- GP additional sessions – The response had been good and collation from practices was on-going
- The Trust had also committed to additional resource over and above the winter plan – Flow practitioners for 4 months, additional medical staff and Home IV's consumables/drugs.

AP raised a query around Yorkshire Doctors Urgent Care (YDUC) ANP funding. TP clarified this and advised YDUC had agreed to cover the full cost and agreed to ensure this was in writing from YDUC.

AP also advised the committee that the ANP would initially be for 3 days, not 5. This was a temporary initial period to be confirmed.

AP/TP left the meeting

7. Service, Quality and Safety

7.1 Children's Community Eating Disorder Service (CEDS)

DN briefed the committee on the performance discussions with TEWV where issues had been raised regarding the capacity of TEWV to deliver services in accordance with the agreed specifications and national waiting times, with consequent concerns for patient safety, patient outcomes and quality of service.

The committee discussed the paper and noted that GP's had also raised concerns to Dr Smith re this service.

The committee noted the report and supported the recommendation that further work was required to analyse the service provision. An options paper would be brought back to the Executive Committee in January.

7.2 Children's Autism Assessments

DN outlined the paper and described the current service for the 0-5 pathway and 5-18 pathway, noting the significant waiting list and diagnosis delays.

The committee discussed concerns that the delays could impact on the child receiving support in school and also the family receiving support with management of the diagnosis. The options of additional funding were discussed and an agreement reached that action was needed re the delays. Prior to any non recurrent funding being put in place, clarification would be sought from TEWV on contract queries raised regarding paediatrician requirements for a NICE compliant diagnosis in an MDT. This would give the assurance that the CCG was not paying twice and approval for the additional monies were agreed in principle on that basis.

7.3 Liaison Psychiatry

DN provided a background to the paper and the committee were asked to consider the options for on-going funding. It was agreed that a further discussion was required and to identify whether that had been planned for in finance investments in 2018/19.

PM/KS left the meeting

Post meeting note - summary from DN

Funding for 1 year from national pot received late in 17/18.
Part of service in place but no consultant until early 2018.
No c/f funding but all clinical posts recruited permanently by TEWV.
Evaluation of 3 months project due in January but without Consultant input, concerns re how complete this might be.
Primary aim of this service to reduce mental health admissions (nationally evidenced) The cost to continue is c£500k and confirmation has been received from finance that it is not currently identified in investments for 18/19.
Execs agreed to check parity of esteem benchmark, to submit again to Execs and rationale to Finance & Performance Committee.

7.4 Perinatal Mental Health Services

As the committee was no longer quorate at this point, a further meeting was required to discuss this item.

Post meeting note – summary from DN

Paper identifies limited local support service and in-patient beds in Morpeth and Leeds. The bid has been developed by TEWV and NY &Y CCGs to support a hub and spoke approach. (£1M across all CCGs). TEWV requesting formal support now for the bid, it is believed the CCG will get non recurrent 1 year funding. PM to email all Accountable Officers in NY to see whether given all their emerging financial issues they are supportive of this development and new costs in 19/20 as a first stage.

Minutes of the Executive Committee, meeting held on

20 December 2017 at West Offices, York

Present

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

In Attendance

Paul Howatson (PH) for DN	Head of Joint Programmes
Simon Cox (SC) to item 6.2	Chief Officer, Scarborough & Ryedale CCG
Dharminder Khosa (DK) to item 6.2	Director of Turnaround and Delivery

Apologies

Denise Nightingale (DN)	Executive Director of Transformation

The agenda was discussed in the following order:

1. **Apologies**
   As noted 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 6 December were approved with a minor amendment to item 6.2 Thresholds Update

4. **Acute System Review York System**

   The feedback call on the strategic programme paper with NHS England & NHS Improvement had been rearranged for the end of December, SC advised the committee that work would continue until then based on the initial feedback.

   SC also provided an update from the recent System Transformation Board meeting where the aim had been to close the 17/18 plan and work through details for the medium term plan. This had not been achieved therefore the Board had agreed to work towards issues locally and take them back to the next meeting in early

January. The Board also agreed that early focus was needed on areas of cost reduction.

PM and SC provided a brief update from the recent Accountable Care System Partnership Board meeting. Details were being worked through on a possible re- launch of the meeting. PM to take forward

5. Finance, QIPP and Contracts

5.1 Latest Financial Position

TP provided an update on the forecast outturn work for regulators, recently updated following the meeting at the end of October. The main change was with VoY CCG where the Trust forecast had increased significantly, mainly due to inclusion of challenges at full value and increased winter activity forecast.

TP also provided an update from recent meetings and discussions with Andy Bertram and Jon Swift, focusing on work to attempt to agree a 17/18 year-end contract figure.

Following the STB meeting with the Trust on Monday, it was agreed to request the CMB to focus exclusively on resolution of outstanding disputes across all CCGs. TP shared the output proposals from this exercise. The committee supported the proposals with the exception of Sepsis where it was decided to await and comply with national NHSE guidance. MC also highlighted there were clinical concerns with Sepsis pathway and TP agreed to escalate this with Andy Bertram and CMB.

TP reported that the rehab beddays challenge would be going to arbitration (expert determination) and that paperwork would be submitted this week. The committee supported this move.

The committee also supported the Emergency Department Front Door and assessment challenges in requiring a clinical perspective to resolve, in particular the involvement of GPs in ensuring the commissioning of the optimal patient pathway.

TP provided a brief update on the month 8 position and that the forecast outturn was deteriorating by £3m due to recognition of risk of challenges and the national NCSO issue. This was done following discussion with NHSE and PM and was supported by the committee.

5.2 System Turnaround Proposals

The committee noted the paper from SC which had been circulated for information.

5.3 Turnaround Update

DK reported the approach being taken on the turnaround work was to ensure the CCG was "audit ready" by the end of January. Monthly financial recovery board meetings were now in the diary to review progress and support on-going delivery of QIPP projects. Focus would be given to the top 10-15 projects which generate the biggest QIPP savings.

DK advised of a potential technical and capability issue on the QIPP trackers and therefore moving to an East Riding model may not be possible in the short-term. The committee challenged this and requested further investigation. DK to progress.

Workshops were now in the diary for the unplanned and planned care teams to understand Aligned Incentives Contract. In addition, a Governance Review meeting was planned to ensure the CCGs were using lean and effective structures, meetings, with appropriate membership.

5.4 Draft Request for Expert Opinion Flowchart

The committee noted and supported the work in progress which would be brought back to the committee in due course.

5.5 Dermatology Consultant Capacity

This item was not discussed and was carried over to the next meeting.

5.6 Commissioning Intentions

Work was being finalised on content and presentation following feedback from the committee. The paper would be presented at the public Governing Body meeting in early January, with a proposal to launch shortly afterwards.

6. Performance & Delivery

6.1 Thresholds Update

The letter agreed at a previous meeting had now been sent to Alex Seale, Director of Commissioning and Transformation requesting a review of the CCG's

participation in the STP's process for agreeing commissioning policies. The letter also confirmed the committee's decision not to accept the STP cataract policy.

A subsequent meeting with SOC/MC and Alex was planned for January.

SOC informed the committee that a draft paper on a process for the Vale of York CCG had been circulated and was awaiting feedback. It was hoped that in January the CCG would have a clear stance on statements which could be signed off, those which required amendments and where new statements were required. SOC to bring back to the Executive Committee in January.

The Committee agreed that a consistent approach across the system was required and would work on that basis. SOC and Peter Billingsley to review for both CCG's.

Governing Body to be informed of this approach and advised once completed.

SC/DK left the meeting

6.2 Parkinson's Disease Nurse Specialist Funding Proposal

The Committee were asked to ratify the use of pump-primed funding, for a 2 year period, provided by Parkinson's UK to employ a community facing Parkinson's Disease Specialist Nurse.

A number of queries were raised and the committee felt a robust evaluation process and baseline was required as well as clarity over the employment of the nurse.

The committee approved the paper in principle, conditional of the evaluation. SOC to bring back to the Executive Committee.

6.3 Medical Non-Emergency Transport Procurement - Award Report

TP set out the award report on the outcome of the procurement process which was being presented to the Finance & Performance Committee on the 21st December, prior to Governing Body approval in January.

The Committee were asked to ratify and note the process that had taken place to identify the bidder as an appropriate procurement process.

The Committee agreed.

6.4 Urgent Emergency Care Network Update/Clinical Advisory Service Model

AP referred to the 2 letters that had been circulated with the papers which included a response to the Humber Coast & Vale, UECN . The Greater Huddersfield (Lead Commissioner for the 22 CCGs) proposals gave a range of three options. The UECN advised that the CCG adopt one with some additional elements to allow the specification to be more aligned to the HCV UECN plans and that we follow a course of action re Greater Huddersfield proposal. The UECN came up with principles that answered this position and asked CCGs' to endorse it.

The committee supported in principle and await response to letter.

6.5 Winter Planning Mobilisation

The committee noted the update from AP.

Work was being completed on a clear detailed summary of the costs and funding which had been requested by TP to correlate the numbers. Summary to be brought back to the Executive Committee on the costing and implications for the additional allocations announced recently.

Under this item, the committee also discussed the various new people currently assisting work within the CCG and requested a brief at the next Executive Committee. CA to prepare.

6.6 DTOC's Trajectory & Letter

The committee noted the update from AP. The letter from the department of Health requested clarification of the DTOC figures. The committee received the DToC figures which would be validated at the Finance & Performance committee. The figures would then be able to provide a forecasted position for Q2/3. Some aspects needed to be resolved through the Business Intelligence team. The second attached letter from the Local Government Association clarified some of the DTOC reporting actions.

KS to spend time with Paul re DTOC

6.7 Paper Referral Switch Off Governance Proposal

SOC provided an update on the paper which had gone back to the author with amendments. Work was being completed on a step wise governance model and was on track to switch off 6 months early.

It was proposed that from the 1st March 2018 paper referrals would be rejected, allowing January – March to be used as an opportunity to stress the deadline of 1st March. A query was raised if the proposal only applied to YHFT. SOC to confirm.

6.8 IAPT Target 18/19 & 19/20

The national target for IAPT access was 15%, the 5 year forward view for Mental health stepped the figures up to reach 25% by 2020/21.

From the IST review in February 2017, they agreed that the CCG could aim to achieve 15% for Quarter 4 in 2017/18 rather than the national expectation of 16.8% given the historic performance of IAPT services across the Vale of York.

The committee discussed whether the access target of 15% was sustainable and what would be the implications in terms of assurance (NHS England), patient experience and resource implications.

TEWV had provided outline costs for stepping up access to IAPT in line with the 5 year forward view and the additional resource required was highlighted to the committee.

The committee expressed their thoughts in terms of what could be done perhaps with other providers without significant additional resource. Would we consider revising service specifications or giving notice if we believed it could be done differently?

IAPT services have developed over time using third sector and online providers in some areas, it was also noted that IAPT services were not provided in some areas by specialist mental health services. It was agreed to receive a paper with a better understanding of the market and the options available to the CCG and that this would be brought back to a future Executive Committee.

PM highlighted the Commissioning Intentions document and the different contracts with York Teaching Hospital Foundation Trust in terms of where the money was being spent and where we should focus resources as the financial position recovers. An example being would we prioritise investing in IAPT and other mental health services? TP to work on details

7. Service, Quality and Safety

7.1 Personal Health Budget Draft Policy

The committee received the new draft policy and agreed further work was required to finalise the policy prior to submitting to Governing Body for approval. It was agreed to delay this to the March Governing Body meeting to allow time for the changes to be made.

7.2 Anti-coag

The committee discussed the slow uptake from General Practice on Anti-coag and concerns raised from York Trust of Anti-coag staff leaving due to awareness of the service winding down.

The trust were reluctant to recruit to posts in a service that would ultimately be moving out and had therefore requested an indication on how the CCG planned to accelerate the uptake of the service to enable them to work towards closing the service and informing /redeploying staff.

A robust discussion was held emphasising the risk to patient safety.

The committee felt they needed to be clearer on where the gaps were in General Practice and why, they could then understand where work was required.

The committee therefore agreed for KS/SOC to take forward with Shaun Macey and Stacey Fielding, this would involve a stocktake, ascertaining any immediate risk and producing a tactical steer for 18/19. To be brought back to the committee.

7.3 Voluntary Sector

PH had attended a voluntary sector partnership meeting with the aim of producing a statement in how the CCG and voluntary sector could work together. At the meeting the voluntary sector had highlighted that City of York Council should also be part of the discussions and agreement.

The committee held a discussion and were keen to ascertain how other CCG's worked with the voluntary sector across the STP.

PH to take forward with CYC and the Voluntary Sector, linking into the Health & Wellbeing Board strategy and bring back to the committee in due course.

7.4 CQC Feedback

The CQC report had been published and the action plan was due by the end of January.

8. Strategy

8.1 Tier 2 Adult Weight Management Procurement

The CCG had received a letter from NYCC (Katie Needham) advising of the outcome of tier 2 weight loss management services, split into lots across North Yorkshire. The Selby District Council service 'move it or lose it' referrals could still be sent in the usual way.

Update re Tier 3 no local providers for York patients, VoY patients had been using Leeds & Wakefield however they had now advised they could only take local patients. A discussion took place regarding the gap in services this would leave and no commissioning stance described. The committee agreed this work as urgent and asked Emma Broughton to expedite a proposal for future funding and the development of future commissioning position.

Occasionally the CCG is asked for advice from IFR on this but nothing recently. Further discussion on mental health cases which are not in the contract for NECs to deliver as part of IFR, or that come to us as we do not have a commissioning position, outside of a formalised process. Head of Legal Services is already assisting with developing a policy and process in order to keep our decision making safe. MC asked for a response to this issue for a future Executive Committee. Main solution is to develop commissioning position for those cases commonly coming for a decision outside of a formalised process e.g. psychosexual counselling.

8.2 Items which should not be routinely prescribed in primary care

SOC presented the paper on the recent NHS England guidance provided to CCG's on 18 low priority medicines which should not be routinely prescribed in primary care. The paper summarised the current position of the CCG in relation to these medicines and the action plan required.

The Committee agreed with the process and continuation of the action plan.

8.3 Gluten Free Foods Provision Options Paper

Following public consultation, concerns had been raised regarding governance risks around the top-up visa card. The committee were therefore asked to revisit their previous decision to consider a further option of ceasing gluten free foods prescribing, other than in exceptional circumstances.

The committee discussed the proposal and noted that this was the current policy in Scarborough & Ryedale CCG, Harrogate and Rural District CCG and Hambleton Richmondshire & Whitby CCG.

The committee agreed with the new proposal however felt that more clarity was required around the “exceptional circumstances”.

SOC to work with Laura Angus and Louise Horsfield on detail. SOC, KS & MC to bring back clear proposal to Executive Committee in January

9. Commissioning Primary Care

The £3 per head and Personal Medical Services principles had been agreed at the Council of Representatives meeting, TP & KS were now discussing if a paper was needed for Governing Body.

KS stressed this was a substantial amount of money now going into the localities and the locality forum should be used to move this forward. Central locality had requested the CCG’s support to progress this.

10. Local Issues

PM confirmed the reset of Governing Body had been agreed at the last Governing Body meeting. An assessment day was being held to establish a clinical chair on the 17th January 2018. The Council of Representatives had requested the candidates for the clinical chair also present to them, an extraordinary meeting would be organised for this.

MC advised of an issue with a recent IVF case and confusion regarding entitlement to an additional course of IVF. MC acknowledged there was some confusion on the website and suggested that herself and KS ensure details were clear on the website to avoid any further delay or confusion. The committee supported this proposal.

12. People, Support & Development

12.1 CCG Structure

The committee approved the CCG structure acknowledging this was a moment in time and was likely to change in April 2018.

12.2 Carry over Annual Leave

As per current policy, the committee agreed that 5 days holidays could be carried over with the approval of line manager.

12.3 Learning & Development Policy

The committee approved the minor changes to the policy.

13. Corporate

13.1 Living Wage Foundation Rate 2017/18

The committee discussed the recent introduction of a national living wage and considered if this paper was still required or had now been superseded. MC to check and bring back to the committee if required.

13.2 Information Governance Policies Amendments

The committee approved the amendments to the policies.

14. Any Other Business

PH notified the committee of the closure of Holme Hall, a Sue Ryder home at Holme on Spalding Moor. The home had notified the CCG of the closure giving 28 days' notice with assurances they would remain open until all patients had moved.

PH advised that the CCG had 7 patients at the home and details were being worked through.

Vale of York
Clinical Commissioning Group

Item 16

Chair's Report: Finance and Performance Committee

Date of Meeting	21 December 2017 and 25 January 2018
Chair	David Booker

Areas of note from the Committee Discussion

21 December

- The Committee requested that further work be undertaken on the CCG's risk reporting processes by reconvening the original working group. There were a number of emerging risks, including those faced by primary care, which had not yet appeared on the Risk Register.

25 January

- The Committee requested that the CCG should lead on a regional system wide process, including York Teaching Hospital NHS Foundation Trust, to set a reasonable year end financial outturn which is acceptable to commissioners.
- The Committee recognised that the creation of Aligned Incentive Contracts with provider organisations is critical for continued financial recovery requesting that consideration be given to location and leadership responsibility. PM would discuss this with Simon Cox to ensure clinical leadership.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Minutes of the Finance and Performance Committee Meeting held on 21 December 2017 at West Offices, York

Present

David Booker (DB) (Chair)	Lay Member and Finance and Performance Committee Chair
Caroline Alexander (CA) – for items 11, 12 and 13	Assistant Director of Delivery and Performance
Michael Ash-McMahon (MA-M) on behalf of Tracey Preece	Deputy Chief Finance Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Joint Medical Director
Dr Kevin Smith (KS)	Director of Primary Care and Population Health

In attendance

Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Keith Ramsay (KR)	CCG Chairman
Michele Saidman (MS)	Executive Assistant
Lee West (LW)	Assistant Head of Finance, NHS England North (Yorkshire and the Humber)

Apologies

Denise Nightingale (DN)	Executive Director of Transformation
Tracey Preece (TP)	Chief Finance Officer

1. Apologies

As noted above.

2. Declarations of Interest in Relation to the Business of the Meeting

AP declared an interest in item 10 as a GP due to one of the schemes in the winter plan being for additional GP sessions. All other declarations were as per the Register of Interests.

3. Minutes of the meeting held on 23 November 2017

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 23 November 2017.

4. Matters Arising

F&P39 Risk - Continuing Healthcare and Transforming Care / Section 117 Vulnerable People Risks: members requested the action plan for the January Committee. SP reported that she and KR had met with the Head of Internal Audit who had subsequently met with DN and TP and was now scoping an independent audit regarding the issues previously discussed by the Committee. SP noted that she had requested the audit be expedited. PM agreed to provide a briefing paper on the position for the February Committee meeting.

F&P41 Finance and Performance Committee Terms of Reference: The Head of Legal Services and Governance had confirmed that, provided there was no conflict with his membership of other committees, there was no reason why KR should not become a member of the Finance and Performance Committee. It was therefore agreed that KR would become a member of the Committee.

F&P42 Financial Performance Report Month 7 and QIPP Progress - concerns relating to implementation of clinical thresholds across the Sustainability and Transformation Partnership (STP): MC reported on discussion at the Executive Committee on the clinical and governance concerns relating to the 22 joint clinical thresholds and advised that their implementation had been delayed. She noted that a formal letter had been sent to the STP advising that, in view of the review of membership of the STP, the CCG was working with NHS Scarborough and Ryedale CCG to align clinical thresholds. SOC was reviewing governance arrangements and prioritising the clinical thresholds for the next meeting of the Executive Committee. SP additionally reported on presentations about clinical thresholds at the Yorkshire Audit Board where concerns had been expressed about delegation and decision making arrangements.

PM highlighted that NHS Vale of York CCG was one of the first to identify governance issues relating to the clinical thresholds noting that all the CCGs in the STP were now reviewing their position in this regard. He explained that the STP CCG Joint Commissioning Committee had been disestablished and that two pieces of work were now taking place to identify for January 2018 what, if anything, the six CCGs should be working on together and the requirements to ensure that the population of the East Riding of Yorkshire was not disadvantaged. At the same time NHS Vale of York and NHS Scarborough and Ryedale CCGs were working together where appropriate within governance arrangements. In response to concerns expressed by SP, PM described ongoing work to develop a joint committee for commissioning acute services for NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs with concurrent discussions taking place for the potential to establish a more appropriate footprint than the Humber, Coast and Vale arrangements.

AP expressed concern about patient choice on the basis of varying thresholds. KS emphasised that commissioners decide and providers provide therefore the CCG's thresholds would apply even if services were delivered out of area.

F&P43 Contract Trading Report: Clarification about the negative variance relating to trading positions with South Tees Hospitals NHS Foundation Trust and podiatry services provided by Harrogate and District NHS Foundation Trust: MA-M reported that the former related to £24k for Critical Care and a rise in non elective spend on review of

the freeze data and the latter was due to an 8% increase in referrals which equated to c£40k. The podiatry demand was being reviewed in terms of appropriateness of referrals and data provided at the time of the procurement to understand and address the issues.

A number of other items were noted as ongoing or on the agenda.

The Committee:

1. Noted the updates.
2. Agreed that KR would become a member of the Finance and Performance Committee.

5. Risk Report

In presenting the risk report PM highlighted that four of the five corporate risks that had materialised as events on the CCG's risk registers had been on-going for a number of months and three of the four related to performance against constitutional targets. He noted that the risk report was still being developed and referred to the fact that the risks reported were not unexpected.

PM reported that three emerging issues had been discussed at the Executive Committee the previous day. These related to anticoagulation, Malton Hospital and dementia. In respect of the latter a meeting with Tees, Esk and Wear Valleys NHS Foundation Trust was scheduled for 8 January.

With regard to anticoagulation MC explained that York Teaching Hospital NHS Foundation Trust may serve notice on the current contract if the threshold of 500 patients was reached. This could result in patients being transferred to General Practice causing potential issues with their capacity, capability and readiness to provide a full service for all anti-coagulation patients. Additionally, failure to agree transformation to anticoagulation services may lead to variation in services at different locations as agreement had not to date been reached with all GP Practices for these services.

KS explained that the current Enhanced Service for anticoagulation, scheduled to finish on 31 March 2018, was for Practices' own patients only. He referred to the previous intention for anticoagulation to be procured through the former Vale of York Clinical Network and noted that the CCG's original model had assumed all provision would be managed by General Practice with no hospital service. The CCG was currently reviewing Practices that provided the service and consideration was required as to what was the most effective approach for patients.

PM reported that the Executive Committee had emphasised the need to resolve patient safety issues relating to anticoagulation and had requested that KS and Shaun Macey, Head of Transformation and Delivery, review alternative provision of this service.

SP referred to the review of risk appetite and queried at what stage triggers were activated. She noted that the issue described was a system issue.

In respect of Malton Hospital PM advised that York Teaching Hospital NHS Foundation Trust had expressed the potential to withdraw from the beds there following the recent preferred bidder multispecialty community provider contract, currently commercial in confidence, awarded by NHS Scarborough and Ryedale CCG. The risk was in terms of service provision and affordability.

PM noted that the Executive Committee had requested that NHS Scarborough and Ryedale CCG act as lead contractor and establish an appropriate bed capacity for NHS Vale of York CCG patients at Malton Hospital. Simon Cox, Chief Officer at NHS Scarborough and Ryedale CCG, would report to the next Executive Committee.

Discussion ensued in the context of potential reputational issues for the CCG and the complexity of the community services provision and sustainability in the North Locality.

MA-M added that the CCG was undertaking a detailed review of all community services budget lines relating to York Teaching Hospital NHS Foundation Trust with a view to receiving line by line assurance of the impact on these areas from the provider. He noted the fact that contractually they had a commitment to maintain services but that there was the potential risk for current staff to transfer to the new provider.

Discussion ensued on risk reporting in general and with particular reference to reporting that related to the CCG's financial position as a risk or as an incident that had occurred. PM emphasised the continued commitment to the CCG's control total and advised that a meeting with York Teaching Hospital NHS Foundation Trust was taking place in early January to consider options for the end of year position.

DB highlighted the continuing work to stratify risk and ensure appropriate reporting of risk to committees. He also noted issues relating to primary care, such as telephony, which required incorporating.

DB proposed that the original risk reporting working group be reconvened and MA-M proposed that this work should also be progressed via the "Heads of" group.

The Committee:

1. Received the Risk Report.
2. Noted the additional emerging issues regarding anticoagulation and Malton Hospital.
3. Requested that the risk reporting working group be reconvened and that the "Heads of" group also progress development of risk reporting.

6. This item had been withdrawn.

7. Financial Performance Report Month 8 and QIPP Progress

MA-M reported that the CCG's total risk adjusted forecast had increased by £3.1m to £22.5m but the forecast remained a deficit of £16.0m with£6.5m as the risk element. The main reasons were the inclusion of the national No Cheaper Stock Obtainable prescribing issue following NHS England guidance and the formal acknowledgement of the risk of outstanding disputes with York Teaching Hospital NHS Foundation Trust,

also consistent with NHS England guidance and treatment by CCGs with material challenges nationally. MA-M noted that the potential impact from the former had reduced from £2.6m to £1.6m following receipt of further data; £858k of this was included in the risk position.

The year to date position was £12.5m deficit against the planned deficit of £4.2m; a deterioration of £2.6m from month 7. This was due to deterioration in a number of commissioning areas but mainly with York Teaching Hospital NHS Foundation Trust where there had been a £575k increase in activity above the CCG's forecast in month. This trend, which was now built into the forecast, was being analysed.

MA-M also explained potential risk relating to challenges for rehabilitation bed days that were currently the subject of arbitration between the CCG and York Teaching Hospital NHS Foundation Trust. He noted that escalation to expert determination had been in agreement with all the commissioners and that the full impact was a potential £4m risk for all commissioners. MA-M additionally noted that this reconciliation issue had been identified on the relevant STP spreadsheet.

In response to members enquiring about potential for earlier identification of deterioration in the financial position MA-M referred to the development of Aligned Incentives which could enable more timely access to collective information.

PM reported on a recent Capped Expenditure Process meeting attended by NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs and York Teaching Hospital NHS Foundation Trust. Discussion had included the aim of agreeing an end of year position for the system. However, as York Teaching Hospital NHS Foundation Trust had not supported this approach due to potential impact from winter, the move to a single contracting mechanism for the start of 2018/19 was in doubt. LW additionally reported on similar discussions taking place across the region between commissioners and providers.

DB referred to the key message from the November Committee meeting regarding recognition of the complexity of the contract and the fact that the Heads of Terms agreement with York Teaching Hospital NHS Foundation Trust did not appear to fulfil the intended purpose. PM reiterated the previous explanation that the regulators would not invoke the Heads of Terms as their view was of a joint commitment by the organisations to work together.

PM assured members that the Executive Committee had considered the risks and issues in detail the previous day and the CCG had a clear commissioning position. KS additionally referred to the impact of the No Cheaper Stock Obtainable drugs noting that, although the financial risk had reduced and a national resolution was being sought, there was a wider effect, including on Prescribing Indicative Budgets, aspects of QIPP delivery and work at scale.

MA-M advised that £2.4m of mitigation within the reported risk related to non recurrent planned care measures to manage activity. These had not yet been agreed with York Teaching Hospital NHS Foundation Trust but would be the focus of the System Transformation Board meeting on 8 January. MA-M also noted availability of a number

of winter funding sources which could be beneficial both to patients and the financial position.

Members sought and received clarification on a number of other aspects of the report. MA-M also explained that NHS Vale of York CCG would be hosting the service for Specialist Rehabilitation and Brain Injury placements, currently a risk share across the North Yorkshire CCGs.

MA-M highlighted a significant allocation change following the annual exercise in respect of Charge Exempt Overseas Visitors. He noted that the CCG had a reduction in allocation of £457k in month 8 as a result of this annual adjustment and explained that this was more than the CCG's baseline budget allocation because of the national NHS deficit position in this area.

MA-M additionally, via a presentation, sought members' views on aligning the format of the Financial Performance Report with that of the Integrated Performance Report. Members supported this proposal and advised that, subject to assurance of availability of the detailed QIPP information, this was not required within the report presented.

The Committee:

1. Received the Financial Performance Report.
2. Requested that the format be changed to align with that of the Integrated Performance Report as soon as practicable.

"Good News"

MC reported that a video of the views of a parent carer whose daughter was at a special school had been well received at the recent Quality and Patient Experience. This was the first occasion when such a presentation had taken place.

AP highlighted the recent set of videos provided for patients on social media giving information about minor illnesses and self-care. In response members commended and expressed appreciation to Sharron Hegarty and the Communication and Engagement Team.

8. Update on Better Care Fund

AP referred to the report which provided an update in respect of the North Yorkshire County Council and City of York Council Better Care Fund plans which had not been approved at the time of the last Committee meeting. He advised that, since the update had been written, confirmation had been received from the national NHS England Better Care Fund that the City of York Council plans had also now been approved.

Quarter two metrics for delayed transfers of care and non elective admissions at York Teaching Hospital NHS Foundation Trust were also provided in the update. AP highlighted a mismatch between reporting and validated data availability to forecast performance.

The Committee:

Received the update on the Better Care Fund.

9. Contract Trading Report Month 7

MA-M referred to previous discussion, particularly in relation to York Teaching Hospital NHS Foundation Trust and highlighted £4.4m of total challenges over the year. Of this c£3m related to rehabilitation bed days, c£500k to assessment unit activity and c£400k to the Emergency Department Front Door. MA-M reported that, following the recent System Transformation Board meeting, each challenge was being reviewed by the CCGs with the aim of a proposal to the Accountable Officers for resolution of those that were outstanding. Options for this were an agreed price, an example of which was £28 per non face to face contact for advice and guidance accepted by the Executive Committee; an agreed methodology, such as evidence of percentages for the Emergency Department Front Door streaming as per the recent joint exercise; or an agreed approach to a joint assessment.

Discussion ensued on the Emergency Department Front Door for which the business case had been agreed on the basis of it being financially neutral to the CCG. Members noted that a model of streaming was now a national requirement. Another joint assessment of activity would be undertaken in early January to reconcile the apparent mis-match between coded activity and observed streaming to the primary care element. In respect of impact from the IT issue identified by AP, MA-M explained that the Emergency Department Front Door used a national data system and that issues would be identified through this. A verbal update would be provided at the January meeting.

PM commended the Contract Trading Report both in terms of informing the Committee and also in providing detailed information to the regulators.

The Committee:

1. Received the Contract Trading Report.
2. Requested a verbal update at the January meeting regarding Emergency Department Front Door activity.

10. Overview: Winter Planning Update

AP referred to the report which provided an update in terms of lead up to winter 2017/18, schemes highlighted for further work by different groups, local and regional proposals, agreed winter plan by partners and local costs, and delivery against the winter plan including escalations and key themes. AP advised that, in addition to the CCG allocation there was money available via the STP allocation which was to cover community bed schemes and respiratory diversionary pathways, however it was too early to report specifics. AP also noted that out of hours providers had reported a 20% increase in respiratory activity over the previous weekend.

MA-M explained that reconciliation was taking place against the winter plan as additional money was received.

Discussion included concern about service delivery due to workforce issues and the fact that the winter investment was intended to reduce demand and improve services for patients. AP and KS explained that it was difficult to attribute reduction in activity to a specific scheme but that numbers of patients attending A and E were a system indicator; there was a need to fully understand the impact of the winter plan.

The Committee:

Received the winter planning update.

CA joined the meeting

11. Integrated Performance Report Month 7

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

In respect of A and E four hour performance CA noted that, although there had been improvement against the Sustainability and Transformation Fund trajectory, this was not consistently delivered daily on either the York or Scarborough Hospital sites. Ambulance handovers remained the main area of concern but this was being mitigated through the York Teaching Hospital NHS Foundation Trust improvement plan.

CA noted that 18 week referral to treatment (RTT) performance at York Teaching Hospital NHS Foundation Trust had been relatively stable but the risk remained high for 52 week breaches. The only specialty currently delivering the RTT target was trauma and orthopaedics and polling dates for orthopaedics were well within 18 weeks. CA reported that she had requested the profile of elective activity in relation to winter planning in order to understand the impact on elective activity in the system. She noted that an update on the York Teaching Hospital NHS Foundation Trust Return to Operating Standards would be presented at the January Committee meeting and advised that the ongoing work at the Trust included input from the NHS Improvement Productivity Team in respect of theatres and outpatients.

CA highlighted that dementia diagnosis rates in Practices had improved for another successive month in November.

In terms of performance deterioration CA reported that diagnostic six week waits were a particular concern in echocardiography and radiology, the latter being a core area for demand and capacity review and modelling as part of the Cancer Alliance Diagnostic Programme currently being mobilised across the Humber, Cast and Vale Sustainability and Transformation Partnership (STP). Dr Dan Cottingham (DC), the CCG's Cancer Lead, was a representative in this regard. CA noted that a capital bid had been submitted for additional diagnostics equipment on behalf of the STP.

CA advised that cancer two week wait performance had deteriorated again in November, noting that dermatology capacity continued to be the most significant outlier by specialty for performance. An additional dermatologist was due to take up post in February 2018 with locums continuing to be used in the interim despite the cap on locum expenditure rates being implemented by York Teaching Hospital NHS Foundation Trust as part of their Financial Recovery Plan This additional capacity should mitigate against further performance deterioration. Members discussed concern about the associated costs.CA also noted that of the non-skin fast track breaches in two week performance 62.5% were due to patient choice or patient cancellations and these were predominantly for lower GI referrals (colorectal). Engagement with General Practice to support patients in managing these referrals and cancellations was required.

CA referred to the separate report on cancer 62 day performance in response to the Committee's concerns at the November meeting about lack of assurance. She noted that performance against this target was a challenging issue nationally and had again deteriorated locally as well as nationally. Together with A and E four hour performance it was a focus for NHS Improvement performance improvement for providers nationally. CA also explained that the Cancer Alliance was working to improve 62 day pathway management between York Teaching Hospital NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust.

CA explained in respect of medical staffing that 8.26% of York Teaching Hospital NHS Foundation Trust's vacancies were on the York Hospital site noting that she had requested a breakdown of the detail. Discussion in relation to the impact on capacity and performance in the relevant specialties took place at the sub contract management board (quality and performance).

AP reported that the Urgent and Emergency Care Network (UECN) had sought and received CCG endorsement of a commissioner approach for integrated urgent care following consideration of three potential options. He noted that the original proposed procurement would not have aligned with the UECN's vision of urgent and emergency care for the Humber, Coast and Vale STP. However, following inclusion of a number of amendments, the CCG had responded back to the UECN agreeing to the stance on the proposed procurement.

Members sought and received clarification on a number of aspects of the Winter Plan schemes and noted in respect of Malton Hospital, as discussed at item 5 above, that an update on the impact assessment, if ready, would be provided at the January Committee meeting.

PM referred to the 15% performance target for Improving Access to Psychological Therapies noting that Tees, Esk and Wear Valleys NHS Foundation Trust had recently achieved 12% but this had subsequently deteriorated to 10%. He reported, however, that they had expressed confidence in achieving the 15% target by the end of the financial year. PM advised that the January meeting of the Executive Committee would include consideration of options for the service in 2018/19.

MC explained in respect of clostridium difficile, for which performance was under trajectory, that no concerns had been identified through trend analysis either of cases attributed to the provider or to the CCG, the latter being all community cases.

In response to members seeking further assurance regarding managing the challenged dermatology capacity, CA explained the intention of considering a variety of different delivery models moving forward, including the role of Practice Nurses and GPs with a Special Interest but there was currently insufficient clinical capacity in the provider service to progress with some of the key actions included in the recovery plan. KS highlighted that dermatology capacity was a national issue and emphasised the need to maximise the productivity of available capacity in different ways. CA added that detailed analysis was also scheduled for the area of head and neck in terms of capacity and skill mix pressures across maxillofacial, oral medicine and the link with ears, nose and throat and dermatology to manage skin cancers

CA referred to a number of breaches of urgent referrals for children to dermatology in August and September; an issue which had been raised with the CCG by a member of the public. CA explained that this had been due to the fact that the patients had not been identified as children when received by the dermatology service and therefore not prioritised. It was confirmed that none of the children had been diagnosed with cancer however this had highlighted the inappropriate management of referrals and these processes had now been rectified and strengthened.

KR referred to actions to address delayed transfers of care noting seven day working by social workers and care staff from 2 December to facilitate discharges. MC explained that this had been in response to need identified by the Emergency Department. The social workers were hospital based and the care workers were part of the Rapid Assessment and Treatment Service.

Update on Cancer 62 Day Performance

CA presented the report which provided detailed information on 62 day wait cancer patients and addressed concerns and requests for further assurance raised at the previous Committee meeting regarding the assurance process. It included an update on current delivery and forecasts against the 62 day performance standard with additional detail around breach data, including analysis of the reasons and key issues; updates on the development of specific tumour site recovery plans for lung, upper gastrointestinal, urology, head and neck, and colorectal; Cancer Alliance wide improvement programmes and the impact this should have on performance improvement for York. Additionally there was a summary of all system cancer meetings, a process flow diagram i and an updated set of recommendations and further actions. CA additionally requested consideration of the fact that DC was only employed one day a week by the CCG to lead the cancer work programme as Clinical Lead, and noted that not all Cancer Alliance programme managers were clinicians or delegated to act as commissioners on behalf of the CCG at the wide number of cancer programmes and workstreams across the STP.

CA reported that DC had attended a recent All Party Britain Against Cancer meeting at which discussion had taken place around the political drive to replace the current 62 day target with the one year survival rate target. It was also noted that the survival rate target was one of the new indicators incorporated in the CCG Improvement and Assurance Framework. KS emphasised that 62 days should be the absolute maximum, not the target, and that performance against both this and one year survival rate should be jointly reviewed and monitored by the CCG.

Members welcomed the report and received clarification on a number of aspects noting that, although work was ongoing to improve performance, the report did not provide assurance of delivery. CA highlighted that root cause analysis of reasons for breaches was not part of the regular information reporting which had been agreed as part of the 2017/18 acute contract but access to this analysis had been requested through negotiation with York Teaching Hospital NHS Foundation Trust and their refreshed performance improvement Board for Cancer. She emphasised that any concerns would be escalated as appropriate through this Cancer Board.

The Committee:

1. Received the month 7 Integrated Performance Report and update on cancer 62 day performance.
2. Requested updates on a quarterly basis for cancer 62 day performance and associated recovery plans, with exception reporting as appropriate.
3. Requested that the Executive Committee consider the clinical capacity for cancer programmes in the context of the current redesign of the Governing Body and clinical capacity within the CCG

12. Referral to Treatment

CA reported that the CCG continued to work with York Teaching Hospital NHS Foundation Trust on performance analysis, improvement and transformation for 18 week referral to treatment recovery and addressing the outstanding backlog of patients. She noted that there would be a joint presentation at the January Committee meeting if there was sufficient time to prepare with the Trust team over winter.

The Committee:

Noted the update.

13. Impact Assessment of the New CCG Improvement and Assurance Framework

CA advised that the refreshed CCG Improvement and Assessment Framework for 2018/19 comprised 51 indicators. The 'Heads of' group and Clinical Executive were currently reviewing the initial assessment and a draft, including confirming ownership of indicators where identified, would be presented to the Executive Committee in January. She noted that this would be incorporated in and aligned with the CCG's restructure and the approach for turnaround in relation to identifying the priorities for each individual to deliver. Reporting to the Governing Body committees on the various indicators within the Framework would also be refreshed as appropriate.

The Committee:

Noted the update.

14. Medical Non-Emergency Transport Service (MNET) Procurement – Award Report

MA-M referred to the report which had been considered and supported by the Executive Committee the previous day.

Discussion ensued in the context of whether lessons had been learnt from issues that had arisen after recent procurements and concerns about lack of clarity about the process, scoring and performance indicators. MA-M explained that all the bidders had been within the financial envelope and the preferred bidder had scored highest on quality; there had been an initial specification against which the bids were made. He noted that the detailed key performance indicators would be agreed after the award of contract.

Members agreed to ratify the report subject to the concerns expressed being addressed in advance of presentation at the Part II Governing Body meeting on 4 January 2018.

The Committee:

Ratified the MNET procurement award report subject to the issues raised being addressed in advance of the Part II Governing Body meeting on 4 January 2018.

15. Key Messages to the Governing Body

- The Committee requested that further work be undertaken on the CCG's risk reporting processes by reconvening the original working group. There were a number of emerging risks, including those faced by primary care, which had not yet appeared on the Risk Register.

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 25 January 2018.

Vale of York
Clinical Commissioning Group

Minutes of the Finance and Performance Committee Meeting held on 25 January 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
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN) - part	Executive Director of Transformation
Tracey Preece (TP)	Chief Finance Officer
Keith Ramsay (KR)	CCG Chairman
Dr Kevin Smith (KS) - part	Director of Primary Care and Population Health

In attendance

Caroline Alexander (CA) – for items 10 and 11	Assistant Director of Delivery and Performance
Becky Case (BC) – for item 9	Head of Transformation and Delivery
Abby Combes – for item 5	Head of Legal and Governance
Michele Saidman (MS)	Executive Assistant
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)

Apologies

Dr Andrew Phillips (AP)	Joint Medical Director
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

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 the business of the meeting. All declarations were as per the Register of Interests.

3. Minutes of the meeting held on 21 December 2017

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 21 December 2017.

4. Matters Arising

F&P30 Risk Update Report - Recovery plans for 18 week referral to treatment: CA had circulated a report separate from the full set of meeting papers.

F&P39 Risk - Continuing Healthcare and Transforming Care / Section 117 Vulnerable People Risks: TP reported that she and DN had met with the Head of Internal Audit and a remit had been drafted for a financial audit to start week commencing 29 January. The focus would be continuing healthcare risks identified by NHS Vale of York CCG but aspects of financial balance, as per NHS Scarborough and Ryedale CCG's response to SP's letter, would be included. TP emphasised the need for assurance and highlighted that an accurate year-end forecast was required noting that the existing methodology may be best utilised for this as it was recognised by all four CCGs and audit. An early agreement of this would enable requisite programmes of work around data quality improvement to continue to resolve the issue in the medium to long term in a managed way. She also noted that this was not an audit of the process but to seek assurance that the processes themselves were fit for purpose and delivering correctly. PM highlighted that the issues were leadership from the financial management perspective and the duration of the issues.

F&P44 Risk Report: TP reported that a training session for the "Heads of" group had taken place from which there had been positive feedback.

F&P45 Financial Performance Report: TP referred to the draft Executive Summary incorporated in item 6.

F&P46 Contract Trading Report: Update on Emergency Front Door activity: TP advised that she would include this update at agenda item 8.

A number of other items were noted as ongoing or on the agenda.

The Committee:

Noted the updates.

"Good News"

TP reported that the contract award letter had been sent to Yorkshire Ambulance Service for the Medical Non Emergency Transport service. She noted that this high quality bid would deliver at least the planned £150k QIPP in 2018/19 and that key performance indicators would now be refined through the contract negotiation period up to July.

KS reported that he had spoken at York Healthwatch Assembly and had received positive feedback. Questions had included the breadth of his role.

KR welcomed the system approach following agreement at the York Health and Wellbeing Board of a "place based" board for York. There had also been general support for the Better Care Fund.

6. Financial Performance Report Month 9

In presenting this report TP noted inclusion again of the proposed new Executive Summary to supplement the main report and that a meeting would be taking place with lay members to obtain feedback and ideas for further improvement

TP reported that the risk adjusted forecast outturn remained at £22.5m deficit. TP explained that this reflected £1.8m full year impact of the No Cheaper Stock Obtainable issue. She highlighted also that the forecast underlying position had stabilised and was largely in line with the 2017/18 opening underlying position of £22.4m advising this had been subject to recent detailed work with the NHS England finance team. Discussion ensued in the context of the CCG having the best prescribing performance in the north of England. Members commended the achievement of Practices with regard to prescribing indicative budgets and the work of North of England Commissioning Support in contributing towards savings.

TP reported that the key reasons for the risk adjusted position of £22.5m deficit remained outstanding disputes with York Teaching Hospital NHS Foundation Trust contract, continuing healthcare, mental health out of contract expenditure and No Cheaper Stock Obtainable prescribing. TP referred to the York Teaching Hospital NHS Foundation Trust forecast contract value of £192.3m which included £1.9m assumptions relating to non elective actions in quarter 4 to reduce cost. She noted that, although there was a lower requirement in month due to improvements in other areas, the full amount would not be delivered at this point in the year. TP reported on discussions to address this at the System Transformation Board on 15 January and tabled in confidence a letter to the Chief Executive of York Teaching Hospital NHS Foundation Trust from PM and Simon Cox, Chief Officer of NHS Scarborough and Ryedale CCG, confirming commissioning intentions regarding managing NHS resources in quarter 4 of 2017/18. TP noted that a similar letter was being drafted to be sent to all providers, including the independent sector.

In response to KR seeking clarification of the £4.9m outstanding contract disputes with York Teaching Hospital NHS Foundation Trust within the forecast outturn TP explained that these related mainly to rehabilitation bed days currently the subject of Expert Determination, Emergency Department Front Door (full year effect c£0.5m), Assessment Unit activity (£0.5m) and sepsis (£105k). TP noted that there were agreed resolution processes for the latter three including pending national guidance on sepsis. She also explained that the York Teaching Hospital NHS Foundation Trust contract was at £192.3m within the CCG's £22.5m deficit figure due to the non recurrent actions but the underlying trading position was around £194-5m. The month 9 position reported by York Teaching Hospital NHS Foundation Trust was a forecast of c£20m year-end deficit, £11m off their plan, and with a further £5m risk due to a technical issue. The CCG's contract within the £20m was £197m, including an assumption on all challenges, including £2m for rehabilitation bed days.

TP advised that the System Transformation Board had requested a specific Contract Management Board to consider the resolution of all outstanding disputes. For the Emergency Department Front Door dispute it was noted that a second joint observational audit of coding and counting activity would be planned if the joint review of the initial one did not resolve the issue. In this regard PM requested that, for

consistency, it should be the same staff from the CCG who had undertaken the first audit.

Discussion ensued on the Emergency Department Front Door service with recognition that ultimately a decision on the model would be required. TP reported that currently the process would be review of the evidence from the counting and coding audits at the Contract Management Board which included clinical, operational and contracting representatives. She also advised that a formal response to the challenges had been requested to evidence whether admissions had met the criteria. TP would report to the Executive Committee following the Contract Management Board meeting.

In response to DB emphasising the need for a realistic figure to be agreed TP reported on discussions with the York Teaching Hospital NHS Foundation Trust Director of Finance and the context both of agreement with the regulators and also the NHS England Yorkshire and Humber position. Discussion ensued about determining a position for the commissioning system in order to make an affordable offer to York Teaching Hospital NHS Foundation Trust. Members agreed that NHS Vale of York CCG should take the lead on establishing a regional system wide commissioning offer within two weeks and subject to assurance that all three CCGs had the support of their governance processes.

With regard to other aspects of the financial position, TP referred to the £600k deterioration in respect of continuing healthcare and mental health out of contract placements noting that DN's view was of potential to recover part of this. The current focus was on bringing the approvals process in house and from a financial perspective the Audit and Transition Board would determine the figure for the annual accounts. TP noted that the other three CCGs had included savings in their forecasts but NHS Vale of York CCG was dependent on ensuring joint packages. She noted that all validation of processes and packages would continue and that there was the potential for savings resulting from the audit referred to at item 4 above. Members sought and received clarification on the review of patients and emphasised the need for a validated solution with appropriate acceptance and commissioner responsibility. TP advised that the intention was to determine the year-end position at month 10 using existing and embedded methodology, noting that the auditors would still test for months 11 and 12.

In respect of reporting the NHS Property Services historic position and 2017/18 charging schedules for all properties, with the exception of West Offices, a consistent, definitive figure had not yet been achieved. Work was taking placed to understand market rents. TP reported that the figure currently included in the reported position would encompass resolution of issues.

TP highlighted separate circulation of the action notes from the first meeting of the Financial Recovery Board due to timing. In response to members' views on future presentation of this information, TP agreed to incorporate it in the Financial Performance Report. She noted that Dharminder Khosa, Director of Turnaround Delivery, was following up on the actions between meetings of the Board. DB commended the focus of the Board and the inclusion of representation from NHS Scarborough and Ryedale CCG.

TP advised that 2018/19 planning guidance, including the CCG's control total, was still awaited but that internal confirm and challenge meetings were taking place both to sense check the second year expectations of the Financial Plan and to assess impact on receipt of the guidance. This would be reported through the committee structure.

TP provided an update on progress towards an Aligned Incentives Contract with York Teaching Hospital NHS Foundation Trust. The agenda for a meeting on 1 February was structured to establish a framework for steps towards introduction of an Aligned Incentives Contract from 1 April 2018. Discussion would include the current cost of services in the system, the amount for which the CCGs would contract, how to close the gap and required clinical attendance at the meeting. Milestones and principles for working together would be established and progressed regardless of the planning guidance. TP also noted attendance at the meeting by Dharminder Khosa and NHS East Riding of Yorkshire CCG and noted that the agenda had been jointly developed.
Members emphasised establishment of an Aligned Incentives Contract as a top priority and key to system recovery. TP confirmed that lessons were being learnt from areas where this approach had already been introduced. Further discussion included the need for consideration of leadership and whether to extend the development wider than the current three CCGs, for example to include NHS Harrogate and Rural District CCG and CCGs on the south bank of The Humber in the discussions. PM agreed to progress this with TP and Simon Cox and noted the role of the forthcoming clinician appointments in this regard.

The Committee:

1. Received the month 9 Financial Performance Report.
2. Requested that reporting from the Financial Recovery Board be incorporated in the Financial Performance Report.
3. Agreed that NHS Vale of York CCG would lead on establishing within two weeks a regional system wide commissioning offer to York Teaching Hospital NHS Foundation Trust.
4. Noted that PM would progress with TP and Simon Cox leadership for progressing the Aligned Incentives Contract, including consideration of extending this beyond the current three CCGs.

AC joined the meeting; DN joined the meeting during item 5

5. Risk 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; gave an overview of programme risk registers; and provided an update on risks arising from published Improvement and Assessment Framework indicators that informed the Board Assurance Framework.

AC advised that The Retreat, listed as a corporate event following an 'Inadequate' report by the Care Quality Commission, was no longer a corporate event and that due to implementation of appropriate management four events had been de-escalated:

failure to achieve Improving Access to Psychological Therapies access and recovery targets within acceptable waiting times, failure to deliver the planned care 18 week referral to treatment target, failure to achieve the dementia 67% coding target in General Practice and delivery of Better Care Fund targets.

With regard to the risk relating to multispecialty community bed provision in the Ryedale area which had materialised during December, KS reported that a resolution to the bed base had been secured with Humber NHS Foundation Trust. He was seeking assurance from York Teaching Hospital NHS Foundation Trust that there would be no other changes however the full impact of this risk could not be assessed until the position of staff was known. The Executive Committee was monitoring this risk which would also be reported to the Quality and Patient Experience Committee.

Members sought and received clarification on a number of the risks, including those relating to estates which required further clarification, and noted that the Risk Report was still evolving in light of the ongoing staff training. In response to KR referring to the emerging risk from the contract with York Teaching Hospital NHS Foundation Trust, TP confirmed that this would be escalated to the Governing Body at month 10 reporting.

The Committee:

1. Reviewed all risks under the management of the Committee, identified a number of amendments and agreed that the contract with York Teaching Hospital NHS Foundation Trust be added to those risks that required Governing Body scrutiny.
2. Ascertained that appropriate risk mitigation plans were in place.

AC left the meeting

7. Update on Better Care Fund

PM confirmed that, in addition to approval of the East Riding of Yorkshire Better Care Fund, the City of York and North Yorkshire Better Care Funds had both been approved. There were no issues to report.

The Committee:

Noted the update.

8. Contract Trading Report Month 8

In presenting the Contract Trading Report TP referred to discussion at item 6 above, advised that the year to date overall acute contract trading position was an under-trade of £395k including contract challenges, the forecast outturn was a £709k under-trade, and noted the overview of the York Teaching Hospital NHS Foundation Trust challenges.

TP highlighted the update on the Community Equipment and Wheelchairs. The Executive Committee had recently received an update which would be followed with a more detailed report. The Finance and Quality Teams were undertaking work in light of the potential for these contracts to overspend. In respect of the Community Equipment

contract with Medequip TP explained that the contract operated on the basis of the cost of the equipment being recharged on actuals as a 'pass through' cost, whereas the provider's activities in the provision of the equipment (such as deliveries, repairs, collections and planned preventative maintenance) were charged on an activity basis. The Executive Committee had supported TP's proposal for bringing in clinical expertise – physiotherapist, occupational therapist or nurse – to review the activity with a view to more clinically based restrictions on the catalogue. TP added that all the North Yorkshire CCGs were concerned about the over-trade on this contract but that the gap had been closed for this year at a loss to Medequip.

TP advised that the Wheelchairs contract with NRS was a block contract for the first year with an option for review of the model at that point subject to a period of notice to change the methodology. Based on information from the provider, there appeared to be approximately 35% less activity being delivered than the core contract baseline. The CCG was therefore looking to give the required notice and move towards an activity based contract with caps and collars for savings to offset the equipment overtrade.

The Committee:

Received the Contract Trading Report.

CA and BC joined the meeting

9. Winter Planning Update

BC referred to the report which comprised a post Christmas and New Year review of the system, a York Hospital site briefing on the Christmas and New Year period, a report on Yorkshire Ambulance Service and primary care winter pressures and an NHS 111 Online (NHS Pathways) Phase 1 feedback and review session report. BC advised that there were currently no significant issues but that Christmas Eve had been very busy due to the days on which the Bank Holidays had fallen. York Hospital had not seen an increase in attendances overall but there had been an increase in admissions some of which were due to 'flu for which York was a "hot spot" nationally.

Discussion ensued on the effectiveness of the 'flu vaccination programme. KS explained that the pressure on Practices had related more to respiratory conditions than 'flu and confirmed that the vaccine had been the right one, had been administered to the right people and there had been good uptake. In his view admissions had been due to there being better flow against previous years and hence potentially empty beds.

BC advised that a system review was taking place in February and noted the examples of improved joint working. She highlighted the new developments, such as the NHS 111 online app, and noted the need for consideration of potential additional funding for system support during the forthcoming Easter period. KS referred to the Improving Access to General Practice developments and the need to maintain access consistently throughout the year. He also noted that the out of hospital "offer" should not be considered as an extension of A and E; BC confirmed that the North Locality was taking this view.

In terms of quality MC referred to the fact that York Teaching Hospital NHS Foundation Trust was an outlier for the 60 minute ambulance handover noting the requirement for this to be declared a Significant Incident. She reported that NHS Improvement had agreed a thematic review approach with York Teaching Hospital NHS Foundation Trust and that a Significant Incident be declared only in cases where harm had occurred. To date there was no such evidence.

In response to MC highlighting concerns about the complex discharge process, BC advised that the Discharge Group was facilitating change and offering support and DN reported that her team was working with staff at York Teaching Hospital NHS Foundation Trust on this issue. PM requested that these concerns be logged and reviewed at the next Committee meeting.

The Committee:

1. Received the review report on Winter 2017/18 as at 12 January 2018.
2. Noted that a report on the discharge issues would be presented at the next meeting.

BC left the meeting

10. Integrated Performance Report Month 8 and 11. Referral to Treatment Recovery

CA presented the report which comprised performance headlines, performance summary against all constitutional targets, and programme overviews relating to planned care, unplanned care, mental health, learning disability and complex care, primary care and annexes providing core supporting performance information. She noted the additional information, mainly relating to York Teaching Hospital NHS Foundation Trust, on referral to treatment targets and performance circulated to members and highlighted the volume of information that required triangulation. CA also advised that it was proposed to adopt a similar approach for performance recovery to the financial confirm and challenge approach at the new Financial Recovery Programme Board.

CA referred to the fact that national planning guidance was still awaited but explained that there were emerging themes and targets which required impact assessment, particularly with regard to referral to treatment. She noted that the Executive Team and the “Heads Of” were working through the requirements. CA also advised that there was a new CCG Integrated Assessment Framework (IAF) and that a Special Measures Framework for 2018/19 was being developed for the CCG with NHS England. She also noted that the CCG and partner organisations were in the process of developing the joint programmes of work which would support delivery system financial recovery.

CA highlighted progress with the dermatology recovery plan and the associated improvement as a result of additional sustainable capacity delivered through the centralisation of services at two sites at York and Malton hospitals. However, ophthalmology was now becoming unsustainable in terms of delivering referral to treatment performance and sustainably managing the increasing backlog and waiting list, and a review with York Teaching Hospital NHS Foundation Trust, similar to that for

dermatology, was proposed as soon as practicable. CA advised that this would be raised at both the System Transformation Board and the Planned Care Steering Group the following week and confirmed that there was clinical engagement from the service and CCGs, mostly to date with developing clinical thresholds. She also noted that the System Transformation Board had agreed priorities for managing costs associated with elective care during quarter 4 for which mobilisation was now being planned following York Teaching Hospital NHS FoundationTrust Board meeting. CA explained the intention of reviewing referral to treatment performance for all providers during February alongside the expected national planning guidance with a report to the March meeting of the Committee.

With regard to cancer 62 day recovery CA noted the ongoing requirements to provide assurance and referred to the agreement at the December Committee for quarterly detailed updates in this regard.

CA highlighted emerging themes of unsustainable services at North Lincolnshire and Goole NHS Foundation Trust and Humber NHS Foundation Trust, including cancer 62 day recovery and specialised commissioning, and noted the Humber Acute Services Review which aimed to gain an understanding of these pathways. CA agreed to discuss with MC and KS concerns about NHS Vale of York CCG representation in this regard and PM emphasised that, although there were capacity issues, the CCG must be appropriately represented in the interest of patients.

KS left the meeting

MC reported that the Executive Committee was giving consideration to the requirements associated with Children's Services transformation, including identification of a lead for this area. She advised that consultant capacity had been increased at York Teaching Hospital NHS Foundation Trust but that out of hospital skills did not yet exist to support this transformation work. The focus would be on reducing paediatric admissions.

CA noted the 'Significant Assurance' report from Internal Audit for performance assurance but advised that there were recommendations for increased reporting which would be considered in the March confirm and challenge.

CA reported that work was taking place both within the CCG and with NHS England in respect of the lifting of legal Directions and to fulfil the assurance requirements to the end of the financial year.

The Committee:

- Received the month 8 Integrated Performance Report.
- Noted that the referral to treatment recovery plan would be presented to the March meeting.
- Noted that CA would discuss with MC and KS concerns about the CCG's representation at the Humber Acute Services Review, the specialised commissioning and Cancer Alliance programmes and meetings.

CA left the meeting

12. Continuing Healthcare Highlight Report

DN referred to the continuing healthcare action plan, presented at the Financial Recovery Programme Board, which summarised achievements to date in support of transformation and QIPP. She provided further information on a number of the achievements.

With regard to Discharge to Assess DN advised that there was a national target of no more than 15% Decision Support Tool assessments in hospital. She explained that the CCG, based on previous experience, had agreed to an additional eight beds, five of which had to date been purchased. Two continuing healthcare nurses had been working with York Hospital since the week before Christmas to ensure appropriate placements and since then three patients had gone through to continuing healthcare. This initiative had supported both the winter position and the profile of continuing healthcare. DN also noted that, following concerns raised by the two nurses about fast track patients, she had formally flagged that the CCG would need to seek evidence regarding the rapidly deteriorating position. The process for such an initiative and associated resource to be further developed.

DN advised that 'without prejudice' payment to care homes for funded nursing care had been stopped. An additional checklist assessment now applied, with reviews taking place as early as possible and back payment being made if appropriate. DN noted that the number of funded nursing care reviews had increased, some relating to care home quality issues. Additionally action was awaited, due to recruitment issues, in relation to a cohort of 30 patients to be reviewed through the national NHS England review commissioned from North of England Commissioning Support. JS noted that he would feed this issue into the national discussions.

DN highlighted the joint training packages being developed for continuing health care nurses and Local Authority staff through a clinical practice development of benchmarking document to standardise Decision Support Tools.

DN noted that fast track patients were being reviewed and a number had been taken off funding following Decision Support Tool assessments.

DN reported that requests for new one (staff) to one (patient) arrangements were being approved on a time limited basis and then subject to further review.

From the strategic perspective DN explained that the Finance Team was working with a Programme Manager to develop a single brokerage system for care to enable standardisation of costs and to address the ongoing issue of the fact that the QA and SystmOne were incompatible which meant that all patients had to be validated through both systems or tracked through the panel to identify potential savings. TP noted that support would be offered to ensure savings were realised but there was currently a gap in terms of evidencing the savings.

DN advised that, although fewer in number than previously, there was still increasing cost pressure from errors which required backdated payment. However, the new monitoring system ensured that approval of payment was subject to consideration and minuting by the panel prior to submission the following day. DN noted that City of York

Council was aiming to resolve these cases by the end of the financial year. DN also reported that she and MC were focusing on the requirements relating to a number of high cost placements coming through for vulnerable people, including from Transforming Care and NHS England, but that this was not expected in the current financial year.

DN explained that the Project Manager for closedown of the Partnership Commissioning Unit had presented information from the QA system that indicated the cost per package average each year. At the time when the brokerage system had been introduced the costs had increased dramatically. DN noted that market capacity was challenging.

TP emphasised the need for financial pressures to be identified in a more timely way. She also noted that an additional four members of staff had joined the Finance and Contracting Team which would aid analysis of the position.

In response to discussion about the need for identification of a continuing healthcare year end position, TP advised that this would be based on the month 10 figures when information from the current audit would be available. The position would be agreed at the Chief Finance Officers meeting and the Transition Board. DN advised that there was no expectation for new high cost patients from Transforming Care in the current financial year and that meetings were taking place with City of York Council to resolve the position regarding back payments. She expressed a level of confidence in the position to the end of March 2018.

DB reiterated the earlier discussion of holding to account.

The Committee:

Received the continuing healthcare highlight report.

13. Key Messages to the Governing Body

- The Committee requested that the CCG should lead on a regional system wide process, including York Teaching Hospital NHS Foundation Trust, to set a reasonable year end financial outturn which is acceptable to commissioners.
- The Committee recognised that the creation of Aligned Incentive Contracts with provider organisations is critical for continued financial recovery requesting that consideration be given to location and leadership responsibility. PM would discuss this with Simon Cox to ensure clinical leadership.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

14. Next Meeting and Forward Plan

The next meeting would be 9am to 1pm on 22 February 2018.

Vale of York
Clinical Commissioning Group

Item 17

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	24 January 2018
Chair	Keith Ramsay

Areas of note from the Committee Discussion

- The Committee recognised the work to manage prescribing budgets in light of the "No Cheaper Stock Obtainable" issue.
- The Committee recognised the work relating to £3 per head and PMS premium monies and the steer from the Council of Representatives to achieve implementation.

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 24 January 2018 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Tracey Preece (TP)	Chief Finance Officer
Dr Kev Smith (KS)	Executive Director of Director of Primary Care and Population Health

In Attendance (Non Voting)

Laura Angus (LA) – for item 9	Lead Pharmacist
Kathleen Briers (KB)	Healthwatch York Representative
Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Shaun Macey (SM)	Head of Transformation and Delivery
Michèle Saidman (MS)	Executive Assistant

Apologies

Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Joint Medical Director
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Sharon Stoltz (SS)	Director of Public Health, City of York Council.

Unless stated otherwise the above are from NHS Vale of York CCG

There was one member of the public in attendance.

No questions had been submitted in advance of the meeting.

The agenda was discussed in the following order.

1. Welcome and Introductions

KR welcomed everyone to 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 22 November 2017

The minutes of the meeting held on 22 November were agreed.

The Committee

Approved the minutes of the meeting held on 22 November 2017.

5. Matters Arising

PCCC25 Matters Arising – Primary Care Assurance Report: This was agenda item 6 below and was also on the agenda of the Part II meeting immediately following the meeting in public.

PCCC27 General Practice Visits and Engagement – Briefing Summary: KS reported that the Primary Care and Population Health Team had had its first meeting the previous day and was reviewing the approach to Practice visits.

The other matter arising was scheduled for the March meeting although was also on the agenda at item 9.

The Committee:

Noted the updates.

6. Primary Care Commissioning Financial Report

TP presented the report which provided information on financial performance of primary care commissioning as at month 9. She explained that the overall year to date position was a £163k overspend and that the forecast outturn had been revised to £42,029m to reflect a £232k overspend against budget due mainly to non recurrent spend; this was not expected to continue into 2018/19. This position was an over-spend on budget not on allocation.

TP highlighted that Scott Road Medical Centre had now signed the Personal Medical Services (PMS) contract as calculated by NHS England and that the PMS premium monies was included in the expenditure on primary care within the core CCG budget.

TP reported an underspend for Enhanced Services due to the unplanned admissions scheme explaining that the scheme had ceased on 31 March 2017 but finalisation of 2016/17 payments was being completed, resulting in an over accrual of £106k. She referred to the components of Other GP services, the position regarding premises costs and that of Quality and Outcomes Framework points and prevalence, also noting that prior year variances had now been released into the position resulting in a £19k forecast underspend.

In response to DB seeking clarification about models of GP Practices in the context of ensuring equity, HM explained that each of the 26 Practices within the CCG had its own business model but was required to comply with a set of Standard Financial Entitlements - i.e. rules - some of which were reimbursable, others were not. Components for which Practices were reimbursed included rent, rates, clinical waste, maternity leave, sick leave of some clinicians, and decontamination of sterile equipment. Contracts also included negotiation on protection of the commercial model. KS added that national risk pooling enabled Practice models to be sustained but the Entitlements were complex and Practices were not always aware of their reimbursement rights.

With regard to premises HM clarified that there was a nationally negotiated contract with the District Valuer to ensure value for money. This included regular review of space against population. There was also comparison with commercial rent.

In concluding this item TP advised that she would present the proposed draft 2018/19 Financial Plan at the next meeting prior to its presentation to the April Governing Body meeting and that this would be informed by a primary care specific 'confirm and challenge' planning session.

The Committee:

Received financial position of the Primary Care Commissioning Budgets as at month 9.

7. General Practice Visits and Engagement Update

KS referred to his update at item 5 above and added that he had visited a number of Practices. He noted that the purpose of the visits included ensuring Practices were aware of their entitlements and to keep them informed of developments.

KS advised that the Council of Representatives had ratified the appointment of Dr Nigel Wells as Clinical Chair of the CCG and a process was currently taking place to appoint from the commissioning perspective a GP Locality Governing Body representative from each of the three localities. In terms of the GP provider role KS reported that discussions were taking place within the localities to establish a "single voice" for primary care for each; this would contribute towards ensuring sustainable General Practice. He also noted that NHS Vale of York and NHS Scarborough and Ryedale CCGs were working jointly in respect of the contract with York Teaching Hospital NHS Foundation Trust.

KS highlighted that the Committee was a forum for commissioner engagement; work was taking place to separate the General Practice commissioner and provider roles to ensure both were maximised. In this regard KS noted three aspects of primary care: as General Practices, as commissioners and as providers at scale.

The Committee:

Noted the update and ongoing work.

8. Primary Care Assurance Report

HM reported that, since presentation of the Primary Care Assurance Report at the last meeting of the Committee, a small group had reviewed the 2016/17 Quality and Outcomes Framework results as agreed. In view of this being the first time for such a detailed report on this information, it would be discussed in detail at the Part II meeting and presented at the March meeting in public.

The Committee:

Noted the update.

10. 2018/19 £3 per head and Personal Medical Services Funding: Principles and Process

SM presented the report which included: explanation of both the Personal Medical Services (PMS) and £3 per head funding; proposals from the Council of Representatives, subsequently ratified by the Governing Body, for the funding; and principles, proposed next steps and process. Two annexes comprised firstly a 2018/19 £3 per head and PMS Outline Project Plan Template and secondly, for consideration of apportioning to each locality, Vale of York GP £3 and PMS weighted national raw and national weighted list sizes. SM also noted the main risk associated with the £3 per head funding was failing to achieve a break-even position in order to enable the funding to continue forward into 2019/20 and the context of Aligned Incentive Contracts which would require work with the CCG and York Teaching Hospital NHS Foundation Trust to demonstrate actual cost reduction from activity changes rather than a tariff based saving.

SM explained the principles and process.

Principles

- The primary principle underpinning any proposals should be to work at scale with the aim of releasing capacity and providing additionality. Therefore proposals should cover a locality, or an identified population health need across a more specific geographical footprint.
- All proposed projects should collaborate across a minimum of two Practices.
- PMS will continue to include an element to fund GP time/leadership in localities.
- The funding from any Practices not yet ready to participate in collaborative projects will be made available for other locality proposals (i.e. Practices may give permission for their share of the funding to be used to support the wider locality programme – and are able to decide which locality projects their funding will support).

Process

- Practices will be notified of their 2018/19 PMS Premium and £3 per Head allocations by 31 January 2018.

- Locality project plan templates should be finalised, peer-reviewed within each locality, and submitted to s.macey@nhs.net no later than 30 March 2018 for approval by the CCG's Primary Care Commissioning Committee.
- Once approved by the Primary Care Commissioning Committee, funding may be drawn down against proposals as per the profiles in the application template.
- Project progress should be peer-reviewed by localities on an on-going basis, with the Primary Care Commissioning Committee being kept appraised of any significant developments or risks.
- The CCG's finance team will maintain an income and expenditure account for each Practice, locality and individual project spend for PMS and £3 per head.
- Localities will be invited to present progress reports to the Primary Care Commissioning Committee at the end of Quarter 2, and will be required to submit a formal report for each project detailing outcomes, return on investment, learning and future plans during Quarter 4.

Members sought and received clarification on aspects of the process noting peer-review of projects, review by the CCG management team and presentation of a report both mid year and at year end to the Committee to inform a decision about continuation. With regard to Aligned Incentive Contracts TP explained that activity would continue to be measured and this approach aimed to reduce the cost of acute services so a link to cost reduction may be possible; alternatively significant changes to activity flow may take place.

AB reported that, as the Council of Representatives supported the approach described, the Local Medical Committee accepted it although it was not in line with official guidance.

SM detailed the process by which the principles had been developed through engagement with the Council of Representatives advising that there had been unanimous agreement at the December meeting. He noted that, if approved by the Committee, the process could commence from 1 April 2018. KS added that the principles should enable projects to be implemented prior to consideration by the Committee but they would subsequently be presented for ratification.

TP noted the wider context of approval by the Governing Body of the 2018/19 Financial Plan, which would include this funding.

With regard to weighting SM reported that the Council of Representatives favoured Practice weighted list sizes based on the Carr-Hill formula, which included deprivation and age profiles, rather than raw list sizes. Members sought clarification on the weighted information and noted that all Practices would receive their allocation but the principle aimed for pooling the resource and working at scale.

In response to KB enquiring about patient involvement, it was noted that mechanisms for communication and engagement would evolve within the localities. However, assurance of patient engagement in developing proposals would be sought as part of the process. This was different to the requirement for consultation to take place in the event of service change.

The Committee:

1. Agreed the principles and process as above.
2. Agreed that the funding be apportioned to each locality based on the national weighted list sizes.

LA joined the meeting

9. 'No Cheaper Stock Obtainable' Update on Risk to Prescribing Indicative Budgets

LA presented the update on risk to Prescribing Indicative Budgets from the national 'No Cheaper Stock Obtainable' issue. She advised that the Executive Committee on 17 January had agreed to continue with Prescribing Indicative Budgets but with review of the model and added that, since the last Committee meeting, she had written to the local MPs to raise the profile of this issue. Following discussion with the three Alliances the revised model would be presented to the Committee.

TP explained that the estimated full year pressure to the CCG from 'No Cheaper Stock Obtainable' had reduced from £2.6m to £1.8m of which £1m was reflected in the month 9 position, with a further £800k forecast as risk. She noted that there was currently no timescale for a resolution to this but highlighted that savings schemes were delivering through the work of the Medicines Management Team, North of England Commissioning Support and the Practices. The CCG was also in a comparatively better position than many due to having one of the lowest prescribing budgets in Yorkshire and the Humber and the engagement of the Practices which members commended. KS added that engagement with primary care was key to maintaining the long term position.

The Committee:

1. Received the update on risk to Prescribing Indicative Budgets associated with 'No Cheaper Stock Obtainable'.
2. Noted that the revised model for Prescribing Indicative Budgets would be presented following discussion with the three Alliances.

LA left the meeting

11. Terrington Surgery Update

KS detailed the background to the position at Terrington Surgery, currently occupied through a Tenancy at Will arrangement and run by the same team as Helmsley Surgery. Following the threat of eviction the Practice had gone to The Press. However, this threat had now been removed and the CCG was working with the Practice on a contingency plan to maintain a GP Practice in Terrington as patients would need to travel a considerable distance to alternative provision; Terrington was also an area of growth.

KS advised that resilience funding had been made available to provide cover for Dr Nick Wilson, enabling him to focus on the emergency but also maintain a service. KS highlighted this as an example of the CCG as a commissioner ensuring availability of services and providing support.

SM explained that to date there was agreement for resilience funding for legal costs and locum backfill, with agreement in principle to identify further General Practice Forward View resilience funding to support ensuring existence of a Practice either on the current or an alternative site. He emphasised the level of impact on the system in the event of the Practice closing or relocating at short notice.

Whilst recognising the need for a solution, KR expressed concern about setting a precedent. In response, HM explained that there were regulatory safeguards, including property values, and noted that any decision about the level of reimbursement support would be taken by the Committee.

In response to MC seeking assurance that the CCG was aware of any potential similar issues with Practice buildings HM explained that in light of a number of issues that were emerging work would be taking place with the Local Medical Committee on premises rules. She also emphasised that Practices were not permitted to retrospectively apply for rent increases and that they should engage with the CCG in the event of any changes to lease arrangements. SM referred to a proposal to review all leases to ensure identification of any risks to the CCG.

KR additionally commended the CCG Communciations Team for their handling of the publicity surrounding this matter.

The Committee:

Noted the update and ongoing support being provided by the CCG to Terrington Surgery.

12. Rent Reimbursements

HM presented the report which referred to rent reimbursement for one of the MyHealth Group sites and rent reimbursement and abatement for South Milford Surgery. She highlighted, in the context of the previous discussion, that the rules and safeguards had been followed in these instances.

The Committee:

1. Agreed the increase in notional rent for MyHealth Group, 46 Viking Road, Stamford Bridge, York, YO41 1AF
2. Agreed the increase in notional rent and noted the abatement period for South Milford Surgery, 14 High Street, South Milford, Leeds, LS25 5AA.

13. NHS England Primary Care Update

HM referred to the report which provided updates on NHS England's revised Policy and Guidance Manual for Primary Medical Services, the General Practice Forward

View, Pharmaceutical Needs Assessment and the National Association of Primary Care (NAPC) Diploma in Advanced Primary Care Management.

With regard to the General Practice Forward View HM reported that, in addition to the programme details presented, there was the potential in the forthcoming planning guidance for the target date for 100% extended access hours to be brought forward to October 2018 from March 2019. HM noted that this was not yet official.

HM reported that in the City of York Council draft Pharmaceutical Needs Assessment the main area of need appeared to be for the University campus; the North Yorkshire County Council draft did not identify any major changes for the CCG footprint.

In response to clarification sought by KR regarding triangulation of the needs of surrounding villages, KS explained in the context of the CCG's three Local Authorities, that a common format was utilised for presentation of the Pharmaceutical Needs Assessment to Health and Wellbeing Boards. HM added that these assessments were succeeded by a commercial pharmaceutical review to assess viability and inform consideration of opening new pharmacies. If NHS England identified requirement for further provision in localities, other arrangements could be established. HM also referred to the fact that, although there may be rural dispensing Practices, they did not provide the full range of services provided by a pharmacy.

HM referred to the funding for the National Association of Primary Care (NAPC) Diploma in Advanced Primary Care Management: one third to be met by the individual or the Practice and two thirds by either NHS England or the CCG. She advised that NHS England locally had agreed that funding would be top sliced to support the two applicants.

The Committee:

Noted the NHS England updates.

14. Key Messages to the Governing Body

- The Committee recognised the work to manage prescribing budgets in light of the "No Cheaper Stock Obtainable" issue.
- The Committee recognised the work relating to £3 per head and PMS premium monies and the steer from the Council of Representatives to achieve implementation.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

15. Next meeting

9.30am on 27 March 2018 at West Offices.

16. 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 18

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	14 December 2017 and 8 February 2018
Chair	Keith Ramsay

Areas of note from the Committee Discussion

14 December 2017

- The Committee noted the forthcoming changes in respect of the roles of the Local Safeguarding Children Boards.
- The Committee welcomed the work to refine and improve the approach to Never Events and Serious Incidents.
- The Committee commended the Quality Team's work in care homes.

8 February 2018

- The Committee welcomed the detailed consideration of the CCG's work with care homes.
- The Committee noted the high profile of Safeguarding Children and Children in Care.
- The Committee noted the work taking place across Yorkshire and the Humber relating to Never Events, including consideration of mechanisms to robustly share learning and more timely alerts.
- The Committee expressed concern at the City of York Council withdrawal from the Harrogate District NHS Foundation Trust Community Infection Control and Prevention Service.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Minutes of the Quality and Patient Experience Committee Meeting held on 14 December 2017 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
Jenny Brandom (JB)	Deputy Chief Nurse
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Andrew Phillips (AP)	Joint Medical Director
Debbie Winder (DW)	Head of Quality Assurance and Maternity

In attendance

Barry Dane (BD)	Healthwatch, York
Sarah Fiori (SF)	Senior Quality Lead
Sarah Goode (SG)	Quality Lead for Primary Care
Karen Hedgley (KH)	Designated Nurse Safeguarding Children
Christine Pearson (CP)	Designated Nurse Safeguarding Adults
Gill Rogers (GR)	Patient Experience Officer
Michèle Saidman (MS)	Executive Assistant

Apologies

Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Abigail Combes (AC)	Head of Legal Services and Governance
Victoria Hirst (VH)	Head of Engagement

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.

4. Minutes of the meeting held on 12 October 2017

The minutes of the previous meetings were agreed subject to amendment under 'Present' that Jenny Carter should read Jenny Brandom.

The Committee:

Approved the minutes of the meeting held on 12 October 2017 subject to the above amendment.

5. Matters arising from the minutes

Matters arising were noted as completed, on the agenda or not having reached their scheduled date.

6. Quality and Patient Experience Committee Forward Plan: Quality Assurance Framework

JB reported that the Quality Assurance Framework, scheduled for the current meeting, required consultation with key partners and would therefore be presented in February.

The Committee:

Noted the update.

7. 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 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.

SG described scoping work she had undertaken through meetings with GPs, Practice Managers and Practice Nurses and highlighted the need for consideration of sustainability and staff training in respect of workforce. SG also reported that, as part of the General Practice Nursing Plan, NHS England North had awarded the region £20k which must be spent by 31 March 2018.

SG and DW provided clarification about the session by CCG clinicians at the Learning Disability Forum Community Voluntary Service in September 2017. They noted that the Service Lead for Tees, Esk and Wear Valleys NHS Foundation Trust and Local Authority colleagues were involved in the action plan which aimed to address potential barriers and encourage uptake of screening.

AK referred to separate reporting for Yorkshire Ambulance Service four hour A and E waits and 12 hour trolley waits and proposed that these should be combined to describe the patient journey. Following detailed discussion of the number of associated metrics and variables AP and AK agreed to work with JB to develop case studies of patient experiences for consideration at a future meeting.

In relation to Infection Prevention and Control information DW highlighted the Antimicrobial Stewardship update. She noted there had been a proposal presented by Boots for near patient testing for sore throats in their stores but, as this required funding, it was not being progressed at the present time.

DW referred to the Serious Incidents, reported by exception. BD emphasised the importance of this information from the patient perspective and expressed concern at the associated timescale for some actions to be taken, particularly in response to Never Events. DW responded that there were set timescales for completing investigations

which York Teaching Hospital NHS Foundation Trust adhered to. All incidents were investigated with action plans identifying relevant actions being generated. DW confirmed assurance in this regard however the theme which continued to be a concern was evidence of embedding of learning from some serious incidents. DW noted that no response had to date been received to the joint letter from NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs to the York Teaching Hospital NHS Foundation Trust Medical Director expressing concerns about the number and similar type of Never Events. Assurance was being sought for evidence of learning, embedding of robust safety checks and actions to address procedural failings. DW agreed to chase this response and provide an update at the next meeting. Slow responses to queries from CCGs regarding serious incidents by York Teaching Hospital NHS Foundation Trust was also generating concern; plans to suggest a change in process were under formulation.

With regard to the recent closure of actions relating to historical serious incidents handed over from Leeds and York NHS Partnership Foundation Trust, the former provider of the CCG's mental health services, to Tees, Esk and Wear Valleys NHS Foundation Trust, DW explained that the incidents had been investigated and assurance had been received from Tees, Esk and Wear Valleys NHS Foundation Trust that there was no longer any associated risk. The delay in this was questioned and DW explained that there had been difficulties for the new provider to gain information to understand if the actions were relevant to new service provision.

DW also reported that discussions were ongoing with Tees, Esk and Wear Valleys NHS Foundation Trust in respect of their internal management of current serious incidents, completing investigations on time and answering, including answering queries; a meeting was scheduled to discuss this. Quality visits were scheduled to gain a better understanding of services and patient experience. This would include seeking assurance of embedding of lessons learnt, particularly in respect of the Crisis Team.

DW reported she had presented on an internal training day on Lead Investigator training by York Teaching Hospital NHS Foundation Trust and heard the session on Duty of Candour delivered by their lead investigator. AP noted the potential for similar training with GP Practices; this would be progressed if agreed as valuable by SG.

DW referred to the Sustainability and Transformation Partnership development of a Local Maternity System noting that the plan had been approved by the Governing Body in November. She expressed concern at the CCG's capacity to be fully engaged in this work and noted in particular a risk to accessing potential opportunities to bid for available funding. DW also explained that perinatal mental health was one of the workstreams of the Local Maternity System and that a bid had been written in anticipation of second wave funding expected early in the New Year. Discussion was taking place about the most appropriate patient footprint for this one year funding, a reduction from the two years at the time of the report to the Governing Body, and the need for succession planning thereafter. DW noted that areas where first wave funding had been received had reported on their experiences and highlighted the need for sustainability. She agreed to seek assurance about the risks and concerns and report back to the Committee.

DW highlighted the screening and immunisation update with particular reference to the flu vaccination campaign noting that the CCG benchmarked comparatively well nationally. She also noted however that technical issues experienced by a number of Practices when uploading data required resolution. DW also referred to the ongoing work relating to Men ACWY (meningitis) vaccination for the 2017 school leaver cohort who were eligible for urgent catch-up in this regard.

With regard to the breast screening programme DW explained that work was under way to identify new sites to meet population need in light of supermarkets declining mobile units. Work was taking place to understand the downward trend in cervical screening.

GR presented the Patient Experience update and highlighted examples of actions arising from complaints and concerns.

In respect of the 2016/17 Patient and Public Engagement Improvement Assessment Framework JB noted that the assessment had been mainly based on information available on the CCG website and the outcome had been an 'Amber' rating from a score of eight out of a potential fifteen points. She highlighted that this was disappointing in the context of the wide range of VH's work and advised that the CCG was going to appeal for other information to be taken into account.

Members sought and received clarification on the care homes and adult safeguarding information, noting the need to increase awareness of the CCG's role. The 'Good Overall' rating of Yorkshire Doctors Urgent Care following inspection by the Care Quality Commission was welcomed and receipt of the report for accuracy checking from the Care Quality Commission Local System Review was noted.

SF detailed the work pertaining to quality in care homes. She welcomed the support of the recently appointed React to Red Assistant Practitioner for the pressure ulcer quality improvement programme and highlighted a number of aspects of the work to support both care homes, including prevention of non-elective admissions, and various training for carers.

JB noted inclusion of the quarter 2 Commissioning for Quality and Innovation outcomes for the CCG's providers.

In respect of cancer JB highlighted that a member of the public had raised with the CCG five two week wait breaches for children at York Teaching Hospital NHS Foundation Trust. This had been due to the wider issue of dermatology consultant capacity. JB noted that all referrals had been seen within a maximum of 34 days and none of the breaches had been diagnosed with cancer. She reported that the previous issues were being rectified by the Referral Support Service now highlighting referrals as soon as they were received. She emphasised that cancer performance continued to be a key concern for the CCG.

JB highlighted that she and the CCG's Head of Joint Programmes had presented the commissioning vision for palliative care at St Leonard's Hospice Board of Trustees Vision Day, which had been well received.

JB noted the updates regarding performance issues relating to dementia diagnosis and in respect of children and young people. She advised that a quality visit to Lime Trees was scheduled in early January.

The Committee:

1. Received the Quality and Patient Experience Report.
2. Requested that case studies of patient experiences of the ambulance service be developed.
3. Requested that DW seek assurance about risks and concerns relating to the Local Maternity System developments.

8. 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 Serious Case Reviews and Learning Lessons Reviews; safeguarding children in respect of the Designated Professionals Strategic Plan; the Independent Inquiry into Child Sexual Abuse; children in care in respect of out of area placements within North Yorkshire and timeliness of health assessments; statutory guidance; primary care; the Care Quality Commission Children Looked After and Safeguarding Reviews; and safeguarding liaison in York Teaching Hospital NHS Foundation Trust's Emergency Departments.

KH highlighted the new Social Work Act which would in effect abolish the Local Safeguarding Children Boards from 1 April 2018. She assured members, however, that local partnership arrangements, which would no longer be prescribed, would continue. KH advised that consultation was taking place on a York Safeguarding Children Board draft Working Together Protocol for the partners, namely Health, the Local Authority and the Police, with an independent chair; MC would be the CCG lead in this forum. KH agreed to include an update on the partnership arrangements in her next report.

KH referred to previous discussion at the Committee regarding children in care from out of area placed within North Yorkshire. She noted the need to understand the resources provided by Tees, Esk and Wear Valleys NHS Foundation Trust in this regard, some of which were specialist therapeutic support. KH also reported that a provider had set up a home in York for young people aged between 16 and 25 years with significant mental health problems; the police had raised concern with partners regarding one young adult (25 years) who was going missing from the placement on a regular basis. More work is required to understand the impact on local resources and how partners can work with this private provider.

KH highlighted the work in primary care to support safeguarding. She noted the consultation and review with GP Practices in relation to midwifery information sharing taking place in NHS Hambleton, Richmondshire and Whitby and NHS Harrogate and Rural District CCGs at the request of the Local Medical Committee. As a result of this commencement within NHS Vale of York CCG had been delayed.

In response to KR seeking an update on the City of York Council Healthy Child Service, JB reported on receipt of a review of the Local Area Team structure and that discussion was taking place for Red, Amber, Green risk rating for delivery of the

service. KH added, from the safeguarding perspective, that additional funding had been agreed for a second safeguarding nurse in the Healthy Child Service. She was working to ensure links with the rest of the health system.

The Committee:

1. Noted the progress made against the Designated Professionals Work Plan.
2. Noted the submission of evidence to the Independent Inquiry into Child Sexual Abuse on behalf of the CCG.
3. Noted the progress in developing safeguarding practice in primary care.
4. Noted the submission of the North Yorkshire Children Looked After and Safeguarding composite action plan and agreed to accept details of the progress against the CCG/Primary Care Action Plan and highlights of the NHS Provider Action Plans at a future meeting.
5. Noted that updates regarding the proposed new partnership arrangements across North Yorkshire, City of York and East Riding of Yorkshire (following abolition of the Safeguarding Children Boards in April 2018) would be presented at the next meeting.

9. Safeguarding Adults

CP presented the report which comprised an update on the Safeguarding Adults team, the North Yorkshire and City of York Safeguarding Adults Boards, safeguarding in primary care, York Learning Lessons Review, care home independent review, Prevent, Safeguarding Week (adults and children), and the Learning Disability Mortality Review in North Yorkshire and York.

CP explained that implementation of the revised regional Safeguarding Adult Policy and Procedures was being delayed until April 2019 due to governance issues in North Yorkshire. Discussion ensued on the implications for this delay.

CP highlighted the NHS England requirement for trusts to achieve 85% compliance with Prevent training across their workforce by March 2018 and that progress was being made with regard to the requirement for CCG's to take over the Learning Disability Mortality Review Local Area Contact role from NHS England.

BD sought clarification about the concerning practice by some care agencies of supplying care staff to health providers without their Disclosure and Barring Service details being disclosed and falsification of documents. CP explained that key guidance was being developed for providers which would include identification of issues and associated examples.

The Committee:

Received the Safeguarding Adults report.

10. Key Messages to the Governing Body

- The Committee noted the forthcoming changes in respect of the roles of the Local Safeguarding Children Boards.

- The Committee welcomed the work to refine and improve the approach to Never Events and Serious Incidents.
- The Committee commended the Quality Team's work in care homes.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

3. Patient Story: The Parent Carer

JB referred to discussion at the previous meeting about an opportunity to hear real time experience of health and social care. She confirmed that the parent carer had given informed consent to share the film noting this would also be used for such as GP education.

Members commended the film and requested that JB express their appreciation to the parent carer for her comprehensive and clear presentation. As transition from child to adult services was discussed as a pertinent issue, an annual update of this patient story was suggested.

The need for consideration of further patient input at the Committee was highlighted and KH noted the potential for a contribution from 'Show Me That I Matter' which she would discuss with VH.

The Committee:

1. Welcomed the patient story.
2. Noted that further opportunities would be sought for patient contribution.

11. Next meeting

9am, 8 February 2018.

Vale of York
Clinical Commissioning Group

Minutes of the Quality and Patient Experience Committee Meeting held on 8 February 2018 at West Offices, York

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
Jenny Brandom (JB)	Deputy Chief Nurse
Michelle Carrington (MC)	Executive Director of Quality and Nursing/Chief Nurse
Abigail Combes (AC)	Head of Legal and Governance
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Dr Andrew Phillips (AP)	Joint Medical Director
Debbie Winder (DW)	Head of Quality Assurance and Maternity

In attendance

Barry Dane (BD)	Healthwatch, York
Susan De Val (SDV)	Commissioning Specialist, Children and Young People
Sarah Fiori (SF)	Senior Quality Lead
Sarah Goode (SG)	Quality Lead for Primary Care
Karen Hedgley (KH)	Designated Nurse Safeguarding Children
Victoria Hirst (VH)	Head of Engagement
Audrey Mattison (AM)	Management PA
Christine Pearson (CP)	Designated Nurse Safeguarding Adults
Gill Rogers (GR)	Patient Experience Officer
Michèle Saidman (MS)	Executive Assistant

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 relation to the business of the meeting. All declarations were as per the Register of Interests.

3. Minutes of the meeting held on 14 December 2017

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 14 December 2017.

4. Matters arising from the minutes

Q&PE10 Quality and Patient Experience Report – Proposal for patient experiences reporting: JB reported on discussion with AK and proposed that Becky Case, Head of

Transformation and Delivery, be invited to the next meeting of the Committee to present a review of patient experiences during the winter period.

A number of matters arising were noted as completed, incorporated within the relevant reports at following agenda items or not yet having reached the scheduled date.

The Committee:

1. Noted the updates.
2. Agreed that a review of patient experiences through the winter be presented at the next meeting.

AC and AK joined the meeting during item 5.

5. Patient Story

KH introduced a video, filmed in consultation with young people, which described their experiences prior to going into care and their engagement with services. She noted that this was used in GP training, had been included in "hot topics" and had received a positive response from primary care in terms of facilitating access to care for young people. KH also presented headline messages from the consultation with young people.

KH reported that Jacqui Hourigan, Nurse Consultant for Safeguarding (Adults and Children) in Primary Care, was working with Practices, many of which had a lead GP for children, and with Harrogate and District NHS Foundation Trust through a collaborative arrangement to ensure all GPs in Practices were aware of Looked After Children on their register. KH also advised that work was taking place with Harrogate District NHS Foundation Trust Looked After Children Nurses to develop materials to help young people understand health assessments, to revise at their request written materials for the older group, and to engage with 'hard to reach' young people.

KH expressed concern about differing approaches to mental health services across the CCG footprint. North Yorkshire County Council commissioned a specific service for young people. However, this was within the City of York Council generic Child and Adolescent Mental Health Services offer; work was taking place to ensure account was taken of parity of esteem. SDV added that there were historic reasons for the different approaches.

In response to AP enquiring about evidence of impact of interventions for Looked After Children KH explained that locally the Designated Doctor was reviewing outcomes from initial health assessments to consider how to meet specific needs. Evidence from national research was that interventions were successful but the older the child coming into care the more likely they were to have mental health needs. KH also emphasised the need to take account of the young person's wishes about which GP they saw, noted aspects of consent and also that assumption should not be made that an accompanying adult was a parent.

KH noted that in the City of York there were 180 young people in care but would ascertain the numbers for the CCG in North Yorkshire.

In response to VH referring to opportunities to include feedback from young people in evaluation reports, KH advised that, although it was at an early stage, the introduction of health passports had been welcomed.

The Committee:

1. Commended the patient story and noted the associated ongoing work.
2. Noted that KH would ascertain the number of young people in care in North Yorkshire.

6. 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 quality in primary care SG commended the General Practice Nursing Awards noting that nominations were currently being reviewed. She also clarified the process for the Practice which was now rated as overall 'Good' by the Care Quality Commission following a previous rating of 'Requires Improvement' due to a regulation breach relating to their dispensary and issues around Infection Prevention and Control.

DW presented the Infection Prevention and Control information explaining that there were two elements to the CCG's service: the shared service hosted by NHS East Riding of Yorkshire CCG and the shared community provided by Harrogate District NHS Foundation Trust. DW advised in respect of the former that she had met with the service leads of NHS East Riding of Yorkshire and NHS Scarborough and Ryedale CCGs in light of a number of issues and in order to establish a focused approach to deliver the service requirements. With regard to the service provided by Harrogate District NHS Foundation Trust DW reported that the previous specification had not been specific enough relating to training, nursing home support and primary care support within the envelope, adding that City of York Council had served notice on their intention to withdraw their £60k contribution to the service from 1 April 2018. As this presented a significant risk to patient safety, potential impact on secondary care and risk of destabilising the shared contract, it was now on the CCG's Risk Register. MC emphasised the need to fully understand this risk noting that it was an affordability issue for City of York Council and also that according to guidance Local Authorities did not have a mandated responsibility in this regard. Members discussed this concern in the context of the recent Care Quality Commission York Local System Review.

DW noted she was hopeful of improvements in Infection Prevention and Control at York Teaching Hospital NHS Foundation Trust following a review of their team and the introduction of a revised structure. She welcomed the fact that they wished to be part of a learning exercise based on the impact of winter 'flu on patient flow for which analysis was expected in March; planning for next winter would be informed by this review. Further discussion included the complexity due to the number of 'flu strains, the impact

of media reporting and the fact that vaccination was not mandated for primary care or care home staff. With regard to the latter DW reported that this would be included in next year's 'flu plans and increased engagement work would take place with primary care to increase knowledge on uptake.

In presenting the information relating to Serious Incidents DW confirmed that the assurance monitoring process was continuing and data was provided in the report identifying that all providers, with the exception of independent providers, had reported a reduced number. The increase in incidents in independent providers was not concerning. DW also explained that the CCG did not routinely receive data about all North Yorkshire CCGs' Serious Incidents but advised that NHS Vale of York CCG shared information about provider Serious Incidents for surveillance purposes.

With regard to Never Events DW referred to the concerning incidents of wrong site surgery declared by York Teaching Hospital NHS Foundation Trust. She reported that a meeting with them, scheduled for 19 February, would be attended by the Chief Nurses and Medical Directors of NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs to seek assurance on the processes in view of the significant concerns arising from the theme of surgical interventions. DW had recently met with the Clinical Director for Anaesthetics who had shared a revised theatre documentation pathway which included amendments to reflect Never Events. DW noted that quality assurance visits would also be undertaken across all sites and that she had been assured that the documentation mentioned above had been updated in consultation with staff across sites. She also highlighted that, as surgical cases accounted for the highest number of Never Events across Yorkshire and The Humber, the CCGs had requested that NHS England give consideration to mechanisms to robustly share learning and more timely alerts. MC added that a cultural change was taking place in terms of openness at York Teaching Hospital NHS Foundation Trust.

BD commended the CCG's robust approach to Serious Incidents and the support of frontline staff but expressed concern from the patient perspective at the theme of wrong site surgery. MC responded that from a quality perspective the CCG received the minutes of the York Teaching Hospital NHS Foundation Trust Patient Safety Committee and noted that discussions were continuing to try and reach agreement for the CCG, as a commissioner, to attend their Serious Incidents Committee, similar to DW's participation in the Tees, Esk and Wear Valleys NHS Foundation Trust process to provide assurance.

Members sought and received further clarification on the Serious Incidents processes. DW also noted implications of administrative pressures on the timescales associated with Serious Incidents reporting.

DW noted improvement in York Teaching Hospital NHS Foundation Trust's compliance with duty of candour requirements.

DW referred to the update relating to Tees, Esk and Wear Valleys NHS Foundation Trust highlighting that assurance relating to Serious Incidents had been provided through increased capacity in the Patient Safety Team. She also noted the establishment of a quarterly Quality Sub Group reporting to the Contract Management Board and reported on two positive multi disciplinary team quality visits to Huntington

House and to Child and Adolescent Mental Health Services at Lime Trees both of which utilised information from serious incidents to support questions to evidence learning.

DW advised that recent 12 hour trolley waits had been delogged as no patient harm had been identified and reported that agreement had been reached with NHS England to only report 60 minute ambulance delays as a Serious Incident in the event of patient harm being identified.

With regard to maternity DW noted that the Quarter 2 Yorkshire and Humber regional maternity dashboard showed an encouraging profile for York Teaching Hospital NHS Foundation Trust. The plan for the Sustainability and Transformation Partnership Local Maternity System, resubmitted at the end of January, included identification of resources required to implement the plan as funds were released by NHS England. DW also noted that, although Yorkshire and The Humber was an outlier in terms of maternity smoking rates at the time of birth, York Teaching Hospital NHS Foundation Trust performance had improved but work continued to improve this further, particularly on the Scarborough site.

DW reported that wave 2 funding for perinatal mental health had just been released and a bid was ready for submission. However, as the funding was only for one year there was a mandate to agree sustainable funding which had a risk; the CCG's commitment to continuation was being sought.

In presenting the Patient Experience update GR clarified a number of the contacts and explained that the CCG had now agreed to prescribe Freestyle Libre, subject to certain criteria, for patients with diabetes. She noted that, following a review, further detail would be provided relating to the patient who was experiencing a long delay in accessing medication for Attention Deficit Hyperactivity Disorder.

VH referred to the Patient Engagement update relating to: patient stories, engagement activities and events, working with the Learning Disability community within the CCG footprint, patient and public engagement Improvement and Assessment Framework indicators for 2016/17, and meeting the legal duty to involve patients and the public in the CCG's work. With regard to the patient story at the December meeting, the parent's concerns about transition from child to adult services at the age of 18 would be discussed with the Local Authority.

VH provided clarification on a number of aspects of the information, including the patient and public engagement Improvement and Assessment Framework indicators which were assessed from information on the CCG's website. The indicators related to the Annual Report, governance, day to day practice, feedback and evaluation and health inequalities. The CCG had been assessed as 'Requires Improvement' on the latter two and further evidence had been provided to appeal this outcome.

Members welcomed the increase in patient and public engagement since VH's appointment and noted the ongoing work to embed the Quality Impact Assessment process across the CCG.

VH requested that she be informed of attendance at any meetings with patients and the public for inclusion in evidence of engagement.

CP presented the regulatory inspection assurance and the update on care homes and adult safeguarding. With regard to the latter she provided clarification and assurance that the CCG was providing support and taking action where required emphasising that the safety of residents was always the key consideration and the need for collaborative working. CP also highlighted the significant achievement of The Retreat now being assessed as 'Good' across all the Care Quality Commission domains following the 'Inadequate' rating in 2017. KR commended the Quality Team support in this regard.

In respect of the diabetes update JB highlighted that interviews were currently taking place for recruitment of a Diabetes Lead Nurse from the Practice Nurses as a key part of improvement in primary care.

SDV noted, in addition to the quality visits to Huntington House and Lime Trees referred to above, the Selby Child and Adolescent Mental Health Services team had reported on the benefit of being co-located with the Local Authority prevention team as this enabled close working with the 0 to 19 service. She also advised that work was ongoing with Tees, Esk and Wear Valleys NHS Foundation Trust in respect of the pressures and pathways relating to autism and community eating disorders, noting significantly sub-optimal performance for waiting times for assessment and treatment and their effect on both outcomes and family life.

SDV welcomed the Government Green Paper on Mental Health which proposed training for lead staff in all schools and school based mental health support services. She noted that two schools based projects in City of York Council and North Yorkshire County Council for children with mild to moderate emotional and mental health needs largely met the proposals outlined within the Green Paper and hoped that additional funding may be sourced in this regard.

DW referred to the update on Special Educational Needs and Disabilities highlighting the need to triangulate information, including the patient voice.

Members welcomed the focus on children and young people and mental health in the CCG's recently published Commissioning Intentions for 2018/19.

The Committee:

Received the Quality and Patient Experience Report.

7. Care Homes Update

SF referred to the Care Homes Work Plan for 2018/19 based on proactive and preventive approaches and noted that, in addition to the 83 registered care homes with 2683 beds, there was a significant number of unregistered homes. The CCG did not have a specific mandate for care homes therefore the work required to avoid admissions was undertaken collaboratively through networking, development of relationships and shared learning.

SF highlighted that the CCG aimed to support care homes to provide high quality, cost effective care for all residents within the Vale of York in partnership with stakeholders from health, social care and the third sector. She detailed the three organisational strategic priorities - primary care and development of General Practice, joint commissioning and acute transformation – as the primary drivers; the secondary drivers were the organisational priorities of patient safety, national standards and finance with the associated workstreams.

Members sought and received clarification on the work plan noting the engagement with care homes and emphasising the need for collaborative working, particularly with regard to the Local Authorities.

The Committee:

Received the NHS Vale of York CCG Care Homes Work Plan for 2018/19.

8. 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 Serious Case Reviews and Learning Reviews and multi agency information sharing; safeguarding children in respect of the Designated Professionals Strategic Plan; children in care in respect of out of area placements within North Yorkshire and timeliness of health assessments; statutory guidance; primary care; and the Care Quality Commission Children Looked After and Safeguarding Reviews. The outcome of the Quality Review of Initial Health Assessments for Looked After Children in North Yorkshire and York, undertaken by the Designated Doctors and Named Nurse for Looked After Children on 24 October 2017, was also included.

With regard to the Local Authority Safeguarding Children Boards KH referred to the Independent Inquiry into Child Sexual Abuse that included Ampleforth College and reported further concerns had recently been escalated in this regard, confirming that NHS Scarborough and Ryedale CCG was fully aware of the new issues. KH provided assurance in relation to the process for an NHS England Serious Incident Investigation and reported that all the Safeguarding Boards were considering future partnership arrangements.

KH referred to the primary care information and highlighted the Multi Agency Risk Assessment Conference pilot of twice weekly meetings in City of York. She noted that, in addition to a number of GPs participating in this pilot, Jacqui Hourigan, Nurse Consultant for Safeguarding (Adults and Children) in Primary Care, provided a link to primary care. Consideration was being given to system support for the continuation of the pilot.

KH reported in respect of the North Yorkshire and City of York Care Quality Commission Children Looked After and Safeguarding Reviews that no concerns had been identified in respect of providers' progress against recommendations.

Members sought clarification on the Review of Initial Health Assessments for Looked After Children in North Yorkshire and York, including in respect of dental treatment and

eye tests. MC advised that there was a perceived gap of monitoring this in the 0-19 service and JB noted that City of York Council Public Health team was arranging a meeting to discuss oral hygiene and tooth decay. KH emphasised the multi agency responsibility for Looked After Children and the need to ensure a plan was in place that was reviewed and monitored.

The Committee:

1. Noted the progress made against the Designated Professionals Work Plan (Quarter 3 2017-18).
2. Agreed to receive more detailed reports regarding the timeliness of health assessments for looked after children, on a quarterly basis, commencing April 2018.
3. Noted the progress in developing safeguarding practice in primary care and agreed to receive updates regarding midwifery notifications and primary care links into the Multi Agency Risk Assessment Conference process.
4. Agreed to receive an update against both North Yorkshire and City of York Children Looked After and Safeguarding Reviews at the next meeting.

9. Safeguarding Adults

CP presented the report which comprised an update on the North Yorkshire Safeguarding Adults Board, York Learning Lessons Review Group, Prevent, and the Learning Disability Mortality Review. She noted that the 2018/19 Safeguarding Adults work plan, previously within the Partnership Commissioning Unit strategy, would be included in her next report to the Committee.

CP referred to discussion at the December Committee meeting regarding the revised North Yorkshire Safeguarding Adults Policy and Procedures, delayed until April 2019, and reported that an independent chair was being sought.

The Committee:

Received the Safeguarding Adults report.

10. Risk Update Report

AC referred to the report which provided details of current events and risks managed by the Quality and Patient Experience Committee, identified those risks escalated to the Governing Body, provided an overview of programme risk registers and an update regarding risks arising from published Improvement and Assessment Framework indicators that inform the Board Assurance Framework.

Members confirmed that, as The Retreat had now been assessed as ‘Good’ by the Care Quality Commission, this risk should be removed from the Risk Register and that the emerging risks relating to anticoagulation services and the multi specialty community bed provision in the Ryedale area should be reported to the Quality and Patient Experience Committee.

AC referred to the information on corporate risks monitored by the Quality and Patient Experience Committee and explained the proposal that risks to patients, safety and quality be reported, noting that some risks would also require reporting to the Finance and Performance Committee. AC advised that the two 'red' risks relating to Continuing Healthcare services were in fact financial risks and therefore should only be reported to the Finance and Performance Committee.

Following discussion it was agreed that MC, JB and AC should review the corporate risks to ensure appropriate reporting to the Committee.

The Committee:

1. Received the Risk Update Report.
2. Noted that MC, JB and AC would review the corporate risks to ensure appropriate reporting to the Committee.

11. Forward Plan 2018/19

JB referred to the draft forward plan for 2018/19 Committee meetings. VH proposed that the patient story for each meeting focus on a particular aspect of each agenda.

The Committee:

Agreed the Forward Plan for 2018/19.

12. Key Messages to the Governing Body

- The Committee welcomed the detailed consideration of the CCG's work with care homes.
- The Committee noted the high profile of Safeguarding Children and Children in Care.
- The Committee noted the work taking place across Yorkshire and the Humber relating to Never Events, including consideration of mechanisms to robustly share learning and more timely alerts.
- The Committee expressed concern at the City of York Council withdrawal from the Harrogate District NHS Foundation Trust Community Infection Control and Prevention Service.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

13. Next meeting

9am, 12 April 2018.

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Item Number: 19

Name of Presenter: Dr Shaun O'Connell

Meeting of the Governing Body

Date of meeting: 1 March 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 – December 2017 and January 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 Shaun O'Connell Joint Medical Director GP Lead for Planned Care and Prescribing	Laura Angus Lead Pharmacist

Recommendations from York and Scarborough Medicines Commissioning Committee December 2017*

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	TA483: Nivolumab for previously treated squamous non-small-cell lung cancer		Nivolumab is recommended for use within the Cancer Drugs Fund as an option for treating locally advanced or metastatic squamous non-small-cell lung cancer in adults after chemotherapy, only if: • nivolumab is stopped at 2 years of uninterrupted treatment, or earlier in the event of disease progression, and • the conditions in the managed access agreement are followed.	Red	No cost impact to CCGs as NHS England commissioned.
2	TA484: Nivolumab for previously treated non-squamous non-small-cell lung cancer		Nivolumab is recommended for use within the Cancer Drugs Fund as an option for treating locally advanced or metastatic squamous non-small-cell lung cancer in adults after chemotherapy, only if: • nivolumab is stopped at 2 years of uninterrupted treatment, or earlier in the event of disease progression, and • the conditions in the managed access agreement are followed.	Red	No cost impact to CCGs as NHS England commissioned.
3	TA485: Sarilumab for moderate to severe rheumatoid arthritis		1.1 Sarilumab, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with a combination of conventional disease-modifying antirheumatic drugs (DMARDs), only if: • disease is severe (a disease activity score [DAS28] of more than 5.1) and • the company provides sarilumab with the discount agreed in the patient access scheme. 1.2 Sarilumab, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to or who cannot have other DMARDs, including at least 1 biological DMARD, only if: • disease is severe (a DAS28 of more than 5.1) and • they cannot have rituximab and • the company provides sarilumab with the discount	Red	The average cost per patient per year is estimated at £11,900 based on the list price. A PAS is in place details of which are confidential. YFT report that sarilumab is locally less costly than tocilizumab and will be used for new patients, with estimated patient numbers of 3 per year across Y&S.

		agreed in the patient access scheme. 1.3 Sarilumab, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to rituximab and at least 1 biological DMARD, only if: • disease is severe (a DAS28 of more than 5.1) and • the company provides sarilumab with the discount agreed in the patient access scheme. Sarilumab can be used as monotherapy for people who cannot take methotrexate because it is contraindicated or because of intolerance, when the criteria in sections 1.1 and 1.2 are met. Continue treatment only if there is a moderate response measured using European League Against Rheumatism (EULAR) criteria at 6 months after starting therapy. After an initial response within 6 months, withdraw treatment if at least a moderate EULAR response is not maintained.		
5	TA487: Venetoclax for treating chronic lymphocytic leukaemia	Venetoclax is recommended for use within the Cancer Drugs Fund, within its marketing authorisation, as an option for treating chronic lymphocytic leukaemia, that is, in adults: • with a 17p deletion or TP53 mutation and when a B-cell receptor pathway inhibitor is unsuitable, or whose disease has progressed after a B-cell receptor pathway inhibitor **or** • without a 17p deletion or TP53 mutation, and whose disease has progressed after both chemo-immunotherapy and a B-cell receptor pathway inhibitor **and** • only if the conditions in the managed access agreement are followed.	Red	No cost impact to CCGs as NHS England commissioned.
6	TA488: Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours	Regorafenib is recommended as an option for treating unresectable or metastatic gastrointestinal stromal tumours in adults whose disease has progressed on, or who are intolerant to, prior treatment with imatinib and sunitinib, only if: • their Eastern Cooperative Oncology Group (ECOG) performance status is 0 to 1 and	Red	No cost impact to CCGs as NHS England commissioned.

		• the company provides regorafenib with the discount agreed in the patient access scheme.		
7	TA489: Vismodegib for treating basal cell carcinoma	Vismodegib is **not recommended** within its marketing authorisation for treating symptomatic metastatic basal cell carcinoma, or locally advanced basal cell carcinoma that is inappropriate for surgery or radiotherapy, in adults.	Black	No cost impact as not recommended.
8	TA491: Ibrutinib for treating Waldenstrom's macroglobulinaemia	Ibrutinib is recommended for use in the Cancer Drugs Fund as an option for treating Waldenstrom's macroglobulinaemia in adults who have had at least 1 prior therapy, only if the conditions in the managed access agreement for ibrutinib are followed.	Red	No cost impact to CCGs as NHS England commissioned.
9	Promazine – antipsychotic.	The group agreed that promazine should be removed from the formulary in line with TEWV recommendation. Promazine is subject to considerable first-pass metabolism, resulting in significant plasma concentration variations between patients and the BNF marks it as a drug considered to be "less suitable for prescribing". It is highly toxic in overdose and can result in grand mal seizures, QRS prolongation and coma. TEWV recommend that it is **not** used. A de-prescribing guideline is currently being developed by TEWV.	N/A	Removal from formulary should result in some costs saved.
10	TEWV anxiety medication pathway	The group found the TEWV anxiety pathway (attached) to be very useful and approved its adoption for the Y&S formulary.	N/A	No significant cost impact expected.
12	Meibopatch® - commercial warm eye compress medical device used for conditions associated with Meibomian gland dysfunction e.g. blepharitis, chalazion, dry eye, eyelid inflammation	The group did not approve the addition of Meibopatch® to the formulary as it was not considered a cost-effective use of NHS resources. There is no evidence demonstrating its therapeutic advantage for Meibomian gland dysfunction over a clean flannel and warm water as warm compress used properly with periodic re-soaking to maintain the heat, and it is more costly than warm compress. Meibopatch is available for patients to purchase themselves if they find it more convenient.	N/A	No cost impact as not approved.

13	Flash Glucose Monitoring (FreeStyle Libre®) for use in adults, children and young people with Type 1 diabetes Mellitus – Y&S position statement and RAG status. *FreeStyle Libre was discussed at both Dec 17 and Jan 18 MCC meetings.	The group agreed the attached position statement for the use of FreeStyle Libre® in York and Scarborough. The statement built on the recommendations issued by the Regional Medicines Optimisation Committee (RMOC) in October 2017 with the inclusion of further details to sharpen the criteria. Consultation took place with the Trust diabetes specialist team and the feedback received was considered by the group. The statement includes eligibility criteria and following a 6 month trial, criteria for continuation. It also includes the requirement that specialist teams must audit outcomes in all patients and the data gathered will be used to inform a review of the position statement. The Association of British Clinical Diabetologists (ABCD) have launched a nationwide FreeStyle Libre® audit and have developed data collection tools which local diabetes specialist teams are encouraged to use in gathering data. It was agreed that the system would be assigned a red RAG status initially. To address the potential administrative burden that may be associated with a red status, it was agreed that as FreeStyle Libre® system is a device, the Trust diabetes specialist team would provide the sensors to patients directly rather than via prescribing on FP10s. The Trust would then periodically bill the CCG directly and must supply audit data demonstrating that each patient treated met the criteria before payment is made.	Red	The annual cost of sensors is £910 per patient. The reader is not prescribable on the NHS but provided free of charge by the manufacturer. Based on acquisition costs, the use of FreeStyle Libre® is expected to be cost neutral if a patient is currently finger prick testing 8 or more times daily, and the introduction of FreeStyle Libre reduces the testing frequency to an average of 0.5 times daily (trial data showed a reduction in blood glucose testing to an average of 0.5 times per day in patients using FreeStyle Libre®). The statement requires that the specialist considers the use of FreeStyle Libre® will be cost effective for the patient. The true cost impact is difficult to estimate at this time due to a lack of data as savings could arise if use of FreeStyle Libre® leads to fewer complications and reduced admissions. FreeStyle Libre® would also be expected to be cost saving for patients who would have progressed to the use of insulin pumps and if those with impaired hypoglycaemia awareness are prevented from progressing to persistent hypoglycaemia which would require the use of continuous glucose monitoring with alarms. Information on estimated number of eligible patients based on the criteria is awaited from YFT.

Recommendations from York and Scarborough Medicines Commissioning Committee January 2018

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	TA486: Aflibercept for treating choroidal neovascularisation		Aflibercept is recommended, within its marketing authorisation, as an option for treating visual impairment because of myopic choroidal neovascularisation in adults, only if the company provides aflibercept with the discount agreed in the patient access scheme. If patients and their clinicians consider both aflibercept and ranibizumab to be suitable treatments, the least costly should be used, taking into account anticipated administration costs, dosage and price per dose.	Red	The list price of aflibercept 40 mg/mL is £816 per 0.1-mL vial. A confidential PAS scheme is in place. The recommended dose is a single intravitreal injection of 2 mg aflibercept. Extra doses may be used if visual or anatomic outcomes indicate that the disease persists. In comparison, list price of ranibizumab 10 mg/mL is £551 per 0.23 mL vial or 0.165 mL pre-filled syringe. A confidential PAS scheme is also in place. Administered as a single 0.5 mg intravitreal injection. Further treatment is recommended if monitoring reveals signs of disease activity. NICE do not expect this guidance to have a significant impact on resources; that is, it will be less than £9,100 per 100,000 population. This is because the technology is an option alongside current standard treatment options. *Estimated patient numbers are awaited from YFT.*
2	TA492: Atezolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable		Atezolizumab is recommended for use within the Cancer Drugs Fund as an option for untreated locally advanced or metastatic urothelial carcinoma in adults, for whom cisplatin-based chemotherapy is unsuitable, only if the conditions of the managed access	Red	No cost impact to CCGs as NHS England commissioned.

		agreement for atezolizumab are followed.		
3	TA493: Cladribine tablets for treating relapsing–remitting multiple sclerosis	Cladribine tablets are recommended as an option for treating highly active multiple sclerosis in adults, only if the person has: • rapidly evolving severe relapsing–remitting multiple sclerosis, that is, at least 2 relapses in the previous year and at least 1 T1 gadolinium-enhancing lesion at baseline MRI or • relapsing–remitting multiple sclerosis that has responded inadequately to treatment with disease-modifying therapy, defined as 1 relapse in the previous year and MRI evidence of disease activity.	Red	No cost impact to CCGs as NHS England commissioned.
4	TA494: Naltrexone–bupropion for managing overweight and obesity	Naltrexone–bupropion is **not recommended** within its marketing authorisation for managing overweight and obesity in adults alongside a reduced-calorie diet and increased physical activity. This recommendation is not intended to affect treatment with naltrexone–bupropion that was started in the NHS before this guidance was published.	Already Black on Y&S formulary	None as not recommended
5	TA495: Palbociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer	Palbociclib, with an aromatase inhibitor, is recommended within its marketing authorisation, as an option for treating hormone receptor-positive, human epidermal growth factor receptor 2-negative, locally advanced or metastatic breast cancer as initial endocrine-based therapy in adults. Palbociclib is recommended only if the company provides it with the discount agreed in the patient access scheme.	Red	No cost impact to CCGs as NHS England commissioned.
6	TA496: Ribociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer	Ribociclib, with an aromatase inhibitor, is recommended within its marketing authorisation, as an option for treating hormone receptor-positive, human epidermal growth factor receptor 2-negative, locally advanced or metastatic breast cancer as initial endocrine-based therapy in adults. Ribociclib is recommended only if the company provides it with the	Red	No cost impact to CCGs as NHS England commissioned.

		discount agreed in the patient access scheme.		
7	Items which should not routinely be prescribed in primary care – Review of Y&S formulary position against NHSE recommendations	The group compared the current Y&S commissioning position against the final guidance from NHSE on items which should not routinely be prescribed in primary care. Many of the items already had a black status on the Y&S formulary. For the items which had no formal commissioning position or with a status that differed from the guidance the group agreed the following in line with the recommendations: • Herbal treatments – Black • Homeopathy – Black • Paracetamol and tramadol combination – Black • Perindopril arginine – Black • Rubefacients (excl. topical NSAIDs) – Black • Immediate release fentanyl – Black for non-palliative care indications; Restricted to palliative care use only on recommendation of a palliative care specialist • Oxycodone and naloxone combination – Black (previously green) • Travel vaccines not prescribable on the NHS i.e. hepatitis B, Japanese encephalitis, meningococcal ACWY, yellow fever, tick-borne encephalitis, rabies, BCG: - Black for the purposes of travel; the vaccines will continue to be recommended but the individual traveller will bear the cost of the vaccination. - The group extended the black position to the use of these vaccines for occupational purposes as this is the employer's responsibility. - For hepatitis B and meningococcal ACWY, green for clinical indications other than the above as recommended in the Green Book.	As stated	The NHSE recommendations are cost saving.
8	Mycophenolate Shared Care Guideline for adult renal transplant – covers mycophenolate mofetil and mycophenolate sodium.	The group approved the attached shared care guideline following minor wording amendments.	Amber SCG	This SCG formalises the Amber Shared Care commissioning position and includes products already in the formulary which are

				used in current practice; therefore no further cost impact is expected.
9	Mycophenolate mofetil (MMF) for ulcerative colitis and inflammatory eye diseases	The group approved the inclusion of these additional indications to the shared care guideline for MMF use for non-transplant indications which is currently in development. Limited data suggested that MMF may be useful for some patients with these conditions who are non-responsive to or cannot tolerate conventional treatment. The group noted that other local areas use MMF for inflammatory bowel disease and inflammatory eye diseases. The Trust has historically used MMF for these indications.	Amber SCG	No significant cost impact expected as use for these indications is current practice.
10	New York anticoagulant clinic heart valve bridging protocol	The group approved the new protocol which had been agreed with cardiology consultants. The new protocol streamlines the number of patients with heart valves who are given low molecular weight heparin (LMWH) if their INR is low.	N/A	Expected to be cost saving as a lot less patients will be given LMWH.
11	Updated vitamin D guidelines and medal ranking	The vitamin D guideline had been updated in line with the National Osteoporosis Society guidelines and NICE Clinical Knowledge Summary. The medal ranking had also been updated with new cost effective preparations for treatment of deficiency and insufficiency. Maintenance following treatment of deficiency and supplementation for replete patients at risk of deficiency according to DOH guidance are now to be purchased OTC only and not prescribed. Both the vitamin D guideline and medal ranking were approved by the group following a minor amendment to the guideline.	Green	Cost saving as updated with new cost-effective preparations. Also maintenance dose following treatment and supplementation for replete patients at risk according to DOH guidance will be OTC only.
12	Wound care formulary	The updated Y&S wound care formulary covering both hospital and community was approved. The group noted that the formulary had been rationalised and was much shorter than the existing formulary. The full and summary versions of the formulary are attached.	N/A	Products chosen for the update formulary are more cost-effective than those in the existing formulary and range of products have been streamlined and reduced from about 110 to 55. Therefore the new formulary is expected to be cost saving.

13	Algorithm for treatment of Type 2 Diabetes Mellitus	An algorithm for the use of formulary agents for management of T2DM had been developed in conjunction with the diabetes specialist team. The algorithm is primarily based on NICE guidance but also reflects local specialist advice on management. The group approved the algorithm subject to verification of some of the recommendations against NICE guidance and amending accordingly.	N/A	The algorithm is based on current NICE guidance, reflects current practice by the diabetes team and includes products already on the formulary; therefore no significant cost impact would be expected.
14	Change in first line DPP4 inhibitor from alogliptin to sitagliptin	A change of the first line DPP4 inhibitor from alogliptin to sitagliptin was requested due to an FDA safety warning on an increased risk of heart failure with alogliptin. Feedback from the diabetes specialist team is that sitagliptin is already used in most patients. This change was approved by the group.	Green	Comparative annual costs: Alogliptin = £345.80 Sitagliptin = £432.38 However, no significant cost impact would be expected as this reflects current practice.
15	Change in RAG status of nateglinide and repaglinide from green to amber specialist recommendation	It was noted that specialists had not included nateglinide and repaglinide within the T2DM algorithm as there were few licensed combination regimens including these drugs therefore they are hardly initiated in patients. These agents were currently green on the formulary. The group suggested that the RAG status should be reviewed to amber specialist recommendation to ensure that their initiation would be appropriate as it would be guided by the specialist. YFT specialists agreed with the revised RAG status.	Amber specialist recommendation	No significant cost impact expected from change in RAG status.
16	Updated “Who to test, when to test?” guidelines	The “Who to test, when to test?” guidelines had been updated and now include guidance on the number of test strip boxes to be supplied to patients for both T1 and T2DM. The group approved the updated guidelines.	N/A	Guidance on quantity of strips to supply may help to prevent excessive prescribing which in turn may lead to cost savings.
17	Prescribing guidance for adjuvant bisphosphonates in postmenopausal women with breast cancer	The group approved the guidance on the use of adjuvant bisphosphonates in post-menopausal women with breast cancer. The guidance includes clinical information on the treatments, responsibilities of specialists and primary care clinicians and an algorithm for selection of suitable patients. The use of oral ibandronate and IV zoledronate for patients who cannot tolerate oral ibandronate has previously been approved (July 2017). However, the implementation of the IV zoledronate treatment option	Amber specialist recommendation for oral ibandronate	Agents previously approved (July 2017).

		is still under consideration therefore is yet to be included in the guideline. The guideline will be updated when details of delivery of IV zoledronate has been agreed. The RAG status of oral ibandronate was requested to change from amber specialist initiation to amber specialist recommendation as specialists may not be able to initiate treatment in some patients who are discovered to have low calcium/vitamin D. Instead of bringing these patients back to hospital to start treatment after correction, these patients would be referred to the GP to correct calcium and/or vitamin D who would then initiate treatment once corrected. This change was approved by the group.		