

GOVERNING BODY MEETING

4 January 2018, 9.30am to 12.30pm

The Studio, Pocklington Arts Centre, 22-24 Market Place, Pocklington YO42 2AR

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

The agenda and associated papers will be available at:

www.valeofyorkccg.nhs.uk

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 5 to 23	Minutes of the meeting held on 2 November 2017	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 25 to 29	Accountable Officer's Report	To Receive	Phil Mettam – Accountable Officer
6.	Pages 31 to 52	Board Assurance Framework Update Report	To Receive and Approve	Phil Mettam – Accountable Officer

STRATEGIC – 10.30am				
7.	Verbal	Update on New Mental Health Hospital for the Vale of York	To Note	Dr Louise Barker – Clinical Director
8.	Pages 53 to 57	Commissioning Intentions 2018/19	To Receive	Phil Mettam – Accountable Officer
9.	Pages 59 to 63	Personal Medical Services Premium and £3 Per Head – Proposal from Council of Representatives	To Ratify and Approve	Dr Kev Smith – Executive Director of Primary Care and Population Health
FINANCE AND PERFORMANCE – 11.00am				
10.	Pages 65 to 80	Financial Performance Report Month 8	To Receive	Tracey Preece – Chief Finance Officer
11.	Pages 81 to 123	Integrated Performance Report Month 8	To Receive	Caroline Alexander – Assistant Director of Delivery and Performance
ASSURANCE – 11.40am				
12.	Pages 125 to 149	Quality and Patient Experience Report	To Receive	Michelle Carrington - Executive Director of Quality and Nursing
13.	Pages 151 to 197	Designated Professionals for Safeguarding Children Annual Report 2016-17	To Receive	Michelle Carrington - Executive Director of Quality and Nursing
14.	Pages 199 to 207	Tees, Esk and Wear Valleys NHS Foundation Trust – Two Years On	To Receive	Dr Louise Barker – Clinical Director
15.	Pages 209 to 226	Audit Committee Annual Report	To Receive	Sheenagh Powell – Audit Committee Chair
16.	Pages 227 to 232	Overview: Winter Planning Update	To Receive	Andrew Phillips – Joint Medical Director
17.	Pages 233 to 254	Equality, Diversity and Human Rights Strategy 2017-2021	To Receive	Michelle Carrington – Executive Director of Quality and Nursing

RECEIVED ITEMS – 12.15pm

18.	Pages 255 to 271	Audit Committee Minutes: 29 November 2017		
19.	Pages 273 to 287	Executive Committee Minutes: 18 October and 15 November 2017		
20.	Pages 289 to 314	Finance and Performance Committee Minutes: 26 October and 23 November 2017		
21.	Pages 315 to 330	Primary Care Commissioning Committee: 22 November 2017		
22.	Pages 331 to 338	Medicines Commissioning Committee Recommendations: 11 October and 8 November 2017		

NEXT MEETING

23.	Verbal	9.30am on 1 March 2018 at West Offices, Station Rise, York YO1 6GA	To Note	All
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CLOSE – 12.30pm**EXCLUSION OF PRESS AND PUBLIC**

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

A glossary of commonly used terms is available at:

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

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Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body held 2 November 2017 at West Offices, York

Present

Keith Ramsay (KR)	Chairman
Dr Louise Barker (LB)	Clinical Director
David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Dr Emma Broughton (EB)	Clinical Director
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Dr Paula Evans (PE)	GP, Council of Representatives Member
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Andrew Phillips (AP)	Joint Medical Director
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
Jo Baxter (JB)	Management PA
Sarah Corner (SC)	Management PA
Debbie Winder (DW) - for item 7	Head of Quality Assurance and Maternity

Apologies

Dr Shaun O'Connell (SOC)	Joint Medical Director
Sharon Stoltz (SS)	Director of Public Health, City of York Council
Dr Stuart Calder (SC)	GP, Council of Representatives Member
Dr Arasu Kuppuswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member

Twelve members of the public were in attendance.

KR welcomed everyone to the meeting.

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

Anne Leonard, on behalf of Defend Our NHS, York

Although we would like to thank the CCG for the language seminar they provided earlier this year in response to complaints about the esoteric language used to describe health

management issues, our fundamental question about the use of difficult terms and their abbreviations remains. The rapidity of the introduction of new terms and abbreviations adds to the confusion. Instead of expecting the public to deal with this by becoming familiar with the ever evolving language of NHS management, would it not be better to simplify the terms in the first place, so the public can understand what is going on in the public service that belongs to them? At the time of the Reformation, the solution to the problem of general ignorance of the Bible and Litany was not to teach everyone Latin, but to translate Latin into English, with huge, unforeseen and beneficial consequences for our society and its future. The same service could be done now by better use of our amazingly flexible language that began to emerge at that time, with the same beneficial results - fuller and evolving public participation in public life and decision making.

Response

In responding KR acknowledged it was the role of everyone within the NHS to use plain language and the CCG would continue to work on this.

AGENDA ITEMS

STANDING ITEMS

1. Apologies

As noted above.

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

There were no declarations of interest in the business of the meeting. Members' interests were as per the Register of Interests.

3. Minutes of the Meeting held on 7 September 2017

The minutes of 7 September were agreed.

The Governing Body:

Approved the minutes of the meeting held on 7 September 2017.

4. Matters Arising from the Minutes

Safeguarding Children Annual Report 2015-16: MC reported that the 2016/17 Annual Report was item 12 on the agenda. Joint commissioning remained a potential on the agenda with City of York Council.

Integrated Performance Report: AP provided an update on the Utilisation Management Review and community bed review. Work was ongoing with York Teaching Hospital NHS Foundation Trust following the recommendations from the report. An Unplanned Care system review workshop had taken place with NHS Scarborough and Ryedale Clinical Commissioning Group, the outputs from this workshop would be shared in due course.

Accountable Officer's Report: The desire to develop a review of clinical networks and processes across the organisations within the Sustainability and Transformation Plan footprint remained and work was still ongoing. PM advised this was made difficult with some of the clinical networks in York being relatively unresponsive which created issues in establishing how to take costs out of the system.

Risk Update Report: In respect of GP involvement in the Local Digital Roadmap, PE advised that the names of the individuals would be reported at the next meeting.

The Governing Body:

Noted the updates and agreed associated actions.

5. Accountable Officer's Report

PM presented the report which provided a mid-year assessment at month 6 on turnaround, legal Directions and the CCG's financial position. The CCG was awaiting the conditions to be applied for organisations in special measures from NHS England; these were being applied to a number of CCGs. PM stressed this was a significant situation to be in and the CCG had therefore placed itself into a position of self-imposed turnaround. Details were being worked through of the required measures which included the development of a new model of commissioning and contracting for acute care across York Teaching Hospital NHS Foundation Trust, NHS Vale of York and NHS Scarborough and Ryedale CCGs. It was hoped the new model would be agreed before the end of December, to be implemented for the new financial year.

PM advised the CCG would be taking a medium to long term view of how the configuration of hospital services should look in the future to serve the populations of NHS Vale of York, NHS East Riding of Yorkshire and NHS Scarborough and Ryedale CCGs. PM stated that two thirds of the CCG's historical deficit was attributed to the cost of acute care and the response to that. The remaining third of the historical deficit related to complex case management, predominantly Continuing Health Care, mental health and specific high cost cases. The CCG had responded to this with the appointment of DN to the post of Executive Director of Transformation which covered both of these areas to assist in supporting the required change to the historical financial challenges.

Additionally a net reduction in running costs of 10% was planned for NHS Vale of York CCG going into 2018/19 and PM would be encouraging the CCG's partners to do the same. It was hoped this would be achieved within one year.

It was expected that a Turnaround Director would also be required by the regulators due to the CCG being in special measures, more details were expected over the next few weeks.

In respect of the financial position PM explained that the CCG at half year was in a broadly positive position, notwithstanding the seriousness of the CCG's historical and current financial deficit. The CCG had finished 2016/17 with a cumulative deficit of £23.8m and it was hoped this year would be an improved position in-year. The CCG was currently working on a forecast of £16m deficit however there were significant challenges to achieve this.

Returning to the broadly positive position at half year, PM highlighted the 4% reduction in GP referrals into the hospital acknowledging the good work through the Council of Representatives Committee, local GPs and the LMC to achieve this.

The CCG's Quality, Innovation, Productivity and Prevention programme (QIPP) had already improved on last year and had delivered £4.3m at month 6.

PM reported that signs of optimism were starting to be seen in stabilising the increased cost that the CCG had been carrying on behalf of the population. He spoke around RightCare, a way of describing how to reduce cost without reducing quality. Focus would be given to the programmes that came under the overall RightCare heading to ensure as much as possible could be carried out over the next few years. PM also reported that feedback on the way the CCG was constructing their approach to this was of a high standard. The clinically led work being carried out could continue to stabilise and potentially reduce the overall cost of the system.

PM reflected on the unprecedented financial challenges York Teaching Hospital NHS Foundation Trust was facing and stressed the on-going importance of working together as a system on behalf of patients, particularly for the elderly and most vulnerable.

In addition to the financial areas, other areas requiring improvement included cancer targets and waiting times/referral to treatment to hospital. PM advised the backlog in the hospital was a concern for all and, whilst GP referrals to hospital had reduced, the waiting times had increased therefore work was required on how to balance this and reduce the overall cost of the system.

In summarising PM reiterated the more positive and stable position of the CCG in comparison to the previous year whilst highlighting there would be no complacency as winter planning and costs were still a concern.

PE had not attended the recent Council of Representatives meeting however was able to provide an update on behalf of the members. Working with the CCG, the members had looked at clinical leadership and its different elements. Members had welcomed the raised profile of the Better Care Fund again and awaited the finer details. Winter planning had been raised as a significant concern and had been discussed at Sustainability and Transformation Plan level. It was felt there was confusion around the GP extended hours and integrated urgent care policies and these were therefore being worked through to ascertain how they would work for Vale of York, actively using the localities.

Rachel Potts, Executive Director of Planning and Governance, had recently stepped down from her role and PM therefore thanked her for her hard work, commitment and the huge contribution she had made to help shape healthcare in the Vale of York.

PM reported that NHS England had supported and approved the appointment of Dr Kevin Smith (KS) to the post of Director of Primary Care and Population Health. This was on an initial part time and interim basis and was a very positive step forward for the health system. KS was held in high regard both locally and regionally. PM reminded members that whilst the CCG was under legal Directions, all senior appointments required the approval of NHS England.

PM reported the CCG was working closely with City of York Council on the Local Plan and looking for opportunities where they could work directly together for the benefit of local people.

The CCG had been selected to participate in an upcoming audit of the conflicts of interest and gifts and hospitality management. PM welcomed the audit and encouraged full engagement. The findings would be reviewed at the Audit Committee in due course.

PM expressed appreciation to Fliss Wood, Performance and Emergency Preparedness, Resilience and Response Manager, for her exemplary work on the Emergency Preparedness, Resilience and Response reports.

In response to DB seeking assurance of increased cooperation between the CCG's two regulators, NHS England and NHS Improvement, PM acknowledged the difficulty the statutory bodies faced in putting the interests of the system first. Capped Expenditure had encouraged organisations to work for the benefit of the system and both regulators therefore continued to work together to ensure they maintained CCG constitutional standards. PM gave RightCare as a good example of working with other organisations to reduce costs, meet statutory duties and look at common ground with clinical networks being a crucial part of this going forward.

In response to a request for an update on social prescribing, PM advised that there were examples where this had been very effective and a presentation had taken place at the recent City of York Council Health and Wellbeing Board. It was expected that the locality structure would pursue this to include personal health budgets. It was also hoped the local Care Quality Commission review with health and social care would highlight this as an opportunity.

A discussion ensued on the desire to re-establish the clinical networks which had changed over the years as teams and workloads had increased. Initiatives such as the Clinical Summit were helping to improve this.

The Governing Body:

1. Received the Accountable Officer's Report.
2. Commended Fliss Wood's work on the Emergency Preparedness, Resilience and Response report

6. Risk Update Report

PM summarised the Risk Report which would go to the Audit Committee for a more detailed discussion.

MC provided an update on the Inadequate outcome from the Care Quality Commission report on The Retreat which had previously been reported at Governing Body. She advised the risk would be reducing in due course as The Retreat was progressing well. They had been open to support and patients were safe.

In respect of Improving Access to Psychological Therapies and recovery targets, confidence was being seen on the pace and progress on the backlog, with a reduction from 1000 to approximately 300. Work was also taking place on the pathway.

LB reported on the dementia coding target in General Practice and DN advised dementia diagnosis performance was improving slowly. The CCG was arranging support visits to Practices and running data to ensure all patients were identified; case finding and monthly information were being supported.

Further discussions on the 18 week Referral to Treatment target and the Better Care Fund plans would take place at later agenda items.

SP advised the risk reporting framework was being reviewed by the Audit Committee.

The Governing Body:

1. Received the Risk Update Report
2. Noted the ongoing work to review risk reporting

DW joined the meeting

7. Humber, Coast and Vale Local Maternity System Plan 2017-20

MC introduced DW, Head of Quality of Assurance and Maternity.

DW provided an introduction to the Local Maternity System and an overview of the Local Maternity System Plan. The plan aimed to develop maternity systems across the Sustainability and Transformation Plan in line with requirements from the national Maternity Review Better Births.

DW explained that this was an opportunity to work together across a wider system, across organisations, to deliver changes that were common to all organisations and services once, and to share learning and good practice so that all the women received the best care that could be offered. It would also help to improve the range of choices for women and families across the whole Local Maternity System.

DW outlined the Humber Coast and Vale Local Maternity System vision to be an area where pre-pregnancy, pregnancy and childbirth services truly reflected the needs of the childbearing population and which focused upon delivering personalised care by compassionate, knowledgeable, skilful staff that was jointly agreed and planned with women and families

It was agreed that Vale of York representation during the development and implementation of the plan was vital to ensure any decisions made were reflective of the variations in demographics across the Sustainability and Transformation Plan. This had been challenging as the CCG had no specialist maternity commissioning resource since the realignment of the Partnership Commissioning Unit.

Key risks to the Sustainability and Transformation Plan and key risks to the CCG were highlighted and discussed. The need to develop the Perinatal Mental Health Service and associated cost identified as a risk was discussed in detail with explanation provided of the risk lack of adequate service provision had on long term outcomes for women and their children.

The Governing Body

Received the Humber, Coast and Vale Local Maternity System Plan 2017-20.

FINANCE AND PERFORMANCE

8. Financial Performance Report Month 6

In presenting the Financial Performance Report at Month 6, TP referred to the last Governing Body public meeting where members considered the financial plan which included the Capped Expenditure Process plans. A robust discussion had taken place around the confidence in deliverability of the plans and members had felt they were unable to approve the plan due to the high level of risk. Governing Body had then met again in private and considered the extent to which they wished to reset the plan to the one approved at the April Governing Body meeting.

TP advised the report therefore reflected the outcome of the Governing Body meetings and a detailed discussion at the Finance and Performance Committee in September.

At month 6 the CCG was forecasting a risk adjusted deficit of £19.5m; this was a gap of £3.5m against the plan of £16m in April. TP advised that the CCG was still formally monitoring against the capped expenditure plan with NHS England which the CCG had been asked to put in the ledger in June.

In respect of the key drivers and pressure areas behind the deficit, TP advised the recovery plans were concentrating on the main contract with York Teaching Hospital NHS Foundation Trust, continuing healthcare, mental health out of contract and QIPP delivery. TP reiterated PM's earlier positive comment about QIPP schemes which were delivering and had already achieved more savings in the first six months compared to the whole of 2016/17. TP highlighted a further risk not reflected in the figures was the potential additional cost of winter over and above the activity levels already included in plans.

TP summarised the month 6 financial position as one of stabilisation, advising that overall, across all expenditure lines, the CCG underlying trading position was stabilising .

Actions to close the gap were currently being worked on to develop a more detailed proposal to feed back to regulators over the coming weeks.

TP highlighted that the CCG was planning on the contract challenges being successful to contain acute cost growth and that if this did not happen the £3.5m gap could increase. The CCG was therefore working on an estimated £5m gap to encompass risks associated with winter, contract challenges and any unforeseen items.

Whilst locally we do not have an agreed plan in place, TP advised capped expenditure was still in force nationally with NHS England and the CCG must continue to take all possible actions to live within its control total. Feedback from the next regulatory meetings would be provided in due course.

TP provided an update from a recent regulatory meeting with NHS England and NHS Improvement with Chief Finance Officers from NHS Vale of York and Scarborough and Ryedale CCGs and the Director of Finance at York Teaching Hospital NHS Foundation Trust to discuss respective forecasts in detail. TP advised that the underlying forecasts were very close which gave assurance that activity was being counted correctly and the CCG's forecasting methodology was still robust. The differences were primarily contract challenges and York Teaching Hospital NHS Foundation Trust's view of QIPP delivery. It was expected nationally that material contract challenges would be resolved prior to the end of December. The Executive Committee agenda on 15 November included an item on rehabilitation bed days and York Teaching Hospital NHS Foundation Trust had accepted a clinical proposal to undertake an audit to ensure the appropriate rehabilitation pathways were commissioned from April 2018.

It had been agreed in principle that a new model of contracting would be implemented from April 2018. Work was on-going with York Teaching Hospital NHS Foundation Trust, NHS Scarborough and Ryedale and NHS Vale of York CCGs to change structures, ways of working and behaviour, learning from a successful incentive based contract utilised by NHS East Riding of Yorkshire and NHS Hull CCGs with Hull and East Yorkshire Hospitals NHS Trust.

TP highlighted that positive feedback had been received on the CCG's Financial Performance Report which was being recommended by NHS England to other CCGs in terms of detail and read-through to NHS England national reporting. The format of the report would continue to be developed and dedicated capacity would be identified to progress this. TP noted that both non finance input and clinical input would be welcomed in ensuring the CCG's financial reporting responded to all stakeholder requirements.

DN noted that in Key Actions and following more recent research since the report was written, the responsible commissioner challenge was a risk rather than a mitigation for the CCG and this related to an individual case. Work in respect of the mitigations would continue during the rest of the year.

Members sought and received clarification on a number of aspects of the report, including in respect of winter pressures, 'flu and lessons learned from previous experience relating to QIPP delivery.

PM explained that although the CCG's position was more stable, TP had outlined a significant challenge in delivering the plan for the current year. Further detailed consideration would take place before the next meeting.

TP referred to the additional £3.4m savings proposals including planned, unplanned and complex care which would be progressed via the Executive Committee and that clinical input would be required.

PM highlighted the need for clarity around governance: the Executive Committee on behalf of the Governing Body would take decisions about which schemes should be progressed. KR clarified that the Governing Body had already set the framework and financial plans and the Executive should develop plans through the Finance and Performance Committee and report to the Governing Body in December if required. TP explained if the gap was not closed then it should be brought back to the Governing Body in December with the forecast being escalated.

SP welcomed the summary and reset of the plan. She emphasised that time was of the essence and sought assurance regarding engagement with the Council of Representatives.

DB agreed that the decisions should be made by the Executive Committee. Assurance and monitoring processes would follow that.

The Governing Body:

Received the Financial Performance Report.

9. Integrated Performance Report Month 6 2017/18

PM referred to the performance headlines noting that in respect of A&E 4 hour waits the performance on the York Hospital site had improved recently due to a number of changes that had been implemented which the CCG fully supported. However, performance on the Scarborough Hospital site had not been as good and access to the Sustainability and Transformation Fund was predicated on the overall performance of York Teaching Hospital NHS Foundation Trust.

PM detailed concerns relating to performance over winter due to the unprecedented current financial challenge across the system and the workforce challenges. A new approach focusing on joint working across the system was required. PM advised that the overall estimate across the system was £2.2m for winter planning split between provider and commissioner organisations PM requested delegated authority to the Executive Committee with reporting to the Finance and Performance Committee for agreement of a financial envelope and deployment of resources.

In response to SP seeking clarification about the figures attached to the winter plan and concern about potential further impact on the CCG's deficit position, TP explained that the Executive Committee could approve sums up to £500,000 as this was within the Scheme of Delegation.

TP also explained that if York Teaching Hospital NHS Foundation Trust increased capacity this may result in activity pressure for the CCG but associated staff costs would be the responsibility of the Trust.

In response to AB asking about the governance and primary care input into the processes, PM explained that the winter schemes were developed through an A&E Delivery Board across the Vale of York and Scarborough and Ryedale. Further discussion included the need to evaluate the schemes which took time, recognition that winter planning was also undertaken at Practice level and a request from AP that Practices inform the CCG if they experienced a spike in patients requiring primary care services as this would normally lead to a peak in attendance in A&E approximately two days later. AP advised that a pilot was taking place with York Medical Group around this which it was hoped to extend to other Practices with appropriate governance arrangements.

Discussion ensued regarding services for vulnerable people, continuing healthcare and responsibilities previously with the Partnership Commissioning Unit. The interests of

patients would be paramount in addressing the service issues notwithstanding the winter pressures. DN detailed ongoing work to review systems and processes both in terms of ensuring appropriate placements and minimising financial risk. She also explained that work included working with Tees, Esk and Wear Valleys NHS Foundation Trust regarding discharge timetables for emerging individual cases. DN welcomed a change in that a system approach was now being adopted in terms of health and social care packages and highlighted the need for further work with City of York Council for contracting arrangements. MC added that the CCG should be sighted on cases prior to discharge emphasising that large sums of money were involved and guidance to ensure the CCG was the responsible commissioner was complex.

PM commented on cancer 62 days performance and the work with the Cancer Alliance. He noted investment at Malton Hospital and the work through the Sustainability and Transformation Plan to try and attract further investment and improve performance.

PM highlighted concern about increasing referral to treatment waiting times with a back log and potential for capacity to be reduced over winter. He referred to the pressures previously discussed and emphasised the additional challenge to the CCG's financial recovery under turnaround. This would be monitored on a monthly basis by the Finance and Performance Committee.

PM referred to KS's appointment and advised that KS would lead on development of the Primary Care Programme.

The Governing Body:

1. Received the Integrated Performance Report.
2. Requested that the Executive Committee undertake the work discussed within its standing orders limit of £500,000 as a matter of urgency.

10. Quality and Patient Experience Report

In presenting this report MC referred to infection rates, noting that MRSA blood stream infection still had a zero tolerance but that there had been seven to date in 2017/18. Four instances were attributed to secondary care and two of the four instances had related to one patient with substance misuse issues which created difficulties around access and lines becoming infected. MC noted that the learning from these incidents around management of lines in hospital was ongoing.

In response to PM enquiring about the CCG's awareness of the top 200 patients in terms of high risk patients and overall cost to the CCG, MC advised that they would likely be frequent attenders at both surgeries and A&E. TP added that the top 200 most expensive patients in terms of use of hospital facilities, secondary care and attendances could be identified. The CCG did not see patient identifiable information but could identify which GP Practices these patients were registered with. EB noted that a piece of work had been done on bespoke packages for high cost patients to reduce the associated costs but this was not currently being progressed by the system. AP suggested looking at the 200 most expensive patients in terms of ensuring they had been offered the relevant services.

MC referred to the direct correlation between clostridium difficile infections being more likely in the elderly highlighting the importance of working with care homes. She also noted that work was taking place with regard to cases of norovirus in care homes.

In terms of frequent attenders MC advised that there was a national Commissioning for Quality and Innovation (CQUIN) indicator for patients with mental health issues attending A&E and the financial risk to not achieving the CQUIN was therefore with York Teaching Hospital NHS Foundation Trust. Twenty patients had been identified in this regard and Tees, Esk and Wear Valleys NHS Foundation Trust were arranging bespoke packages to prevent them going into A&E where possible. AB agreed that the scheme would also have a benefit to Primary Care in having clear plans for this cohort of patients and directing them to the correct resources for treatment or support.

MC noted that some of the most vulnerable patients were not known to services until they arrived at A&E, partly due to services being responsive rather than proactively identifying these patients. She also highlighted the role of social prescribing which should be kept under review.

DB referred to the HealthNavigator work and asked whether there was potential for proactive targeting of a cohort of people who needed extra support.

PM requested that benefits transferable from the successful transformation in the Bolton area be implemented where possible in the CCG and while this was a progressing other opportunities should be sought for immediate implementation. MC suggested a stock take to identify gaps proposing this be linked to turnaround and efficiency savings to ensure appropriate targeting.

With regard to Serious Incidents MC highlighted that, while progress had been made, there had been another Never Event in October due to human error of the wrong patient details being scanned into the computer. All the safeguards had been in place but the initial information had been incorrect. The system and process had been reviewed by CCG staff with the hospital.

MC reported that there had been a Serious Incident within the CCG which had been investigated. The report had been signed off by the Executive Committee. The cause had been failure to follow guidance when the referral came in to the CCG. Work was ongoing with Primary Care about safety issues and testing out a lessons learnt bulletin.

With regard to patient experience MC noted positive feedback from a relative of a patient receiving continuing healthcare about support given during difficult times. She also referred to complaints about changes to the podiatry service advising that action had been taken to provide clearer information to patients affected. In response to SP asking about the procurement process and associated cost savings in light of concerns about previous procurements, MC explained that in this instance there had been no extra cost to the CCG but the Patient Experience Officer had spent a lot of time signposting people to other services.

LB wished to recognise the CCG's attendance at the significant event meetings held within Tees, Esk and Wear Valleys NHS Foundation Trust. The CCG's contribution was highly regarded and very beneficial. Attendance was not routine practice amongst other CCGs.

MC reported on discussion at the Council of Representatives about improving use of YOR-Insight on the CCG website to make it more user friendly and support gathering intelligence from primary care.

MC commended the work undertaken by Healthwatch in relation to the Unity Health appointment system described in the report.

MC explained requirements relating to a Freedom to Speak Up Guardian advising that she would fulfil this role for the CCG, with an alternative person identified if required.

MC highlighted aspects of work with care homes now included in the report and noted linking with the GPs.

MC referred to the single item meeting of the Quality and Patient Experience Committee in August 2017 to discuss concerns around Child and Adolescent Mental Health Services. She advised that DN and her team were working with Tees, Esk and Wear Valleys NHS Foundation Trust on the agreed actions.

In response to clarification sought by KR in relation to the alleged abuse of soldiers by instructors at the Army Foundation College at Harrogate, MC advised that students could attend from the age of 16 years and the child safeguarding age limit was 18 years. MC explained that the outcome of the court case was awaited. She noted that children attended the college from all over the country, a large number of whom were Looked After Children, and they were the responsibility of the relevant CCG from the safeguarding perspective. NHS England commissioned health for the army but, as the college was a subcontracted provider, the position was as yet unclear. The army also had its own safeguarding board but had been unaware of any issues and best practice was not being followed at the college. Investigation continued to identify learning.

MC referred to previous concerns about children's homes in Selby advising that at present NHS Vale of York CCG had no children in these homes but the children were registered with local GP practices.

An issue had been highlighted around the fact that midwifery services did not routinely let GPs know that a woman was pregnant. Work was ongoing in this regard by the Local Medical Committee with NHS Hambleton, Richmondshire and Whitby and Harrogate and Rural District CCGs as a test site for improved ways of working.

MC reported that the Partnership Commissioning Unit realignment was ongoing but would take until February or March 2018 to complete. SP raised a concern that had also been raised at the Finance and Performance Committee about the delay in the final stage of transition and the impact on the service. TP stated that additional support had been put in place to help NHS Scarborough and Ryedale CCG who would look after the service until it transitioned.

AB referred to the ongoing discussion with the Council of Representatives regarding the care home work and the link to the £3 per head GP Forward View noting that a number of Practices had expressed concerns at the money being used to support this trial as it was designed to benefit all Practices which this specific work did not. MC explained that an amendment to the proposal was being considered by the Executive Committee and PM stated that discussion at the Council of Representatives had confirmed the position that the CCG would proceed with the £3 per head at risk and would, within the financial context discussed earlier, seek to deploy the resources on a locality basis to try and get the benefits of scale but with recognition of differing views between Practices. The resources would be made available to every Practice while trying to progress three or four areas of work with a view to embedding successes to ensure sustainable General Practice for the benefit of patients and a net financial benefit in the system.

The Governing Body:

Received the Quality and Patient Experience Report

11. Better Care Fund Update

AP presented the report which detailed the issues relating to submission of the 2017-19 Better Care Fund plans. He noted that the City of York Council and North Yorkshire County Council plans had not been approved due to a technical data error submission of zero NHS attributed delayed transfers of care for both NHS Vale of York and NHS Scarborough and Ryedale CCGs in an earlier return submitted by the A and E Delivery Board covering both areas. The national expectation was for delayed transfers of care to account for no more than 3.5% of bed days' utilisation; this presented a significant challenge across the system despite a number of plans to bring this to effect. The CCG and City of York Council had retrospectively applied to adjust this figure through the national Integration Programme Board and still awaited the outcome for this request. AP noted that both the NHS England regional team and local BCF manager had been extremely supportive of the intensive amount of additional work within the local systems to move the York and North Yorkshire plans to approval. AP agreed that a letter from PM and City of York Council to the national team and the regional team would be appropriate.

Members sought and received clarification on aspects of the Better Care Fund, including the fact that many of the schemes were closely linked to schemes in the winter plan; this included provision of community beds for step down and community IV. In response to PE seeking clarification of publication of the plans to enable primary care colleagues to be informed, AP advised that this would be through Health and Wellbeing Board processes.

In response to KR enquiring about any further update before the Health and Wellbeing Board, AP advised that a letter had been drafted as a proposed submission to the team. He expected this to go to the Health and Wellbeing Board.

PM commended Paul Howatson, Head of Joint Programmes, for his work on the Better Care Fund. His diligence and proactive work meant that the CCG and City of York Council were in a far better place than at the same time last year. PM also credited Elaine Wyllie, who as a former Strategic Programme Consultant with the CCG, had undertaken significant work in this regard.

The Governing Body:

1. Noted the issues detailed in the Better Care Fund report and supported the remedial actions being taken to address the issues.
2. Expressed continued support of the CCG's officers and partner organisations in relation to the Better Care Fund work.
3. Commended the work of Paul Howatson and Elaine Wyllie in respect of the City of York Council Better Care Fund.

12. City of York Safeguarding Children Board Annual Report 2016/17

In presenting this item MC advised that a challenge from the Safeguarding Children Board was whether the voice of the child was being heard sufficiently. She also referred to integrated commissioning with City of York Council and the need to ensure appropriate development and governance in this regard.

The Governing Body:

The Governing Body received the City of York Safeguarding Children Board Annual Report 2016/17.

13. City of York Safeguarding Adults Board Annual Report 2016/17

MC was presenting this report for information. She noted the infographic detailing the main findings and work of partners.

The Governing Body:

The Governing Body received the City of York Safeguarding Adults Board Annual Report 2016/17.

14. Committee Terms of Reference

Members welcomed the highlighting of proposed changes to the terms of reference.

The Governing Body:

Approved the amendments to the terms of reference of the Audit Committee, Quality and Patient Experience Committee and the Remuneration Committee

RECEIVED ITEMS

15. Audit Committee Minutes

The Governing Body:

Received the minutes of the Audit Committee held on 30 August 2017.

16. Executive Committee Minutes

The Governing Body:

Received the minutes of the Executive Committee held on 19 July, 16 August and 20 September 2017.

17. Finance and Performance Committee Minutes

The Governing Body:

Received the minutes of the Finance and Performance Committee held on 24 August and 28 September 2017.

18. Primary Care Commissioning Committee

The Governing Body:

Received the minutes of the Primary Care Commissioning Committee held on 19 September 2017

19. Quality and Patient Experience Committee

The Governing Body:

Received the minutes of the Quality and Patient Experience Committee held on 12 October 2017.

20. Medicines Commissioning Committee

The Governing Body:

Received the recommendations of the Medicines Commissioning Committee held on 9 August and 20 September 2017.

21. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 4 January 2018 at Pocklington Arts Centre, 22-24 Market Place, Pocklington, York YO42 2AR.

Any Other Business:

Appreciation was expressed to the Head of Communications and Media Relations for the live tweets during the meeting and to JB and SC for stepping in and doing the minutes.

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.

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>


NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 2 NOVEMBER 2017 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	<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • Review of capacity requirements for commissioning the children's agenda was ongoing 	MC	Ongoing

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
7 September 2017	Risk Update Report	<ul style="list-style-type: none"> PE to discuss with PM GP involvement for the Local Digital Roadmap 	PE/PM	
2 November 2017		<ul style="list-style-type: none"> Update to be reported at next meeting 	PE/PM	4 January 208
2 November 2017	Integrated Performance Report Month 6 2017/18	<ul style="list-style-type: none"> Executive Committee undertake the work discussed within its standing orders limit of £500,000 related to winter planning as a matter of urgency. 	PM and Executive Directors	

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Item Number: 5	
Name of Presenter: Phil Mettam	
Meeting of the Governing Body Date of meeting: 4 January 2018	 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	
<input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital- single acute contract <input type="checkbox"/> Transformed MH-LD- Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area	
<input checked="" type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input checked="" type="checkbox"/> North Yorkshire County Council	
Impacts- Key Risks	Covalent Risk Reference and Covalent Description
<input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	
Emerging Risks (not yet on Covalent)	
Recommendations The Governing Body is asked to note the report.	
Responsible Executive Director and Title Phil Mettam Accountable Officer	Report Author and Title Sharron Hegarty Head of Communications and Media Relations

GOVERNING BODY MEETING: 4 JANUARY 2018

Accountable Officer's Report

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

1.1 The CCG awaits information from NHS England that will outline the conditions to be applied for organisations in special measures. The CCG has placed itself into a position of self-improved turnaround. This involves developing a new model of acute commissioning, consolidating the approach across Vale of York and Scarborough and Ryedale CCGs. Additionally it will involve a planned 10% net reduction in running costs.

1.2 The financial forecast as at Month 8 is an in-year deficit of £16m which is in line with the financial plan approved by the Governing Body in April. That plan also included risk of £5m in addition to the planned £16m deficit making a total risk adjusted plan of £21.m. The current Month 8 report has a total risk adjusted deficit of £22.5m.

- Although the in-year financial position remains challenging, this indicates the CCG finances are stabilising, arresting the scale of deterioration seen in previous year. Indeed the forecast underlying position is broadly in line with where we ended 2016/17. The progress with cost reduction is reasonable and better than in the past.
- The CCG continues to build on the principles of the Capped Expenditure Process with NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust and recently submitted to regulators a jointly agreed strategic outline of a financial recovery programme for the healthcare system. This is intended to provide the foundation for a more developed programme for system reconfiguration across the locality as a sub-unit of the Humber, Coast and Vale Sustainability and Transformation Partnership.

2. Council of Representatives meeting

2.1 Among the agenda items at its latest meeting on 14 December 2017, members received the Accountable Officer's briefing and updates from the North, South and Central localities.

2.2 Members approved proposals to re-set the CCG Governing Body. This included the process to recruit a Clinical Chair and the recruitment of a clinician from each of the North, South and Central localities that will represent the needs of their population.

- 2.3 This move to clinical leadership within the CCG will play a significant factor in the enabling of NHS England to consider lifting the legal Directions. The current Lay Chair of the Governing Body is Keith Ramsay. It is expected that Mr Ramsay will help to facilitate a transition of the role of Chair to a clinician by April 2018 and that he will remain a highly valued lay member of the Governing Body.

3. Better Care Fund update

- 3.1 Formal notification of Better Care Fund Plan endorsement was received from the national team on the 21 December 2017 and partners will move to seek formal approval of the Section 75 agreement. Next steps are to confirm the governance arrangements of the North Yorkshire County Council and City of York Council Better Care Fund plans.

4. Local System Review

- 4.1 The Care Quality Commission (CQC) has published its report following its system review of health and social care in York. System partners have welcomed the CQC's recognition of the work to strengthen relationships, and that the Health and Wellbeing Board is well placed to support the future development of the health and social care system. It was also pleasing to see the findings recognise the valuable contribution of staff and the voluntary sector, plus the progress being made to modernise accommodation for older people.
- 4.2 Whilst there are positives, partners recognised that there is more to be done to find solutions in areas such as seven day working and carer recruitment. Work is already underway to address this with the recent appointment of a pathways manager and a commitment to seven day working to support hospital discharges. York faces challenges in recruiting to the health and care sector but it is a priority of the York skills plan and a partnership working group to help attract and retain people in the care sector has been set up.
- 4.3 Looking ahead we are working together across the health and social care system and voluntary sector to help us improve services and outcomes for residents across York.

5. York Armed Forces Covenant

- 5.1 York remains a garrison city with two barracks at Strensall that closes in 2021, Fulford Road that is earmarked for closure in 2031, and the RAF base at Linton-on-Ouse. There are also a number of former RAF communities in the Vale of York.

5.2 The CCG is working closely with partners and an ex-military project worker to support work that recognises the sacrifices made by the armed forces community. The NHS Constitution and its accompanying handbook have been updated to include the key health Armed Forces Covenant commitment of 'no disadvantage'. This ensures members of the armed forces community, including those serving, reservists, their families and veterans are supported, treated equally and receive the same standard of healthcare as other people.

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

6.1 Regular system-wide winter calls are being held with health and social care partners across York and Scarborough. On-Call Directors are required to dial into system calls at 10am on Saturdays and Sundays and report any exceptions to NHS England.

6.2 The CCG took part in two Loggist training courses in December 2017 which was also attended by York Teaching Hospital NHS Foundation Trust staff.

6.3 Also in December 2017, York Teaching Hospital NHS Foundation Trust, Yorkshire Ambulance Service, Public Health England and NHS England were involved in an Emergo Exercise to test out a Mass Casualty Event. York Teaching Hospital NHS Foundation Trust has agreed to share the findings and outcomes from the exercise with the CCG and these are expected soon.

6.4 The Tour de Yorkshire routes for 2018 have now been released. These do not impact on the Vale of York locality.

7. National plans and strategic issues

7.1 Full details have now been published of the £45 million fund to stimulate the use of online consultations announced in the General Practice Forward View. Every GP practice in England is eligible to access the support from this national funding which will be allocated at CCG level. During autumn/winter 2017, a series of webinars will provide opportunities for practices and commissioners to learn more and ask questions.

7.2 NHS England organised a promotional week in November 2017 to encourage more people from black and minority ethnic (BME) backgrounds to give feedback on their experience of cancer treatment as they are currently under-represented. NHS services are asked to support the initiative on social media during the promotional week and beyond.


7.3 The rollout of free Wi-Fi capability to GP practices across England is proceeding at pace with the target finish date for all CCGs the end of December 2017.

- 7.4 Findings have been published by the Care Quality Commission from the latest survey on patient experience of community mental health services. More than 12000 people took part who had been seen for mental health conditions last autumn. Around two-thirds reported a positive experience of overall care but responses suggest scope for further improvements in a number of areas including: crisis care, access and coordination of care, involvement in care and monitoring the effects of medication. The survey contributes to NHS England's Overall Patient Experience Score, which has been updated alongside a diagnostic tool for understanding patient experience data.
- 7.5 To support commissioners in effectively discharging their delegated functions, NHS England has published the Primary Medical Care Policy and Guidance Manual (PGM) previously the 'Policy Book'. The PGM has been designed to support the principle of proportionality. By applying the policies and guidance contained in the PGM, commissioners should be able to respond to local issues within a national framework.
- 7.6 All commissioners are required to have systems in place for the 'fair processing' of patient objections. A revised Assuring Transformation (AT) information leaflet has been made available. The CCG has confirmed that it has made the information leaflet available to patients and their families/carers; that their mental health/learning disability hospitals are making the new leaflet available to inpatients/families and that there are systems in place to manage patient objections.

8. Recommendation

- 8.1 The Governing Body is asked to note the report.

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Item Number: 6	
Name of Presenter: Phil Mettam	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Board Assurance Framework Update Report	
Purpose of Report For Approval	
Reason for Report To provide assurance to the Governing Body that effective systems and procedures are in place to discharge CCG statutory and mandatory duties and obligations and that risks are strategically managed, monitored and mitigated. This report provides: <ul style="list-style-type: none"> • an update regarding the refresh of the Board Assurance Framework, (BAF) for 2017–18 • an overview of latest performance against Improvement and Assessment Framework, (IAF) indicators that inform both the BAF and risk registers • presents the CCG’s Statement of Risk Appetite for approval; 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	
<input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Reducing Demand on System <input checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract	<input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability
Local Authority Area	
<input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council	<input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council
Impacts/ Key Risks	Covalent Risk Reference and Covalent Description
<input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	All corporate risks escalated to the Governing Body.

Emerging Risks (not yet on Covalent)

Multi-Specialty Community bed provision

Recommendations

The Governing Body is requested to:

- approve the CCG's Risk Appetite Statement;
- review risks arising and to consider risk appetite for events and high scoring risks;
- receive the progress report regarding the refresh of the CCG's Board Assurance Framework.

Responsible Executive Director and Title

Phil Mettam, Accountable Officer

Report Author and Title

Pennie Furneaux, Risk and Assurance Manager

Annexes (please list)

Annex A: CCG Statement of Risk Appetite

Annex B: Events Report

Annex C: Corporate Risk Register January 2018

GOVERNING BODY

BOARD ASSURANCE FRAMEWORK UPDATE REPORT

4 JANUARY 2018

1. Progress in Developing the CCG's Board Assurance Framework

1.1. The CCG's Board Assurance Framework, (BAF) is under review to ensure that it correctly aligns with initiatives and work streams. Risk management ownership has been aligned to the committee risk structure and is outlined in the Risk Management update section within this report.

1.2. The BAF aligns with the CCG's priorities identified in the Operational Plan. The three strategic priorities identified to staff at the November briefing session are as follows:

- Financial position
- Meeting national standards
- Patient safety

and the three strategic paths that the CCG needs to achieve are:

- Primary care and development of general practice
- Joint commissioning
- Acute transformation

1.3. The BAF also references the appropriate Improvement and Assessment Framework Indicator where appropriate.

1.4. A draft framework for the BAF is under development for presentation to the Executive Committee for approval.

1.5. The CCG BAF will incorporate the final impact assessment of the following CCG assurance priorities:

- Refreshed national CCG IAF with agreed exec and clinical ownership (aligned with the new CCG structure)
- CCG final commissioning intentions for 2018/19 onwards
- Any refreshed national planning guidance (this has not been clarified yet but may include changes to the national acute contract and will undoubtedly reflect changes in contracting frameworks in the STP/ nationally as health systems move to non PbR frameworks and accountable care)
- The outcomes of on-going audits – contracting, quality assurance and performance are all underway
- The refreshed CCG/ system engagement programme
- The York and Scarborough system medium term plan including any acute service review for this part of the STP
- The on-going turnaround work across both VoY and S&R CCGs
- The on-going alignment of the VoY and S&R CCGs planned care programme and teams to support acute reconfiguration

1.6. It is therefore proposed that the:

- CCG BAF is further developed as the above priorities;
- contacts are finalised; and
- the Executive Committee takes responsibility for finalising the BAF to support approval by Governing Body in March 2018.

All risks will then be fully refreshed in line with the BAF and actively managed by Executive Directors.

CCG IMPROVEMENT AND ASSURANCE FRAMEWORK UPDATE REPORT

2. Integrated Assurance Framework Guidance

- 2.1 NHS England broadcast a webinar to advise CCGs regarding developments impacting the CCG Improvement and Assessment Framework (IAF) on the 14th December.
- 2.2 NHS England advised that the assessment framework for 2017/18 remains aligned to four assessment domains as follows:
- Better Health
 - Better Care
 - Sustainability
 - Leadership
- 2.3 This system of assessment links NHS Constitutional requirements, CCG statutory duties and core performance/finance metrics.
- 2.4 For 2017/18 the overall number of PIs has reduced from 61 to 51. The focus of changes to PIs relates to the aim of releasing resources in areas where CCGs have improved their performance and re-focussing on areas of priority.
- 2.5 The CCG's overall rating will be assessed by balancing performance in each of the domains: metric performance (weighted 50%) with the finance and leadership domains (25% each).
- 2.6 The importance of the following was stressed in order to achieve a good rating:
- lay member awareness of the assessment framework and implementation of guidance; and
 - patient/public engagement, as evidenced through the corporate website and Governance Body Papers/Board Assurance Framework
- 2.7 It is expected that the CCG will be receiving further guidance and advice over the next week or so regarding 2017/18 assessments.
- 2.8 Looking forward to 2018/19, NHS England advised that there will be two consecutive assessment regimes as follows:

- CCG IAF for statutory CCG bodies; and
- Integrated SOF (Single Oversight Framework) for Accountable Care Organisations.

3. Quarter 1 CCG Improvement and Assessment Framework Performance

3.1 The Quarter 1 2017/18 IAF Dashboard was published on the 28th November.

3.2 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.
- Diabetes: attendance at structured courses
- Improving Access to Psychological Therapies: Recovery rates
- Improving Access to Psychological Therapies: Access
- Early Intervention in Psychosis 2 week referral
- Learning Disabilities Health Check
- Diagnosis rate for people with dementia.
- A&E 4 hour Performance
- Population Use of Hospital Beds Following Emergency Admission
- CHC Assessments taking place in acute setting
- Effectiveness of working relationships

3.3 Management is analysing the data and looking to agree a plan to deliver improvements in prioritised areas.

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

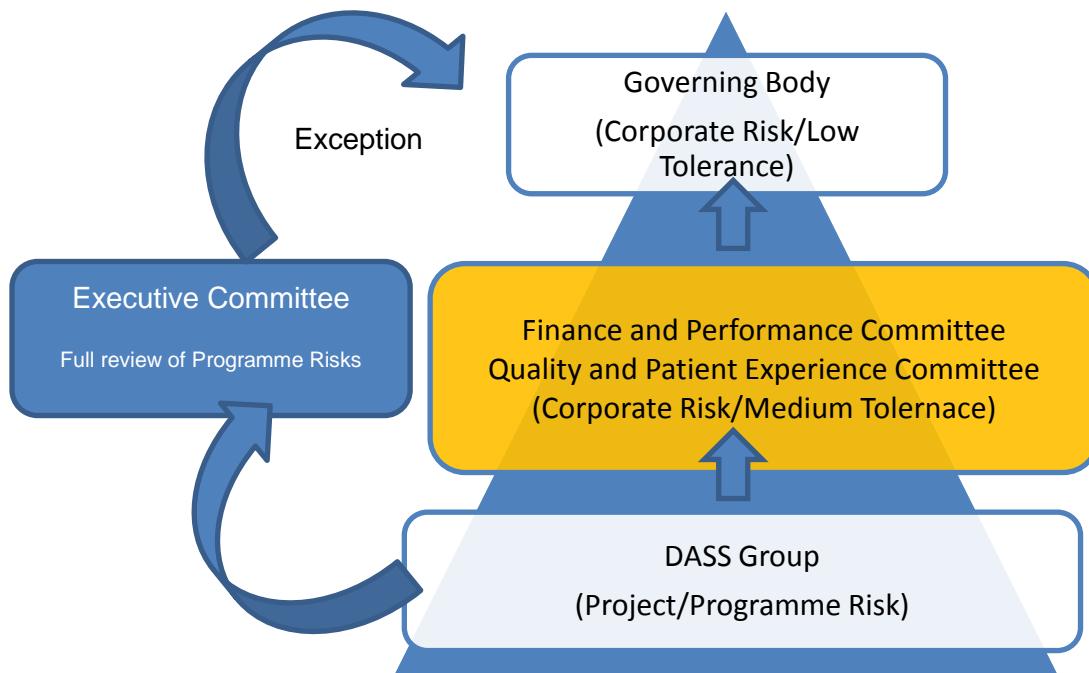
3.5 The next update to the dashboard is expected to be published on the 22nd January 2018.

RISK MANAGEMENT AND CORPORATE RISK UPDATE REPORT

4. Risk Management: Strategy and Policy

4.1 There are established systems in place to monitor and manage risks arising through sub-committees of the Governing Body and working groups. A risk presentation was made to the December meeting of the Governing Body. The purpose of the presentation was to facilitate evaluation the organisation's risk appetite. This resulted in the formulation of a Risk Appetite Statement that is presented along with this report for approval.

- 4.2 Risks are escalated through a “pyramid” of risk. Sub-committees of the Governing Body are required to confirm the risks that need reporting to the Governing Body.



- 4.3 The CCG’s Risk Management Strategy and Policy has been reviewed and changes made to reflect revisions to the organisational structure and to include a defined approach to risk appetite. The approach to risk appetite includes a CCG Risk Appetite Statement which, following consideration by Governing Body members at the December Governing Body Workshop, is appended for approval. The Risk Management Strategy and Policy will then be updated accordingly and presented for approval.

Annex A: CCG Statement of Risk Appetite

5. Corporate Events

- 5.1 There are five corporate risks that are listed as events on the CCG’s risk registers; four of these continue to be on-going for number of months.
- 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; and
 - Failure to achieve the Dementia 67% coding target in general practice

Three out of four refer to performance against constitutional targets.

- 5.2 Delivery of BCF targets is also identified as an event for the second month running, however; this event is considered to have low/medium impact on the healthcare system. The impact is assessed as an inability to deliver the benefits of the BCF programme which will result in continued pressure on the wider healthcare system.
- 5.3 Full details are provided at **Annex B: Events Report**
- 5.4 NEW: A previously unidentified risk materialised during December relating to Multi-Specialty Community bed provision in the Ryedale area. The scope and impact of risks are currently being prepared and a verbal update will be provided to members.

6. Corporate Risk Register

- 6.1 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.
- 6.2 A number of risks that were reported to last month's Governing Body are now being managed and monitored under the sub-committees of the Governing Body, as per the revised policy. Red risks moved to sub-committee management are detailed in the table on the next page.
- 6.3 Minutes of the relevant committees will provide assurance regarding risk management and monitoring process.
- 6.4 Risks will be escalated or de-escalated in line with sub-committee recommendations.
- 6.5 Full details of corporate risks escalated to Governing Body for consideration are detailed at **Annex C: Corporate Risk Register January 2018**

Profile of Corporate Risks Escalated to Governing Body as at 20th December 2017

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

Current Profile		Profile at last meeting	
	<p>Headline Red Risks:</p> <ul style="list-style-type: none"> • Delivery of QIPP schemes • Maintaining expenditure within allocation • Delivering the Local Digital Roadmap agenda <p>(Full details are provided per Annex C)</p>		<p>Red Risks moved to sub-committee review:</p> <ul style="list-style-type: none"> • CAMHS Child Autism • Divergent healthcare strategies leading to unsustainable financial plan. • Delivering 1% surplus • CHC compliance • Transitioning staff • 18 week RTT wait

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

7. Emerging Risks

7.1 Following the meeting of the Finance and Performance Committee on 21st December; risks relating to Anti-Coagulation Services and currently managed through programme/team risk registers are being reviewed for escalation to the corporate risk register. There are currently two risks detailed in risk registers as follows:

- There is a risk that the current acute provider may serve notice on the contract resulting in patient care transferring to General Practice causing potential issues with their capacity, capability and readiness to provide a full service for all anti-coagulation patients. (Finance Team Risk Register)

- Some GP practices may not be willing to provide Anti-coagulation services potentially resulting in service variation. (Planned Care Programme Risk Register)

7.2 A full assessment of Anti-Coagulation Service risk, including the score and scale of impact is currently in hand and also identification of related risks.

Risk Appetite Statement

NHS Vale of York CCG

This Risk Appetite Statement establishes risk tolerance in the following four categories:-

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

The CCG considered a number of factors to determine risk appetite. With due regard to the risk appetite, when a risk is recorded in the register, it will be categorised as high risk (red), medium risk (amber) or low risk (green) and will be based on an assessment of risk by staff in possession of this statement of risk appetite.

The risk appetite of the CCG was established by the CCGs Governing Body using the criteria below.

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

Annex A

	Approach to Achieving aim/objectives	Potential reward/benefit from risk taking	Organisational culture
Averse	Safe; exposure to only the very lowest levels of risk	Very low	Little or no empowerment beyond most senior team considerable control over all activities
Cautious	Guarded; as little risk as reasonably possible	Low	Empowerment to senior and key middle managers; strong control over most activities
Moderate	Balanced; exposure to middle-ground risks	Medium	Empowerment to front-line managers; control over some activities, more latitude for others
Open	Creative; elevated levels of risk exposure	High	Empowerment to all managers, supervisors and selected staff; control over small core of activities, considerable latitude for others
Hungry	Pioneering; substantial levels of risk exposure	Extremely High	Widespread empowerment to all managers and staff; very few controls, individual initiative strongly encourage and supported

Overall Risk Appetite Statement

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.

This statement must be kept under review as the CCGs mission, objectives and values develop over time and positions change.

Annex A

Risk Category	Risk Appetite
Safety Risk	Low
Compliance Risk	Open
Financial Risk	Open
Service Delivery Risk	Open

Safety Risks

The CCG has a low appetite for risk relating to safety. This will cut across a number of areas including where constitutional targets not being met puts patient safety at risk as well as the commissioning of safe services. The CCG must understand the impact of decisions on patients and the safe delivery of services must be the paramount consideration of the organisation.

Whilst the CCG has a moderate tolerance of risk where there are individual concerns about a patient's safety, for example one care home is closing and the CCG has one patient who is within that home and may be at risk either of poor care or of requiring a move; the CCG maintains a low tolerance to a situation where this highlights a more systemic issue with care home provision. The CCG therefore requires the individual incident to be highlighted and appropriately recorded but also the broader corporate and strategic issue this incident may highlight to be appropriately escalated.

Compliance Risks

The CCG has a moderate appetite for compliance risks except where these risk the safety of patients. The CCG understands that it is required to comply with its duties and obligations under legislation and the NHS constitution however the CCG is content that necessary plans are in place to address these as far as this is within the CCGs control. For this reason the CCG is content to accept a level of risk which is associated with a failure to comply with these requirements as steps are taken to address these.

Whilst this is the case the CCG is keen to ensure that where a failure to comply with a requirement directly impacts on patient safety, the CCG has a low appetite for these risks. For example a patient waiting longer than four hours in A&E who suffers no harm as a result is tolerable; a patient who waits longer than four hours in A&E and as a result of this wait suffers harm is intolerable.

Finance Risks

The CCG is currently in deficit and is in Legal Directions in part as a result of this. The CCG therefore has an open risk appetite for financial risks. Broadly speaking this means that the CCG will tolerate a risk of financial loss of between £100,001 and £1,000,000 however this is dependent upon the circumstances. For example where this is unplanned






Annex A

expenditure that ought to have been anticipated had proper horizon scanning or risk management been undertaken this is less tolerable than a change in system position etc.

Service Delivery Risks

The CCG is open to risk to service delivery, again, except where this compromises patient safety. For example should staffing be an issue which may cause difficulties with meeting service needs, the CCG is tolerant of this and does not seek escalation of the issues above operational managers. The CCG is concerned where this puts patients at risk however.

Events Report-Risks that Have Materialised

Code & Title	Operational Lead	Lead Director	Latest Note	Latest Note Date	Impact	Status
JC-PROG.02 IAPT - Failure to achieve sustainable access and recovery targets within acceptable waiting times	Sheila Fletcher; Paul Howatson; Beverley Hunter	Executive Director Transformation and Delivery	The CCG is working with TEWW and the Intensive Support Team to monitor progress against the recommendations they made. Weekly conversations are being held between the CCG and provider to address the access and waiting times concerns.	14 Dec 2017	4	
PLC.05 Constitution target – Planned Care - VoYCCG failure to meet 18 week RTT target	Fliss Wood	Executive Director System Resources and Performance	95% of requested theatre lists have gone ahead year to date, however the total number of requested remain 19% lower than the list identified in the SLA . This may be due to a combination of leave, consultant vacancy and nurse staffing shortages. The Trust is working with an external consultant in order to increase in session productivity and efficiency across the Trust theatre provision.	05 Dec 2017	4	
JC.24 Risk of increased demand on local system following the Inadequate CQC report on The Retreat	Jenny Brandom	Executive Director Quality and Nursing	A remedial action plan is in place and regular meetings and assurance visits are undertaken. The action plan is progressing well and regular updates are provided to the Governing Body. The CQC will be carrying out a planned inspection on 7/8/9 November 2017. Inspection carried out – await final report.	13 Dec 2017	4	
JC-PROG.01 Dementia - Failure to achieve 67% coding target in general practice.	Paul Howatson	Executive Director Transformation and Delivery	Work continues with TEWW and system partners to generate a collaborative action plan to tackle dementia diagnosis and the overall pathway. Colleagues from the team have booked further meetings with practices to encourage the running of the dementia coding toolkit. A further meeting of system partners to review the whole dementia pathway across health and social care has been arranged for 8th January to ensure that necessary improvements are made.	13 Dec 2017	4	
JC.16 Delivery of BCF targets is dependent on partners and outside the immediate control of the CCG. There is a potential risk that partners are unable to deliver agreed trajectories	Paul Howatson; Beverley Hunter	Executive Director Joint Commissioning	The BCF plans for North Yorkshire and York have now been recommended for approval by the Integration Partnership Board and NHS England after satisfying a number of additional requirements - currently awaiting formal approval. Further additional evidence was required in relation to the plan for York. Once received the CCG and CYC can then formally agree the Section 75 documentation.	14 Dec 2017	3	

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CORPORATE RISK REGISTER JANUARY 2018

Risk ID and Summary	Description	Potential for patient harm, impact on service/care delivery	Mitigating Actions	Latest Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
ES.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, MHL & 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. Initial recommendations from the confirm and challenge sessions in November have been presented to the Executive Committee in December. A number of different actions will be implemented with the CCG programmes and teams in January 2018.	Caroline Alexander	Accountable Officer	16	8		15-Dec-2017
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	Following the breakdown of the proposed CEP schemes the CCG has deteriorated its forecast deficit by £9.7m for its share of the control total shortfall to a £16.0m deficit in 2017/18. The CCG is implementing the transformational programmes identified as part of its MTFs and the System Transformation Programme laying the foundations for the delivery in future years with effect from 1st April 2018.	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		13-Dec-2017
PLC.05 Constitution	The % of patients on a completed admitted pathway within 18 weeks	Delays in patients receiving treatment	October 2017 performance is 87.4%	95% of requested theatre lists have gone ahead year to date, however	Fliiss Wood	Executive Director System	16	12		06-Dec-2017

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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
target – Planned Care - VoYCCG failure to meet 18 week RTT target	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.		against incomplete target of 92%	the total number of requested remain 19% lower than the list identified in the SLA . This may be due to a combination of leave, consultant vacancy and nurse staffing shortages. The Trust is working with an external consultant in order to increase in session productivity and efficiency across the Trust theatre provision.		Resources and Performance				
ES.04 Local Digital Roadmap: The CCG may not develop adequate enabling programmes of work to deliver the Local Digital Roadmap agenda.	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 funding opportunities and this may result in delays in delivering the national requirements.		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, 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.	Meeting scheduled with Scarborough Ryedale CCG to reset this work. Still concerns around clearly identified clinical leadership and resource to engage with Providers to move this programme forward. Opportunities to engage Providers around the LDR Universal Capabilities that deliver operational benefits.	Phil Mettam	Accountable Officer	15	9		18-Oct-2017
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	Michelle Carrington	Executive Director Quality and Nursing	12	2		06-Dec-2017


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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
				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						
ES.09 Vacancies in the Executive Team may potentially impact delivery of CCG objectives	There is a lack of capacity to delivery key strategic programmes, in particular executive lead for Primary Care development and transformation. This may lead to difficulties in developing a Primary Care strategy and promoting work streams to fully develop care pathways outside hospital settings with the appropriate contractual frame works to drive forward transformation and improve quality. A range of options have been implemented to cover these gaps.			The turnaround proposals for the CCG are being considered by NHS England and are under on-going review within the CCG	Phil Mettam	Accountable Officer	12	8		06-Dec-2017
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	<p>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 employment of a Turnaround Director to review 2017/18 delivery and actively pursue additional proposals for 2018/19, such as bringing forward RightCare.</p> <p>The CCG continues to work on the aligned incentive principles agreed with S&R CCG and YTHFT with a view to developing an alternative form of contracting for the 1st April 2018. A key part in enabling this will be the agreement of the 2017/18 year-end position. An initial alignment exercise has been undertaken with a view to trying to do something before the end of</p>	Michael Ash-McMahon	Executive Director Chief Finance Officer	12	5		11-Dec-2017


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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
				2017 and allow focus to shift to future years.						
ES.32 Lack of wider stakeholder support for delivery of plans	Articulation of a clear vision that all stakeholders support. The impact for the CCG is that it is dependent on strong joint working with many of its partners and from local people in order to effectively address the financial deficit and transform services to improve population health.	The impact for patients is that they are unable to understand how services are and will be delivered to meet their needs and improve their health now and into the future. Local people will not be able to understand the public health needs locally and how people need to, and can be enabled to, care for themselves more effectively and maintain good health for longer.	The CCG has now transitioned into delivery of its 2017/18 programmes as outlined in the Operational Plan. Many of the work streams are being developed collaboratively with partners including the programmes for unplanned care and planned care which are being jointly scoped and delivered with YTHFT under the Heads of Term for the contract. Additionally, the CCG will work to clearly identify the impact (benefits and improvement in outcomes) on the local populations in each of the three ACS localities as requested at CYC Scrutiny meeting in March 2017. This includes a request from the CCG to partners to jointly consider how the system will support (fund or otherwise) non-recurrent investments required to support system delivery. This will be shared on a regular basis as the programmes are developed. The CCG AO meets regularly with the local councillors across the Vale of York 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	The CCG continues to work with partners to develop a system medium-term plan. This system plan remains at Executive Programme Board level and engagement has not been jointly mobilised with partners. The CCG is finalising its commissioning intentions and these will be presented to Executive Committee in December and Governing Body in January before being shared with partners.	Caroline Alexander	Executive Director Transformation and Delivery	12	12		15-Dec-2017

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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
			local people and organisations. The first lay member summit was held on Friday 7th April.							
ES.34 There is a potential risk that the Constitution may not be fit for purpose and adequately define statutory duties.	The current constitution does not reflect structure. Whilst in legal directions interim arrangements were acceptable. Now Accountable Officer has been recruited on a permanent basis the CCG needs to start to resolve this. Whilst the structure does not reflect the constitution the decision making power of the CCG is more restricted and potentially open to challenge.		The CCG constitution review is underway to reflect the current structure. Currently the CCG is operating within the confines of legal directions and therefore has mitigated the risk of the outdated constitution however the CCG needs to develop an appropriate constitutional framework as a matter of urgency. There remain some outstanding matters for resolution before the constitution can be approved by Council of Members and sent to NHSE for approval.	Additional revisions are being made to the Constitution and will be presented to the January meeting of the Governing Body.	Abigail Combes; Helena Nowell	Accountable Officer	12	4		04-Dec-2017
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 work streams. 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.		Shaun Macey	Executive Director Transformation and Delivery	12	4		06-Dec-2017
ES.37 General Practice Capacity				Strategic plans to deliver financial sustainability are dependent on redesigning system pathways to manage care closer to home for	Shaun Macey	Executive Director Primary Care and Population	12			20-Dec-2017

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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
				<p>patients, and reduce avoidable secondary care activity.</p> <p>This is predicated on a shift of workload out of hospitals and into GP-led services in the community.</p> <p>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.</p>		Health				
ES.38 System Estates Strategy				<p>In order to support strategic plans around moving activity and funding around the system, and meeting demographic growth, the CCG needs to develop an overarching strategic estates strategy for the system that Providers are aligned with.</p> <p>This is a complex piece of work, and will include NHSPS, third-party owned, and privately-owned premises.</p> <p>Steph Porter leading from a CCG perspective.</p>	Michael Ash-McMahon; Shaun Macey	Executive Director Chief Finance Officer	12			20-Dec-2017
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.	<p>YHFT is prioritising timed pathways with under performance on 62 Day targets focusing on Lung and Upper GI.</p> <p>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.</p> <p>RCA's are undertaken on all 62 Day breaches and 104 day clinical harm reviews which are reviewed by the YHFT Cancer Board.</p>	<p>Cancer Alliance funding has increased diagnostic capacity across the STP. Funding has also been allocated to increase the number of radiographers and training for reporting to reduce delays in the pathways. Demand and capacity modelling is being undertaken across York & the Humber to improve timed pathways and capacity.</p>	Fliss Wood	Executive Director System Resources and Performance	12	6		05-Dec-2017

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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
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.	delayed diagnosis may impact on the staging of the cancer and potential poorer patient outcomes, and more complex care required.		NEW RISK: The 2 week fast track target has not been met since February 2017 due to problems recruiting Dermatology consultants.	Fliss Wood	Dr. Dan Cottingham	12	4		06-Dec-2017
JC-PROG.01 Dementia - Failure to achieve 67% coding target in general practice.	Non delivery of mandatory NHSE targets Lack of sufficient providers in some areas resulting in delayed transfers of care or limited choice available to patients meeting new standards	Further pressure from NHS England to rectify this. Service users may not be appropriately flagged and therefore on-going referrals from primary care will not have the relevant information to make reasonable adjustments for their carers support.	CCG/PCU leads have devised a comprehensive action plan. CCG to provide focussed support targeting the larger practices with the lowest coding rates. All practices will be encouraged to re-run the toolkit and review all records identified. Controls include: Programme meeting and TEVV CMB	Work continues with TEVV and system partners to generate a collaborative action plan to tackle dementia diagnosis and the overall pathway. Colleagues from the team have booked further meetings with practices to encourage the running of the dementia coding toolkit. A further meeting of system partners to review the whole dementia pathway across health and social care has been arranged for 8th January to ensure that necessary improvements are made.	Paul Howatson	Executive Director Transformation and Delivery	12	9		13-Dec-2017
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.	Performance continues to be better than previously in the year, with an average for November of 91%, above trajectory. Improvements in discharge and numbers of stranded patients are hard to sustain but all teams are working. Additional funding through spot purchase and support for CHC and MH patients has been identified and approved as part of winter planning and an additional bid for Budget funding went in on the 1st December.	Becky Case	Executive Director Transformation and Delivery	12	8		05-Dec-2017
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		13-Dec-2017
JC.27 There is	The current risk relates to the BCF	Further restrictions in	The CCG is	The North Yorkshire plan has been	Paul Howatson	Executive	4	9		13-Dec-2017

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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
a risk that jointly agreed BCF plans for CYC and NYCC HWB footprints may not be in place in a timely and appropriate manner	plans failing the Qtr 3 assurance process by NHS England placing the system in escalation to the National Team, potentially placing the CCG under a financial pressure should NHS England reduce the iBCF funding. The CCG may fail to agree the investment levels and range of schemes in VOY area due to financial pressures being managed by system and partner organisations.	the use of funds allocated to BCF and iBCF leading to a destabilised system and reduced capacity.	<ul style="list-style-type: none"> . maintaining an open dialogue with partners . using national resources to support local discussions and development of 2017/19 plan . seeking to use additional social care grant monies to support health investments in 2017/19 (composition of plan in negotiation with the Local Authority 	approved and we are just awaiting the formal approval of the York plan from the national team. It has now been approved by the region. This can be removed from the Corporate Risk Register in January.		Director Transformation and Delivery				

Item Number: 8	
Name of Presenter: Phil Mettam	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Report Title – Commissioning Intentions 2018/9	
Purpose of Report For Information	
Reason for Report This paper provides an update for the Governing Body on the Commissioning Intentions for 2018/19.	
Strategic Priority Links <input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Reducing Demand on System <input checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description
Emerging Risks (not yet on Covalent)	
Recommendations The Governing Body is asked to support the proposal that the Governing Body Part II consider and approve the commissioning intentions for issuing week commencing 8 January 2018	

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 CCG COMMISSIONING INTENTIONS 2018/9

1. Introduction

The Governing body received a paper on 7th December that outlined the approach to the development of Commissioning Intentions for the Vale of York CCG for 2018/19.

This paper provides a further update and seeks approval from the Governing Body that Part II of the Governing Body considers and approves the Commissioning Intentions, for issuing week commencing 8th January 2018 (in line with the timescales previously advised).

2. Purpose of Commissioning Intentions

Commissioning Intentions identify what will be done in 2018/19 to ensure that that the services that are 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 priorities. They are also of interest to patients and the public and reflect the priorities that were identified by people in the Vale of York at engagement events that took place in July and August 2017.

3. Commissioning intentions 2018/18

As reported to the Governing Body on 7th December 2017, the scope of the document covers; national, Humber Coast and Vale Sustainability and Transformation Partnership (HCVSTP) priorities, and the joint approach with Scarborough and Ryedale CCG.

The Vale of York CCG priorities are then described in the context of the need to focus on the core requirements of patient safety, achievement of national and constitutional standards and achieving financial sustainability, while making progress on the three strategic objectives; development of primary care, joint commissioning with Local Authority partners and acute transformation.

The document is structured as follows;

Part 1 - provides an overview of how the annual commissioning intentions fit with the strategy for system change i.e. the longer term strategic direction for the CCG and the wider Health and Care system.

Part 2 - is in two sections;

Section A: Strategic context

This covers the following;

- The relationship between the CCG commissioning intentions and national and STP priorities, as well as joint work across York and Scarborough (in particular the approach to acute transformation)
- The document also covers how the themes that emerged from the Patient and Public engagement events that took place during 2017 have been used to inform prioritisation.
- Commissioning Landscape/the financial context; there is detail on how the financial deficit will be addressed, how this fits with the long term financial strategy and specific priorities for 2018/9, covering the approach to the aligned incentive contract, mental health and learning disability services, general practice and primary care, joint commissioning, the priorities for Quality Innovation Productivity and Prevention (QIPP) and how efficiencies to commissioning will be achieved through joint work with Scarborough and Ryedale CCG (S&R CGG).
- Issues that relate to regulation are also covered, in particular the aim to take the CCG out of legal directions in 2018/19 and to respond positively to the recent CQC review.
- Clinical Priorities that reflect the opportunities for acute transformation (both on a broad scale and at an individual pathway level) and those presented by Right Care for improvements in efficiency and clinical outcome are also outlined.

Section B: Commissioning Priorities for 2018/9

This covers specific priorities for 2018/19, in the following areas;

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

The CCGs three strategic pathways (development of primary care, joint commissioning with Local Authority partners and acute transformation) and the Operational Planning Guidance and “nine must do’s” were used as a framework for this.

4. Conclusion and Next Steps


The commissioning intentions are ambitious but realistic, subject to approval; the next steps are to;

- I. Quantify these intentions to enable contractual changes where these are needed
- II. Develop more detailed plans these are not yet in place;
- III. Work with commissioners within HCVSTP to align commissioning plans and contractual arrangements

5. Recommendations

The Governing Body is asked to support the proposal that the Governing Body Part II consider and approve the commissioning intentions for issuing week commencing 8th January 2018

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Item Number: 9	
Name of Presenter: Dr Kev Smith	
Meeting of the Governing Body	 Vale of York Clinical Commissioning Group
Date of meeting: 4 January 2018	
Personal Medical Services Premium and £3 per Head – Proposal from Council of Representatives	
Purpose of Report To Ratify	
Reason for Report At the December meeting of the Council of Representatives, the following principles were proposed by member Practices around the process for the distribution of Personal Medical Services (PMS) premium and General Practice Forward View £3 per Head funding streams for the 2018/19 financial year. These principles will be taken to the January meeting of the Primary Care Commissioning Committee for approval re. i) the delegated PMS premium funding, and ii) their strategic alignment within the Primary Care programme. The Governing Body is asked to ratify these principles and approve the release of £3/head funding in accordance with the NHS Operational Planning and Contracting Guidance 2017-2019.	
Strategic Priority Links <input checked="" type="checkbox"/> Primary Care/ Integrated Care <input type="checkbox"/> Planned Care/ Cancer <input type="checkbox"/> Urgent Care <input type="checkbox"/> Prescribing <input checked="" type="checkbox"/> Effective Organisation <input checked="" type="checkbox"/> Financial Sustainability <input type="checkbox"/> Mental Health/Vulnerable People	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> City of York Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description

Recommendations

N/A

Responsible Executive Director and Title	Report Author and Title
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Dr Kev Smith, Director of Primary Care and Population Health	Shaun Macey Head of Transformation & Delivery
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PMS Premium and £3 per Head – Proposal from Council of Representatives

1. Background

NHS England undertook a review of PMS contracts in 2014 and established a programme of work to phase out PMS premium payments to Practices over a 4 year period on the understanding that this funding would be reinvested into General Practice. The PMS premium was originally intended to fund Practices to deliver services over and above core GMS requirements. This 4 year transition period will come to an end in April 2018, with approximately £313,000 of PMS premium coming back to the CCG on a recurrent basis for reinvestment into Practices. In its fully delegated Primary Care Commissioning capacity, the CCG reviews and approves the use of this funding on an annual basis through its Primary Care Commissioning Committee.

The General Practice Forward View £3 per Head funding stream was established by NHS England as part of the NHS Operational Planning and Contracting Guidance 2017-2019¹. This is non-recurrent funding which CCG's are required to provide from within their NHS England allocations for CCG core services. This investment should commence in 2017/18 and can take place over two years as determined by the CCG - £3 in either 2017/18 or 2018/19, or the funding can be split over the two years. The CCG's Council of Representatives has proposed that this funding is made available from the start of the 2018/19 financial year. The net amount of this funding across NHS Vale of York CCG Practices with a combined list size of approximately 354,000 patients is £ 1,062,000.

2. Proposal from the Council of Representatives

The following proposals apply to 2018/19 PMS premium and £3/head funding streams and were drafted by GP and Practice Manager locality leads on 13th December 2017, and then refined and agreed by the Council of Representatives on 14th December 2017.

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>

2.1. PMS Premium and £3 per Head

- PMS is recurrent funding and is ring-fenced so not subject to the same constraints/requirements as the £3/head funding. This could be used for services that are over and above core GMS requirements, to support sustainability of General Practice.
- £3/head is non-recurrent, and should be used to fund transformational projects that meet population needs, sustain General Practice and deliver cash savings to ensure longevity of a project and be supported by the CCG on an on-going basis.

2.2. Principles

- 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 2 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

2.3. Next Steps

- Individual Practices will be informed of their indicative share of a locality allocation
- The locality will then facilitate the development of proposals for the use of this funding and Practices will then agree which locality proposals their indicative funding will support
- Projects should be population centred – can start small to test, but ultimately should benefit all patients in a locality
- Localities will peer-review projects and submit a locality proposal that may consist of more than 1 project

At the 14 December 2017 meeting of the Council of Representatives, agreement was reached to:

- Work as localities
- Collaborate across Practices

- Present proposals to Primary Care Commissioning Committee for final sign-off
- Maintain current 3-part split of PMS funding

Due to potential conflicts of interest, it was agreed that the proposal to use national allocation weightings to determine locality funding would be taken to the Primary Care Commissioning Committee for decision alongside other potential options for weighting.

3. Financial position


The £3/head funding is not currently sat in a separately identified, uncommitted investment reserve. In the 2017-19 financial plan the CCG provided for the £3/head investment in full in 2017/18. However, this investment was subject to the achievement of associated QIPP schemes.

The decision needs to be seen alongside the NHS Operational Planning and Contracting Guidance 2017-2019 requirement to simply make this available in full over 2017-19 without a specific, scheme by scheme return on investment. However, the principles articulated from the Council of Representatives above should provide the commitment and assurance needed that there will be additionality to support the CCG's work to developing the out of hospital agenda and transform secondary care.

4. Approval

The Governing Body is asked to ratify these proposals from the Council of Representatives and approve the release of the £3/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.

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Item Number: 10									
Name of Presenter: Tracey Preece									
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group								
Financial Performance Report Month 8									
Purpose of Report For Information									
Reason for Report <p>To brief members on the financial performance of the CCG and achievement of key financial duties for 2017/18 as at the end of November 2017.</p> <p>To provide details and assurance around the actions being taken.</p>									
Strategic Priority Links <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Strengthening Primary Care</td> <td><input type="checkbox"/> Transformed MH/LD/ Complex Care</td> </tr> <tr> <td><input type="checkbox"/> Reducing Demand on System</td> <td><input type="checkbox"/> System transformations</td> </tr> <tr> <td><input type="checkbox"/> Fully Integrated OOH Care</td> <td><input checked="" type="checkbox"/> Financial Sustainability</td> </tr> <tr> <td><input type="checkbox"/> Sustainable acute hospital/ single acute contract</td> <td></td> </tr> </table>		<input type="checkbox"/> Strengthening Primary Care	<input type="checkbox"/> Transformed MH/LD/ Complex Care	<input type="checkbox"/> Reducing Demand on System	<input type="checkbox"/> System transformations	<input type="checkbox"/> Fully Integrated OOH Care	<input checked="" type="checkbox"/> Financial Sustainability	<input type="checkbox"/> Sustainable acute hospital/ single acute contract	
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Local Authority Area <table style="width: 100%; border: none;"> <tr> <td><input checked="" type="checkbox"/> CCG Footprint</td> <td><input type="checkbox"/> East Riding of Yorkshire Council</td> </tr> <tr> <td><input type="checkbox"/> City of York Council</td> <td><input type="checkbox"/> North Yorkshire County Council</td> </tr> </table>		<input checked="" type="checkbox"/> CCG Footprint	<input type="checkbox"/> East Riding of Yorkshire Council	<input type="checkbox"/> City of York Council	<input type="checkbox"/> North Yorkshire County Council				
<input checked="" type="checkbox"/> CCG Footprint	<input type="checkbox"/> East Riding of Yorkshire Council								
<input type="checkbox"/> City of York Council	<input type="checkbox"/> North Yorkshire County Council								
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> 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)

This report highlights a number of emerging risks. Although these are covered off within some of the broader risks described in Covalent it is worth noting them specifically here:

- Trading positions that vary to plan
- The Executive Committee committed £315k for winter, although the local health system has been successful in a number of bids for additional funding that may off-set this in full or in part.
- Finally, further work needs to be done to understand the Transforming Care Programme impact and CHC emerging risks within Complex Care.
- Degree of non-recurrent measures (£2.4m) required to deliver the risk-adjusted forecast.

Recommendations

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

Responsible Executive Director and Title	Report Author and Title
Tracey Preece, Chief Finance Officer	Michael Ash-McMahon, Deputy Chief Finance Officer Caroline Goldsmith, Deputy 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: December 2017

Financial Period: April 2017 to November 2017 (Month 8)

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	6.6	1.0	G→
In-year total expenditure does not exceed total allocation (Programme and Running costs)					451.8	467.9	(16.0)	R→
Better Payment Practice Code (Value)	95.00%	99.63%	4.63%	G↑	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	98.15%	3.15%	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					462.2	467.9	(5.7)	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	4.9	4.3	0.5	G↑	7.3	6.6	0.7	G→
Programme spend within plan	302.5	311.3	(8.8)	R↓	450.9	461.3	(10.4)	R→
Actual Surplus / (Deficit) within plan (In-year)	(4.2)	(12.5)	(8.3)	R↓	(6.3)	(16.0)	(9.7)	R→
Actual Surplus / (Deficit) within plan (Cumulative)					(30.1)	(39.8)	(9.7)	R→
Risk adjusted forecast deficit					(16.0)	(22.5)	(6.5)	R↓
Cash balance at month end is within 1.25% of monthly drawdown (£k)	403	137	266	G				
QIPP delivery (see section 9)	8.6	4.9	(3.7)	R↓	14.4	10.7	(3.7)	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 *total risk adjusted* forecast has increased by £3.1m this month to £22.5m from the £19.4m reported in previous months. Of this, the forecast remains at a deficit of £16.0m and the risk element is £6.5m. The key drivers for this are the inclusion of the national NCSO prescribing issue following NHSE guidance and the formal acknowledgement of the risk of outstanding disputes with York FT, also consistent with NHSE guidance and treatment by CCGs with material challenges nationally.
- **Month 8 Year-to-date:** plan £4.2m deficit, actual £12.5m deficit so behind plan by £8.3m. This is a deterioration from month 7 of £2.6m driven primarily by the deteriorating acute position (York FT) with CHC, mental health out of contract, prescribing and primary care commissioning also areas of deterioration this month.

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

Dashboard Heading	Overall Risk Adjusted Forecast £m
YTHFT	191.0
Other Acute Commissioning	44.8
Mental Health Services	46.9
Community Services	29.5
Continuing Care	27.9
Funded Nursing Care	4.2
Other Commissioning	27.7
Primary Care Prescribing	50.7
Primary Care	42.0
Running Costs	6.6
0.5% CQUIN	1.0
0.5% Risk Reserve	2.0
Contingency	0.0
Total Expenditure	474.3
Total Allocation	451.8
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 8	(4.9)
Forecast to deliver in remainder of year	(5.8)
QIPP gap (included in overall gap)	3.7

● **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 requested a Maximum Cash Drawdown (MCD) adjustment as part of a national return based on the Month 6 outturn, with no response to date. The further deterioration in Month 8 means that the CCG will need to work with NHS England to manage this.

● **Key Actions & Areas for Discussion:**

- **Level of risk** - the CCG is reporting £6.5m of net risk which is £12.2m of gross risk less £5.7m mitigations, of which £2.4m relates to non-recurrent planned care measures with York FT which have not yet been agreed. The CCG would require all outstanding contract disputes to be successful and all other mitigations to be in place to remain within the £22.5m risk adjusted forecast if the £2.4m non-recurrent measures are not agreed. (see section 5). Discussions are now underway with York FT with the System Transformation Board meeting on 8th January dedicated to this.
- **CHC & mental health out of contract (& PCU)** – expenditure areas continue to deteriorate. Significant clinical, financial and data validation work is underway.
- **Prescribing** - Pharmacy costs of £789k relating to No Cheaper Stock Obtainable (NCSO) items are included in the YTD and forecast position. The total forecast has been calculated at £1.6m therefore £858k is included in the risk position as per NHS England instruction.
- **Winter** - the Executive Committee committed £315k for winter after Month 7 reporting, although additional funding has now been confirmed which will off-set this in full or in part. There are a number of sources of winter funding now available and the flow of these is being determined to ensure best use of the additional monies.

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

Report produced: December 2017

Financial Period: April 2017 to November 2017 (Month 8)

1. Red / Amber financial statutory duties and measures

- *'In-year total expenditure does not exceed total allocation'* – forecast expenditure is £16.0m higher than the CCG's in-year allocation.
- *'CCG cash drawdown does not exceed maximum cash drawdown'* – the cash drawdown required for the year would in theory exceed the Maximum Cash Drawdown (MCD) as advised by NHS England. However, CCGs are not allowed to exceed this so either an adjusted MCD is agreed by NHS England or the CCG must ensure it manages its working capital to stay within the original MCD. The CCG requested an MCD adjustment on the 11th November as part of a national CCG return. However, this was based on a forecast outturn of £465.3m from Month 6 rather than the latest forecast of £468.3m. The further deterioration since then means that the CCG will need to work with NHS England to manage this and submit a further request if requested. The CCG has already started to consider how it could potentially manage its payments in the final quarter of the year should no further adjustment be made.
- *'Programme spend within plan'* – programme spend is forecast to overspend by £10.4m. This is offset by an under-spend on running costs of £0.7m which results in the overall position being £9.7m worse than plan.
- *'Actual position is within plan (in-year)'* – the in-year position is consistent with month 7.
- *'Actual position is within plan (cumulative)'* - the cumulative position has moved as above.
- *'Risk adjusted deficit'* – £6.5m of net unmitigated risk has been identified. This includes £7.7m in relation to in-year contract trading positions and £3.7m of QIPP slippage.
- *'QIPP delivery'* – year to date QIPP delivery is 57.0% of plan which equates to £3.7m under delivery.

2. Month 8 & Year-to-date Supporting Narrative

The plan at Month 8 was for a deficit of £4.2m; however the actual deficit is £12.5m, £8.3m worse than planned.

The current QIPP position is as follows:

		£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		(4.9)
Further Delivery required		(5.8)
Shortfall		3.7

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
York Teaching Hospital NHS Foundation Trust	(£5.4m)	Year to date Trauma and Orthopaedic planned activity is £372k above plan offset by underspends on the Ramsay contract.
Ramsay and Nuffield Health	£1.2m	Ramsay is currently under trading by £1.2m however this is partly offset by an overtrade with Nuffield of £77k.
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.
Out of Contract Placements and SRBI	(£1.3m)	Increased trading costs in both Out of Contract and SRBI placements.
Continuing Care and Funded Nursing Care	(£1.2m)	Funded Nursing Care is currently underspent by £395k which is more than offset by an over-spend in Continuing Healthcare of £1.6m.
Reserves	(£1.4m)	This reflects the impact of prior year pressures where estimates were made at year end. The 2016/17 year-end position with YTHFT has now been agreed and is reflected here. It also includes the release of the contingency and the £2.8m CEP adjustment.
Other Prescribing	(£0.5m)	Increased costs on ONPOS offset by an under-spend on Primary Care Prescribing.
Other acute contracts	(£0.8m)	Overspends on Hull and East Yorkshire Hospitals NHS Trust (£138k), Mid Yorkshire Hospitals NHS Trust (£180k), Harrogate and District NHS Foundation Trust (£193k), South Tees NHS Foundation Trust (£79k) and Leeds Teaching Hospitals NHS Trust (£234k), offset by an underspend on North Lincs & Goole NHS Foundation Trust (£34k).
Running costs	£0.5m	Small improvement in year to date position explained

NHS Vale of York Clinical Commissioning Group Financial Performance Report

		further in the running costs dashboard in Appendix 2.
Other Primary Care	£0.4m	Slippage in the Out of Hospital QIPP means the associated investment has not yet been committed.
York Teaching Hospital NHS Foundation Trust – MSK	£0.3m	Contract is currently under trading due to lower levels of activity and vacancies and has now been agreed as a block amount for 2016/17 that reflects the actual cost of delivery.
York Teaching Hospital NHS Foundation Trust – Community	£0.1m	Underspend on non-medical prescribing.
Primary Care Commissioning	(£0.1m)	QOF achievement in 2016/17 better than expected.
Other variances	(£0.2m)	
Total impact on YTD position	(£8.3m)	

3. Financial Plan & Forecast Outturn Supporting Narrative

The current financial plan (as submitted 12th June under CEP) is an in-year deficit of £6.3m, resulting in a cumulative deficit of £30.1m. The forecast as at Month 8 is an in-year deficit of £16.0m which is in line with the financial plan approved by the Governing Body in April. This plan also included risk of £5.0m in addition to the planned £16.0m deficit making a total risk adjusted plan of £21.0m.

As far as possible and within the overall parameters of the figures above all budget lines have been forecast in line with the YTD position and the usual forecasting methodologies, apart from the York Teaching Hospital NHS Foundation Trust acute spend. This is reflected in detail in Appendix 1 and summarised in the table below.

Reported forecast outturn key variances

Description	Value	Reason
Reserves	(£9.8m)	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	£1.9m	Ramsay is forecast to under trade by £2.0m which is offset by an over-trade with Nuffield Health of £117k.
Out of Contract Placements and SRBI	(£1.6m)	Increased trading costs in both Out of Contract and SRBI placements.
Other acute contracts	(£1.0m)	Overtrading positions including £324k on Leeds Teaching Hospitals NHS Trust and £287k on Harrogate and District NHS FT.
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	£0.7m	Achievement of running cost QIPPs
Prescribing	(£0.5m)	Under trading position on Primary Care Prescribing (£305k) and overtrading position on Other Prescribing (£834k) partly in relation to ONPOS.
CHC and FNC	£0.4m	Overtrading position on CHC (£361k) and under trading position on FNC (£764k).

NHS Vale of York Clinical Commissioning Group
Financial Performance Report

Primary Care Commissioning	(£0.2m)	Forecast worsening position as provided by NHS England in part due to better QOF achievement in 2016/17 than expected.
York Teaching Hospital NHS FT - Community	£0.2m	Forecast underspend on non-medical prescribing of £359k offset by an over-spend in other prescribing.
Other Primary Care	£0.1m	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 Community	(£0.1m)	Community Equipment overtrade (£538k) off-set by Health Navigator (£111k) and slippage in investment in the Out of Hospital QIPP (£291k).
Other variances	(£0.6m)	
Total impact on FOT position	(£9.7m)	

4. Allocations

The cumulative allocation at Month 8 is as follows:

Description	Recurrent/ Non-recurrent	Category	Value
Allocation brought forward			£428.5m
Charge Exempt Overseas Visitors (CEOV) adjustment	Non Recurrent	Programme	(£457k)
Total allocation at Month 7			£428.0m

The CCG received a reduction in allocation of £457k in month 8 as a result of the annual Charge Exempt Overseas Visitors adjustment.

5. Gap and key delivery challenges

There are significant pressures on the CCG's financial plan. In the Month 8 non-ISFE submission, the CCG reported a gross risk of £12.2m and mitigations of £5.8m to close the gap:

Pressures

Description	Value	Commentary
Acute SLAs	£7.7m	Trading position
QIPP under-delivery	£3.7m	Risk against delivery of £14.4m QIPP
No Cheaper Stock Obtainable (NCSO)	£0.9m	Pharmacy costs of NCSO not included in the forecast
Total	£12.2m	

Proposals & contingencies

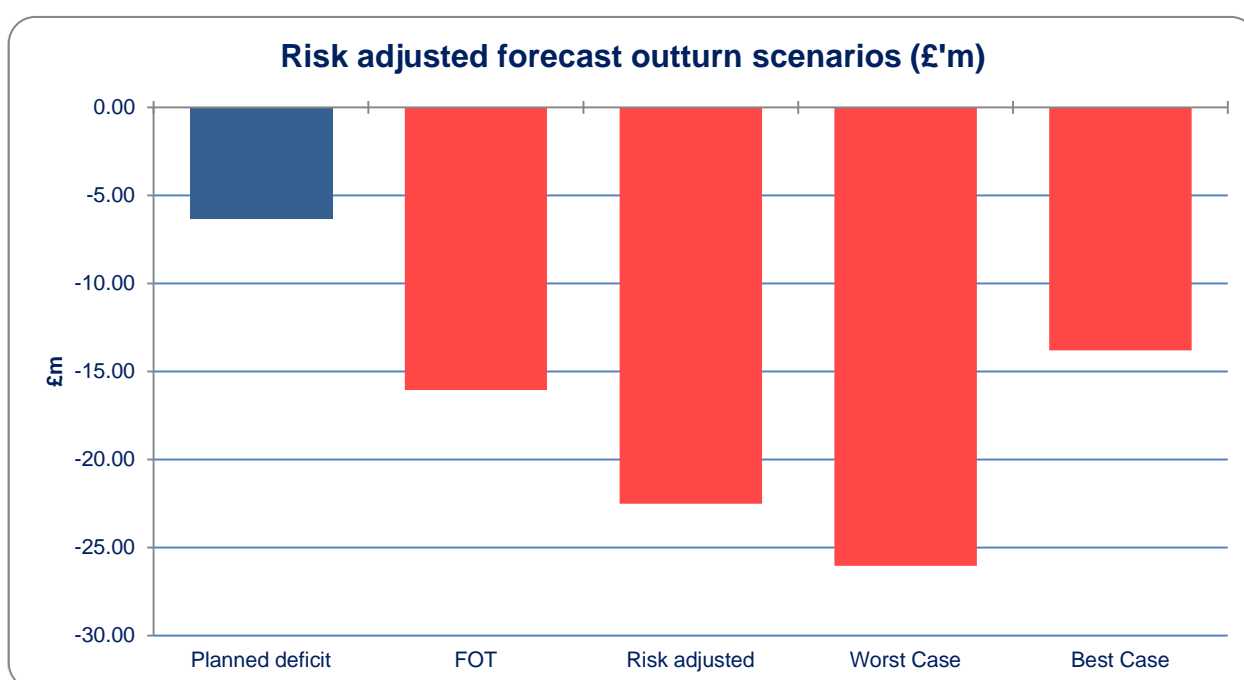
Description	Expected Value	Commentary
Contingency	£2.2m	0.5% contingency provided for in plan
Acute SLAs	£2.4m	Additional non recurrent measures
Additional QIPP	£0.3m	RightCare Gastro proposal £0.3m
Other Services	£0.5m	Reserves
Mental Health SLAs	£0.3m	TEWV system support
Total	£5.7m	

Net Mitigated Risk	£6.5m	
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The critical point of the net risk adjusted position is that the CCG has included £2.4m of additional non-recurrent measures, previously £2m at Month 7 reporting. This was discussed with the Accountable Officer prior to inclusion and submission and Executive Committee and NHS England have also been briefed.

The following graph shows potential risk adjusted outturn based on the following scenarios. These are in line with the risk adjusted positions used by NHSE.

- FOT – forecast outturn at Month 8
- Risk adjusted – probable – applies risks and mitigations with probability weighting
- Worst case – assumes all risks materialise and only uncommitted contingency mitigates
- Best case – assumes no risks materialise and uncommitted contingency mitigates



There are also a number of assumptions made in the programme areas and there are therefore inherent risks in some, particularly where contracts are activity based. The principal activity based risks are:

- Acute activity – which is confirmed 2 months in arrears.
- Continuing Healthcare – forecast is based on a ‘probable’ methodology so deemed realistic.
- Prescribing – information runs two months behind. Whilst the forecasting methodology takes this into account and has seen improvement recently there remains an inherent risk.
- Community Equipment – currently being billed on the contract split % rather than an actual organisational basis. Work is on-going with the provider and other commissioners to resolve this issue and the overspend described earlier, the latter of which is becoming an increasing challenge for partners to achieve.

Emerging risks:

Pharmacy costs of £789k relating to No Cheaper Stock Obtainable (NCSO) items are included in the YTD and forecast position. The total forecast has been calculated at £1.6m therefore £858k is included in the risk position as per NHS England instruction.

The Executive Committee committed £315k for winter, although additional funding has now been confirmed which will off-set this in full or in part.

Continuing Healthcare (CHC) services are currently being in-housed following the dissolution of the Partnership Commissioning Unit (PCU). As handovers are taking place, the CCG is becoming increasingly aware of inconsistencies in the data which may potentially have a financial impact (not yet quantified). Invoicing for CHC services will transfer to the CCG from 1st February 2018. Due to the often complex nature of these invoices it is a risk that the Better Payment Practice Code will be adversely impacted.

6. Underlying Position

The underlying position reported at Month 8 based on a £16.0m deficit is detailed below:

Description	Value
Deficit at month 8	(£16.0m)
Adjust for non-recurrent items in plan -	
IR rules and HRG4+ allocation	£2.5m
IR rules and HRG4+ expenditure	(£2.5m)
Repayment of system support	(£0.3m)
0.5% headroom	(£2.0m)
Non recurrent QIPP (BMI & Smoking)	£3.0m
Prior year pressures	(£1.0m)
No Cheaper Stock Obtainable (Pharmacy adjustment)	(£0.8m)
Primary Care Commissioning	(£0.1m)
Underlying financial position	(£14.8m)

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.

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	166	74	259	108	
Cataract Thresholds	161	Apr-17	200	0	300	150	
Faecal Calprotectin	PC4	Oct-16	53	-31	53	53	
Biosimilar high cost drugs gain share	016	Apr-17	240	124	318	201	
Remove SpR block from contract	168	Apr-17	634	634	952	952	In contract, delivery on track
Commissioning for Value (PNRC)	006	Apr-17	100	25	150	75	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	2,000	1,747	3,000	3,000	
RightCare - Circulation (Heart Disease)	008	Oct-17	33	33	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	250	250	750	750	
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	333	167	1,000	500	
UNPLANNED CARE							
Community Podiatry	IC4	May-17	250	216	393	393	In contract, delivery on track
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	281	235	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	217	187	217	217	In contract, delivery on track
Community Equipment service re-procurement	187	Apr-17	418	119	418	102	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	
Unplanned Care Programme (including urgent care and out of hospital care)	149	Jul-17	458	0	824	275	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	504	135	756	756	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	67	0	200	200	
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

NHS Vale of York Clinical Commissioning Group Financial Performance Report

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	38	36	36	
GP IT - NYNET	003	May-17	117	117	183	183	
Roll out indicative budgets to other specialities	020	Jul-17	42	0	75	0	
PRESCRIBING							
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	185	185	277	277	
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	85	85	128	128	
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	71	71	106	106	
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	25	25	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	50	50	75	75	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	600	600	900	900	
CCG wide: Continence & Stoma Care	199	Oct-17	18	18	53	53	
COMPLEX CARE							
Continence Supplies	C1	Apr-17	23	5	23	23	
CHC review 1 to 1 care packages	024a	Apr-17	98	0	98	98	
CHC review: Short Breaks	024b	Apr-17	51	0	51	51	
CHC review panel decisions (jointly funded packages of care)	024c	Apr-17	83	0	83	83	
Complex Care - CHC and FNC benchmarking	024d	Oct-17	517	0	1,550	0	
Recommission MH out of contract expenditure	025	Apr-17	200	0	300	200	
BACK OFFICE							
Commissioning support (eMBED) contract savings	004	Apr-17	138	138	207	207	In contract, delivery on track
Vacancy control	027	Apr-17	36	36	54	54	
Total identified QIPP			7,045	4,851	14,396	10,745	
Unidentified QIPP			0	0	0	3,651	
Additional QIPP required as a result of removing CEP			0	0	0	7,840	
Total QIPP requirement			7,045	4,851	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. Note that figures highlighted in purple are those where the QIPP scheme is in place and known to be delivering but the savings cannot yet be quantified due to the timing of the information to report the actual position.

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	123,531	128,970	(5,439)	107,846	111,421	(3,575)	15,685	17,550	(1,864)	184,446	184,446	0	184,446	184,446	0	0	0	0
Yorkshire Ambulance Service NHS Trust	8,559	8,559	0	7,489	7,489	0	1,070	1,070	0	12,838	12,838	0	12,838	12,838	0	0	0	0
Leeds Teaching Hospitals NHS Trust	5,505	5,739	(234)	4,810	4,955	(145)	695	784	(89)	8,261	8,585	(324)	8,261	8,514	(252)	0	72	(72)
Hull and East Yorkshire Hospitals NHS Trust	2,011	2,149	(138)	1,757	1,854	(98)	254	294	(40)	2,994	3,163	(169)	2,994	3,136	(142)	0	27	(27)
Harrogate and District NHS FT	1,226	1,419	(193)	1,065	1,240	(175)	161	179	(17)	1,843	2,130	(287)	1,843	2,129	(286)	0	1	(1)
Mid Yorkshire Hospitals NHS Trust	1,398	1,578	(180)	1,221	1,375	(154)	177	203	(26)	2,087	2,296	(210)	2,087	2,263	(177)	0	33	(33)
South Tees NHS FT	845	924	(79)	738	828	(90)	107	96	11	1,258	1,377	(118)	1,258	1,405	(147)	0	(28)	28
North Lincolnshire & Goole Hospitals NHS Trust	380	345	34	331	313	18	48	32	16	565	514	51	565	534	30	0	(20)	20
Sheffield Teaching Hospitals NHS FT	143	129	14	125	109	16	18	20	(2)	215	201	14	215	199	16	0	2	(2)
Non-Contracted Activity Other Acute Commissioning	2,608	2,608	(0)	2,282	2,282	(0)	326	326	(0)	3,912	3,912	(0)	3,912	3,912	(0)	0	0	(0)
Ramsay	616	574	41	539	494	45	77	80	(4)	923	901	22	923	905	18	0	(4)	4
Nuffield Health	4,528	3,282	1,246	3,937	2,792	1,145	591	490	101	6,721	4,696	2,024	6,721	5,393	1,328	0	(696)	696
Other Private Providers	1,971	2,048	(77)	1,714	1,740	(27)	257	308	(50)	2,926	3,043	(117)	2,926	2,974	(48)	0	69	(69)
	693	745	(52)	607	631	(24)	87	115	(28)	1,040	1,120	(80)	1,040	1,088	(48)	0	32	(32)
Sub Total	154,012	159,070	(5,058)	134,460	137,525	(3,065)	19,553	21,545	(1,993)	230,029	229,223	806	230,029	229,736	292	0	(513)	513
Mental Health Services																		
Tees Esk and Wear Valleys NHS FT	26,432	26,420	12	23,128	23,118	10	3,304	3,303	2	39,524	39,506	18	39,524	39,422	101	0	83	(83)
Out of Contract Placements and SRBI	3,485	4,764	(1,280)	3,049	4,011	(962)	436	753	(317)	5,227	6,821	(1,594)	5,227	6,476	(1,249)	0	345	(345)
Non-Contracted Activity - MH	281	277	4	246	242	4	35	35	0	421	417	4	421	417	4	0	0	0
Other Mental Health	156	156	0	136	136	0	19	19	0	233	233	0	233	233	0	0	0	0
Sub Total	30,353	31,617	(1,264)	26,559	27,507	(948)	3,794	4,110	(316)	45,405	46,977	(1,572)	45,405	46,549	(1,144)	0	428	(428)

NHS Vale of York Clinical Commissioning Group Financial Performance Report

	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	13,131	13,017	114	11,514	11,382	133	1,616	1,635	(19)	19,596	19,363	233	19,596	19,308	288	0	55	(55)
York Teaching Hospital NHS FT - MSK	1,685	1,385	300	1,412	1,175	237	273	210	63	2,777	2,105	672	2,777	2,533	244	0	(428)	428
Harrogate and District NHS FT - Community	1,771	1,854	(83)	1,553	1,628	(75)	218	226	(8)	2,643	2,710	(67)	2,643	2,710	(67)	0	0	(0)
Humber NHS FT - Community	657	654	4	575	574	1	82	79	3	985	982	3	985	985	(0)	0	(3)	3
Hospices	831	831	1	728	727	1	104	104	0	1,247	1,246	2	1,247	1,246	2	0	0	(0)
Longer Term Conditions	306	318	(13)	267	271	(3)	38	47	(9)	458	472	(14)	458	454	5	0	18	(18)
Other Community	1,380	1,338	42	1,185	1,224	(38)	194	114	80	2,179	2,290	(112)	2,179	2,390	(211)	0	(99)	99
Sub total	19,760	19,396	364	17,234	16,980	254	2,526	2,416	110	29,885	29,169	717	29,885	29,625	260	0	(457)	457
Other Services																		
Continuing Care	17,691	19,282	(1,591)	15,641	16,945	(1,304)	2,050	2,337	(287)	25,990	26,350	(361)	25,990	26,303	(313)	0	47	(47)
Funded Nursing Care	3,337	2,941	395	2,920	2,607	313	417	335	82	5,005	4,241	764	5,005	4,330	675	0	(88)	88
Patient Transport - Yorkshire Ambulance Service NHS Trust	1,341	1,359	(18)	1,174	1,181	(7)	167	178	(11)	2,007	2,056	(49)	2,007	2,051	(44)	0	5	(5)
Voluntary Sector / Section 256	318	387	(69)	284	345	(60)	34	43	(9)	547	553	(7)	547	553	(7)	0	(0)	0
Non-NHS Treatment	388	381	7	341	340	2	47	41	6	576	567	8	576	574	1	0	(7)	7
NHS 111	542	536	6	474	463	11	68	73	(5)	813	801	12	813	794	19	0	7	(7)
Better Care Fund	7,384	7,398	(14)	6,461	6,520	(59)	923	878	45	11,075	11,158	(83)	11,075	11,159	(84)	0	(1)	1
Other Services	1,462	1,483	(21)	1,277	1,296	(19)	185	188	(2)	2,203	2,247	(44)	2,203	2,244	(41)	0	3	(3)
Sub total	32,463	33,768	(1,305)	28,573	29,696	(1,123)	3,890	4,072	(183)	48,215	47,974	241	48,215	48,008	208	0	(33)	33

NHS Vale of York Clinical Commissioning Group Financial Performance Report


	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	33,408	33,297	112	29,317	29,119	198	4,091	4,178	(87)	50,196	49,891	305	50,196	49,470	726	0	422	(422)
Other Prescribing	449	979	(531)	393	810	(418)	56	169	(113)	673	1,507	(834)	673	1,517	(844)	0	(10)	10
Local Enhanced Services	1,172	1,091	81	990	937	53	182	154	28	1,918	1,955	(37)	1,918	1,920	(2)	0	35	(35)
Oxygen	176	197	(22)	154	172	(18)	22	26	(4)	263	294	(31)	263	291	(28)	0	2	(2)
Primary Care IT	669	734	(65)	588	645	(58)	82	89	(7)	1,147	1,183	(36)	1,147	1,178	(31)	0	5	(5)
Out of Hours	2,112	2,123	(12)	1,848	1,867	(19)	264	256	8	3,167	3,201	(33)	3,167	3,226	(58)	0	(25)	25
Other Primary Care	439	41	398	350	34	316	89	7	83	856	707	149	856	777	79	0	(69)	69
Sub Total	38,424	38,463	(39)	33,639	33,584	54	4,785	4,878	(93)	58,221	58,739	(518)	58,221	58,378	(158)	0	360	(360)
Primary Care Commissioning	27,892	28,018	(126)	24,402	24,393	10	3,490	3,625	(135)	41,797	42,037	(240)	41,797	42,037	(240)	0	0	0
Trading Position	302,905	310,332	(7,427)	264,867	269,685	(4,818)	38,038	40,647	(2,610)	453,553	454,119	(567)	453,553	454,334	(781)	0	(215)	215
Prior Year Balances	0	1,006	(1,006)	0	1,006	(1,006)	0	0	0	0	1,006	(1,006)	0	1,006	(1,006)	0	0	0
Reserves	(1,879)	0	(1,879)	(1,644)	0	(1,644)	(235)	0	(235)	51	3,900	(3,849)	508	4,104	(3,597)	(457)	(205)	(252)
Contingency	1,499	0	1,499	1,312	0	1,312	187	0	187	2,248	2,248	0	2,248	2,248	0	0	0	0
Unallocated QIPP	0	0	0	0	0	0	0	0	0	(4,994)	0	(4,994)	(4,994)	0	(4,994)	0	0	0
Reserves	(380)	1,006	(1,386)	(332)	1,006	(1,338)	(47)	0	(47)	(2,695)	7,154	(9,849)	(2,238)	7,358	(9,597)	(457)	(205)	(252)
Programme Financial Position	302,525	311,338	(8,813)	264,535	270,690	(6,156)	37,990	40,647	(2,657)	450,858	461,273	(10,415)	451,315	461,693	(10,378)	(457)	(420)	(37)
In Year Surplus / (Deficit)	(4,230)	0	(4,230)	(3,701)	0	(3,701)	(529)	0	(529)	(6,345)	0	(6,345)	(6,345)	0	(6,345)	0	0	0
In Year Programme Financial Position	298,295	311,338	(13,043)	260,834	270,690	(9,857)	37,462	40,647	(3,186)	444,513	461,273	(16,760)	444,970	461,693	(16,723)	(457)	(420)	(37)
Running Costs	4,857	4,343	514	4,250	3,851	398	607	492	115	7,287	6,581	706	7,287	6,618	669	0	(38)	38
Total In Year Financial Position	303,152	315,681	(12,529)	265,083	274,542	(9,458)	38,069	41,139	(3,071)	451,800	467,854	(16,054)	452,257	468,311	(16,054)	(457)	(457)	0
Brought Forward (Deficit)	(15,839)	0	(15,839)	(13,859)	0	(13,859)	(1,980)	0	(1,980)	(23,759)	0	(23,759)	(23,759)	0	(23,759)	0	0	0
Cumulative Financial Position	287,313	315,681	(28,369)	251,224	274,542	(23,318)	36,089	41,139	(5,051)	428,041	467,854	(39,813)	428,498	468,311	(39,813)	(457)	(457)	0

Financial Period: April 2017 to November 2017

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	587	601	(15)	513	541	(28)	73	60	13	880	904	(24)	880	878	2	0	26	(26)
System Resource & Performance	1,181	946	235	1,033	827	206	149	119	29	1,777	1,447	329	1,777	1,427	350	0	20	(20)
Planning & Governance	797	675	122	697	603	95	100	73	27	1,196	1,010	186	1,196	1,028	168	0	(18)	18
Joint Commissioning	313	280	33	274	243	31	39	37	2	470	434	35	470	437	33	0	(2)	2
Transformation & Delivery	231	195	36	202	171	32	29	24	5	347	293	53	347	301	45	0	(8)	8
Medical Directorate	630	597	33	551	560	(9)	79	37	42	945	919	25	945	977	(33)	0	(58)	58
Finance	645	641	3	564	558	6	81	83	(3)	967	941	26	967	931	36	0	10	(10)
Quality & Nursing	450	338	113	395	290	105	55	48	7	671	521	150	671	529	142	0	(8)	8
Recharges & PCU	198	71	126	173	60	113	25	11	13	297	111	186	297	110	187	0	1	(1)
Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QIPP	(174)	0	(174)	(152)	0	(152)	(22)	0	(22)	(261)	0	(261)	(261)	0	(261)	0	0	0
Overall Position	4,857	4,343	514	4,250	3,851	398	607	492	115	7,287	6,581	706	7,287	6,618	669	0	(37)	37

Note that CHC staffing has been moved from running costs to programme in Month 8 hence the reduction in Recharges & PCU.

Item Number: 11	
Name of Presenter: Caroline Alexander	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Integrated Performance Report Month 8 2017/18	
Purpose of Report For Information	
Reason for Report <p>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 7 for performance and contracting, and Month 8 for finance and QIPP. The report should be read alongside the QIPP Supplementary Report (Annex to full Finance Report) and the Month 7 Contract Report.</p>	
Strategic Priority Links <input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Reducing Demand on System <input checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council	<input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description 29 risks as captured in the Risk report for November 2017
Emerging Risks (not yet on Covalent) n/a	

Recommendations

N/A

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

Integrated Performance Report



Validated data to October 2017
Month 07 2017/18

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- Contracting
- Quality, Innovation, Productivity and Prevention (QIPP)
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- Contracting
- Quality, Innovation, Productivity and Prevention (QIPP)
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Primary Care

- Overview of progress with the GPFV programme and QIPP (see QIPP Supplementary report: Annex to Finance report)
- Performance – primary care dashboard now reported to Primary Care Commissioning Committee

Annexes:

Includes core supporting performance documents and updates on other/ enabling/ quality workstreams linked to performance

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

A&E 4 hour target

York Trust's performance against the 4 hour standard in October 2017 was 86.59% against planned STF trajectory of 91%, an improvement compared to 83.1% in September. There was a significant in-month turnaround from 79.25% for the first full week, rising to 91.08% for the final full week. Provisional November performance remained much improved at 91.67%.

Ambulance handovers remain an area of concern with concordat actions incorporated into the performance improvement plan. Bed occupancy has hit 98% at York Hospital during the period to 15/12/17.

Immediate recovery plans were implemented following a performance deterioration on 9th October; these focused on enhancing site management and management of flow through the introduction of a manager of the day and increasing leadership from the on-call manager role. Senior nursing roles have been re-aligned to support ED and acute flow. The clinical site management has been refined to create additional 'Operational Flow Practitioner' roles to be in place for winter. Additional winter funding has been confirmed for the local system (verbal update).

RTT 18 week

CCG RTT performance improved slightly in October 2017, standing at 89.2% compared to 88.8% in September against target of $\geq 92\%$. This equates to 1,663 patients (of 15,451) seen outside 18 weeks. The largest number of CCG 18 week breaches in October were in Ophthalmology (380), followed by General Surgery (252) and Urology (157).

York Trust's RTT performance for October is 87.4%, this is 4.6% off trajectory and therefore the planned return to 92% by the end of October was not achieved. Performance did improve by 0.5% compared to September 2017, the first month on month improvement since May 17. There was one declared 52 week breach (not a VOY patient) in October for Thoracic Medicine (sleep service). The impact on RTT of the winter pause in elective care delivery is not yet known.

The York Trust admitted backlog remained relatively stable through October, up by 8 patients. The non-admitted backlog decreased for the second consecutive month, down 10% from 1,884 at the end of September to 1,699, with significant progress made on RTT validation across specialities.

At the end of September there were 25,174 patients on the incomplete pathway with 3,164 of those waiting over 18 weeks. Long waits continue to be a significant concern with 77 patients waiting over 40 weeks (at time of report). The risk remains high for 52 week breaches, in particular for sleep services, maxfax and dermatology. Additional capacity has been agreed with Leeds to support long wait patients in maxfax. Long wait patients are reviewed weekly and prioritised through theatre planning and bed meetings.

Performance Headlines

IMPROVEMENTS IN PERFORMANCE :

Dementia diagnosis

Performance improved for another successive month in November to 61.0% from 60.2% in October, against target of 66.7%

On-going impact of project to support practices in diagnosing dementia.

Performance Headlines

DETERIORATION IN PERFORMANCE :

Diagnostics 6 week wait

After 5 consecutive months of improvement, NHS Vale of York CCG's performance deteriorated in October 2017 to 1.99% against target of $\leq 1\%$, up from 1.6% in September. This equates to a total of 68 breaches out of 3,409 patients on the waiting list. York Trust also failed the $\leq 1\%$ target in October 2017 with 1.7% of patients waiting longer than 6 weeks. This equates to 92 breaches from a cohort of 5,469 patients.

Primary issues at York Trust in October 2017 were in Echocardiography due to Consultant unplanned leave in September, and Radiology reporting processes resulting in below expected performance. Remedial action and improved processes have been put in place to ensure future compliance.

Cancer 2WW

CCG Performance deteriorated slightly in October 2017 with 86.8% of patients seen within the two week target, down from 88.1% in September. This equates to 130 (of 987) breaches of the target, compared to 95 (of 795) in September. York Trust performance (one month behind) in September 2017 was 84.8% against 93% target, an improvement from 83.4% in August. This equates to 175 patient breaches, of which 80.6% were diagnosed as no cancer. Dermatology continues to account for the high number of York Trust's fast track breaches, 77% of the total in September.

The Dermatology recovery work continues, with the commencement of the new model of service in Malton in November. York Trust's performance is slightly improved on 14 day fast track, however there were 2 children breaches in September, both for Dermatology. Immediate action is being taken to ensure all children are flagged on the weekly PTL and a review of all children's performance is underway. Of the non-skin fast track breaches, 61.5% were due to patient choice or patient cancellations. The Trust is working with the CCG to target these breaches.

Performance Headlines

DETERIORATION IN PERFORMANCE (Continued):

Cancer 62 day wait

CCG performance deteriorated to 72.5% in October 2017 against the $\geq 85\%$ target, down from 74.1% in September. This equates to 28 of 102 patients waiting over 62 days.

York Trust performance (one month behind) in September 2017 deteriorated to 76.4%, down from 83.2% in August. Complex diagnostics (32%) and capacity constraints (27%) were the primary reasons for delay. Of the 37 patients affected at York Trust, 11 of those were treated over 104 days, with a clinical harm review to be reported on each. The high number of long delays is of concern. 5 of those were primarily attributed to a lack of elective capacity, these all related to above the clavicle skin and head and neck cancers.

York Trust report that the Cancer Board has been reconfigured with focused work groups to be established on timed pathways, diagnostics, quality surveillance and patient outcomes and living with and beyond cancer. Individual recovery plans are being completed for each tumour site not meeting 62 days standard. There has been a service change in October for Oncology at the East Coast, with patients requiring Oncology for urological or Upper GI cancers receiving first treatment at Hull. The Trust is arranging meetings with Hull to discuss the ongoing capacity challenges and 62 day pathway management for the East Coast. A further update on 62 day performance is presented to the Committee this month.

Performance Headlines

SUGGESTED ISSUES FOR DISCUSSION:

1. **Cancer 62 day performance:** further update subsequent to November report (see attached)
2. **DTOCs:** verbal update from Andrew Phillips & Denise Nightingale (see annex for recent system/regulator correspondence)
2. **Medical Staffing update** - for note (see Annex)
3. **Winter Plan:** additional funding received to system. Funding now includes: £1.218M original winter planning funding, augmented by £785K to support clinical flow practitioners/ community IV/ medical and support staff for ED overnight. Additionally £235K for increased primary care access and £65K for mental health services over winter
4. **Urgent & emergency care network:** emerging integrated urgent care specification/ options are being developed. Proposed update in January 2018
5. **RTT recovery:** full report in January 2018
6. **Dermatology:** YTHFT agreement to continue funding of dermatology locum to support Consultant capacity pressures. Strong focus on actions from second Dermatology deepdive.
7. **Malton Hospital:** impact on bed numbers and utilisation as S&R CCG MCP develops. Proposal to present assessment of impact in January 2018.

Performance Summary: All Constitutional Targets 2017/18

Validated data to October (Month 07)

Planned Care

Indicator	Level of Reporting		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-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	90.8%	90.6%	90.3%	90.5%	90.7%	89.7%	90.2%	90.2%	89.7%	89.3%	88.8%	89.2%	90.0%	89.3%	89.2%	89.6%	91.4%		↓
		Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		92.0%
Number of >52 week Referral to Treatment in Incomplete Pathways	CCG	Actual	1	0	0	0	2	2	2	0	1	0	0	0	4	1	0	5	5		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Diagnostics																					
Diagnostic test waiting times	CCG	Actual	1.21%	1.70%	1.76%	2.00%	2.12%	3.76%	3.49%	2.83%	2.18%	1.63%	1.60%	1.99%	2.83%	1.60%	1.99%	1.99%	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	92.1%	98.1%	90.2%	97.0%	93.3%	90.5%	89.6%	90.4%	85.9%	85.2%	88.1%	86.8%	90.2%	86.4%	86.8%	88.1%	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	98.2%	95.5%	95.7%	95.7%	98.3%	91.9%	95.5%	96.6%	96.8%	96.8%	100.0%	97.6%	95.2%	97.6%	97.6%	96.5%	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	96.2%	98.5%	96.3%	98.2%	96.6%	95.0%	98.9%	97.8%	97.4%	97.4%	96.6%	95.2%	97.5%	97.2%	95.2%	97.0%	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	86.7%	84.8%	97.1%	92.1%	100.0%	95.2%	93.8%	96.9%	88.1%	97.7%	95.5%	85.1%	95.3%	93.1%	85.1%	92.6%	95.0%		↓
		Target	94.0%	94.0%	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%		
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%	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%		
Cancer 31 day waits: subsequent cancer treatments-radiotherapy	CCG	Actual	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	100.0%	99.7%	99.6%		-
		Target	94.0%	94.0%	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%		
% 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	77.3%	81.7%	82.4%	74.0%	78.7%	83.6%	74.3%	76.6%	82.0%	87.3%	74.1%	72.5%	77.8%	81.2%	72.5%	78.5%	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	84.6%	94.1%	94.7%	93.3%	85.7%	83.3%	100.0%	100.0%	88.2%	100.0%	94.4%	88.9%	94.6%	94.7%	88.9%	93.8%	91.9%		↓
		Target	90.0%	90.0%	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%
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	CCG	Actual	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.5%		-
		Target																			
Cancelled Operations																					
Cancelled Operations - York	YFT (Trust Wide)	Actual		1.0%			7.8%			1.9%			1.1%		1.9%	1.1%		1.5%	5.1%		
		Target		3.8%			2.0%			11.7%			1.4%		11.7%	1.4%		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	0	0.1	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		
Number of MSA breaches for the reporting month in question	CCG	Actual	0	0	1	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		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-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	81.9%	81.2%	78.3%	81.5%	89.4%	92.9%	88.1%	91.9%	87.1%	88.2%	83.2%	86.7%	90.9%	86.2%	86.7%	88.3%	86.4%		↓
	Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	4418	4607	4302	3991	4551	4485	4802	4714	4937	4716	4590	4795	14001	14243	4795	33038	55185		↑
A&E - % Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	69.4%	68.7%	63.3%	68.7%	81.7%	87.5%	79.6%	86.1%	77.7%	79.1%	71.2%	77.1%	83.5%	77.7%	77.1%	83.5%	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%	95.0%		
A&E Attendances - Type 3, SitRep data	% of YFHT activity (CCG weighted)	Actual	1522	1555	1483	1397	1652	1785	1818	1730	1894	1927	1704	1,749	5333	5525	1749	12607	20011		↓
A&E Attendances - Total, SitRep data	% of YFHT activity (CCG weighted)	Actual	7,485	7,741	7,291	6,807	7,881	8,083	8,466	8,201	8,755	8,599	8,024	8,319	24,749	25,377	8,319	58,446	95,514		↓
A&E Attendances - VoY CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	7,104	7,268	6,914	6,256	7,205	7,055	7,603	7,240	7,636	7,055	7,124	7,779	21,898	21,815	10,195	53,908	86,952		↑
A&E waiting time -% of patients seen and discharged within 4 hours -CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	77.82%	74.81%	73.33%	79.49%	90.02%	90.35%	83.86%	88.72%	82.10%	84.85%	81.06%	85.19%	87.56%	82.65%	85.19%	85.25%	83.55%		↑
		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%		
Trolley Waits																					
12 hour trolley waits in A&E - Vale of York CCG	CCG	Actual	1	9	6	2	0	0	1	0	2	0	0	0	1	2	0	3	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	3	11	45	6	9	0	3	0	2	1	1	2	3	4	2	9	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	68.3%	62.9%	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%		75.0%	75.0%		
Achieved 8 Min	YAS (Region)	Actual	196.021	242	252	216	265	269	259	261	281	267			789	809		1337	1171		
Total Calls (C1)	YAS (Region)	Actual	287	384	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	82.4%	78.2%	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	70.0%	62.3%	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	86.0%	82.1%	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			
Category 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	80.7%	77.1%	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	94.2%	88.8%	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 4T - Tail of Performance 95%	YAS (Region)	Actual																			
Category 4T - Tail of Performance 100%	YAS (Region)	Actual																			
Category 4H - (Hear and Treat) Hear and Treat within 90 Minutes	YAS (Region)	Actual	100.0%	93.3%	94.1%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%			100.0%	98.6%		99.5%	96.4%		
Category 4H - Tail of Performance 95%	YAS (Region)	Actual																			
Category 4H - Tail of Performance 100%	YAS (Region)	Actual																			

Ambulance Handover Time																						
Indicator	Level of Reporting		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-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	32.00%	27.00%	39.00%	44.20%	21.80%	7.40%	18.30%	14.90%	16.80%	22.30%	31.40%	30.30%	12.90%	23.30%	30.30%	20.10%	29.40%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	403	369	510	533	294	117	182	222	260	357	456	436	521	1073	436	2030	4771			
		Den	1258	1367	1307	1207	1346	1572	994	1487	1552	1601	1450	1440	4053	4603	1440	10096	16224			
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	Trust Site	Actual	15.00%	11.80%	17.10%	23.10%	6.00%	2.60%	6.40%	5.00%	5.00%	6.10%	12.80%	13.70%	4.40%	7.80%	13.70%	7.30%	12.90%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	189	161	224	279	81	41	64	74	77	98	186	197	179	361	197	737	2088			
		Den	1258	1367	1307	1207	1346	1572	994	1487	1552	1601	1450	1440	4053	4603	1440	10096	16224			
Ambulance handover time - % Delays over 30 minutes (York Hospital)	CCG	Num	447	530	596	352	131	78	209	126	200	188	245	192	413	633	192	1238	3813		↓	
		Den	2009	2017	1978	1760	1869	1906	1921	1794	1820	1767	1765	1954	5621	5352	1954	12927	23476			
Ambulance handover time - % Delays over 60 minutes (York Hospital)	CCG	Num	167	264	330	137	16	17	71	23	75	49	79	62	111	203	62	376	1655		↑	
		Den	2009	2017	1978	1760	1869	1906	1921	1794	1820	1767	1765	1954	5621	5352	1954	12927	23476			

Mental Health/ IAPT

Indicator	Level of Reporting	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-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 w ho have depression and/or anxiety disorders w ho receive psychological therapies	CCG	Actual	1.12%	0.90%	1.10%	0.70%	0.62%	0.64%	0.72%	0.94%	0.82%	0.93%			2.30%	1.74%		4.05%	13.32%		↓	
		Target	1.25%	1.25%	1.25%	1.25%	1.25%	1.40%	1.40%	1.40%	1.40%	1.40%			2.00%	0.67%		2.66%	8.57%			
% of people w ho are moving to recovery	CCG	Actual	53.85%	44.83%	46.43%	50.00%	53.85%	42.50%	54.17%	42.31%	40.91%	37.93%			45.56%	39.22%		43.26%	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%			
% of people w ho have depression and/or anxiety disorders w ho receive psychological therapies	CCG	Actual	1.1%	0.9%	1.1%	0.7%	0.6%	0.6%	0.7%	0.9%	0.8%	0.9%			2.3%	1.7%		4.1%	13.3%		↓	
Number of people w ho 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		-	
Number of people w ho receive psychological therapies	CCG	Actual	350	280	345	220	195	200	225	295	255	290			720	545		1265	4165		↓	
		Target	208	208	391	208	208	208	208	208	208	208			624	208		832	2679			
The proportion of people that w ait 18 w eeks or less from referral to entering a course of IAPT treatment against the number of people w ho finish a course of treatment in the reporting period.	CCG	Actual	89.29%	100.00%	93.55%	93.33%	93.10%	97.62%	96.15%	92.59%	95.65%	96.77%			95.79%	96.30%		95.97%	83.60%		↑	
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%			95.00%	95.00%		95.00%	95.00%			
The proportion of people that w ait 18 w eeks or less from referral to their first IAPT treatment appointment against the number of people w ho enter treatment in the reporting period.	CCG	Actual	100.00%	98.21%	98.55%	100.00%	100.00%	100.00%	100.00%	98.31%	98.04%	98.28%			99.31%	98.17%		98.81%	87.15%		↓	
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%			90.00%	90.00%		90.00%	90.00%			
The proportion of people that w ait 6 w eeks or less from referral to entering a course of IAPT treatment against the number of people w ho finish a course of treatment in the reporting period.	CCG	Actual	71.43%	91.18%	80.65%	80.00%	82.76%	90.48%	80.77%	77.78%	82.61%	80.65%			84.21%	81.48%		83.22%	66.24%		↑	
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%			75.00%	75.00%		75.00%	75.00%			
The proportion of people that w ait 6 w eeks or less from referral to their first IAPT treatment appointment against the number of people w ho enter treatment in the reporting period.	CCG	Actual	95.71%	94.64%	94.20%	95.45%	92.31%	80.00%	42.22%	49.15%	47.06%	62.07%			55.56%	55.05%		55.34%	78.03%		↑	
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%		50.00%	50.00%			
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	71.43%	52.94%	51.61%	46.67%	44.83%	57.14%	84.62%	85.19%	134.78%	109.68%			72.63%	120.37%		89.93%	66.56%		↑	
		Target	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%			40.00%	40.00%		40.00%	40.00%			
Average number of treatment sessions	CCG	Actual	6	6	6	6	7	6	8	7	6	5			7	6		6	5		↓	
% of those patients on Care Programme Approach (CPA) discharged from inpatient care w ho are follow ed up w ithin 7 days	CCG	Actual		96.9%			99.2%			96.2%					98.8%	96.2%	98.8%		97.3%	96.9%		↑
		Target		95.0%			95.0%			95.0%					95.0%	95.0%		95.0%	95.0%			

Dementia																					
Indicator	Level of Reporting	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Q1 2017/18	Q2 2017/18	Q3 2017/18	2017/18	2016/17	Direction of Travel (last 12 Months)	3 Month Trend
Estimated diagnosis rate for people with dementia	CCG	Actual	55.7%	55.1%	55.2%	55.1%	55.4%	58.3%	58.3%	59.1%	59.4%	59.6%	60.2%	58.7%	59.6%	60.2%	60.2%	60.2%	55.4%		↑
		Target	62.8%	62.8%	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%		

HCAI and Quality

Indicator	Level of Reporting		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-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	0	0	1	1	1	1	1	1	2	2	2	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	5	9	7	4	5	4	4	6	5	6	14	12	14	25	22	61	61		↑
		Target	5	9	7	6	6	7	6	8	4	7	6	7	21	17	7	25	78		
Incidence of healthcare acquired infections (HCAI): MRSA - York FT	YFT TRUST APPORTIONED	Actual	0	1	0	0	0	0	1	0	0	1	1	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	2	8	10	5	5	2	2	5	2	3	5	7	9	10	11	30	46		↑
		Target	3	6	3	5	3	3	1	3	3	2	1	3	7	6	3	16	45		
Healthcare acquired infection (HCAI) measure (Escherichia Coli infections)	YFT TRUST APPORTIONED	Actual	32	19	24	27	22	31	21	24	20	23	19	33	76	62	42	180	307		↑
		Target	21	22	27	36	23	26	21	24	20	27	25	20	71	72	20	163	269		
Serious Incidents/ Never Events																					
Number of Serious Incidents (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	8	12	7	7	5	6	1	0	7	4	3	0	7	14	0	21	117		↓
		Target	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	3		
Number of Never Events (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	3		↓
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Smoking at time of Delivery																					
Maternal smoking at delivery.	CCG	Actual		10.3%			12.3%			10.1%			12.0%		10.1%	12.0%		11.1%	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 October (Month 07)

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

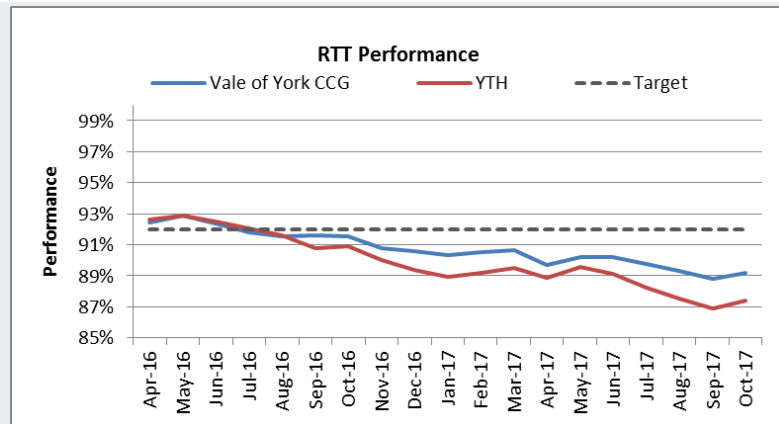
CONTRACTING: PLANNED CARE OVERVIEW

Point of Delivery	Total	
	Var	%
Day Case	(806,304)	(5.53%)
Elective	462,239	4.04%
- PbR / Non PbR	374,350	3.35%
- Excess Bed Days	87,889	34.54%
Regular Day Attendance	(56,736)	(121.69%)
Total Inpatient	(400,801)	(1.54%)
First Attendances	147,066	1.81%
Follow Up Attendances	(39,255)	(0.50%)
Procedures	476,742	13.12%
Non Face to Face	(31,704)	(27.93%)
Total Outpatient	552,849	2.80%
Audiology	223,916	15.38%
Best Practice	25,693	9.39%
Blocks	(2,426)	(0.86%)
Direct Access	495,819	7.34%
Excluded Devices	(85,744)	(7.97%)
Excluded Drugs	(335,366)	(3.96%)
Excluded Other	6,475	9.27%
Radiology OP	(28,456)	(1.54%)
Orthotics	86,342	9.87%
Therapies	248,736	15.03%
Unbundled HRGS	(22,518)	(7.70%)
Vitreous Eye Treatments	33,133	1.79%
Other	6,467	4.21%
Total Other PoD	652,069	2.60%
Total CQUIN	315,921	20.64%
	1,120,038	1.55%

Overview	Planned care is underspent by £1.1m to date
Inpatients	<p>Currently over trading by £400k.</p> <ul style="list-style-type: none"> Day Cases are overtrading overall by £806k. This is due to a £1.3m overspend at YTH from:- a) the Urology One Stop Clinic in Malton not being fully implemented resulting in the planned transfer of day case to OP Procedure activity not occurring to the extent planned b) T&O activity repatriated from Ramsay & Nuffield c) surgical specialties above plan. The Electives overspend at YTH has decreased (£12k over) and Hull & East Yorkshire has increased (£85k over related to high cost / low volume activity). The continued under trade at Ramsay serves to offset these overspends overall. Trauma and Orthopaedics (Day case and Elective) - YTH is overspent by £338k in total, whilst Ramsay and Nuffield contribute an underspend of £1.2m.
Outpatients	<p>The under trade continues at £553k.</p> <ul style="list-style-type: none"> First attendances are under trading overall. This does not relate to any specific specialty. OP procedures are under trading due to Urology (offset against some of the Day Case overtrade).
Other Points of Delivery	<ul style="list-style-type: none"> Excluded Devices are now overspent due a high level of spend on supported ventilation devices at Leeds Teaching Hospitals (overtrade of £68k in month). This is being investigated
CQUIN	Under trade of £248k, largely relates to the 0.5% national reduction applied to providers which did not achieve financial balance in 2016/17 .
Adjustments	This relates to First to Follow Up and Pre-assessment ratios applied to the Ramsay and Nuffield. Adjustments related to YTH are detailed in the contract trading report.

PERFORMANCE PLANNED CARE: REFERRAL TO TREATMENT (RTT)

Vale of York CCG			York Teaching Hospital			Admitted Backlog (YYH)	
Sept	Oct	DoT	Sept	Oct	DoT	05/11	03/12
88.8%	89.2%	↑	86.9%	87.4%	↑	1,437	1,428



York Trust's RTT performance in October 2017 was 87.4% , a 0.5% improvement on September. This is 4.6% off trajectory and therefore the planned return to 92% by the end of October 2017 was not achieved.

The admitted backlog remained relatively stable through October, and the non-admitted backlog reduced from 1884 in September to 1699.

There was one declared 52 week breach in October for Thoracic Medicine (sleep service). Long waits continue to be a significant concern in particular for Sleep Services, Max Fax and Dermatology. Additional capacity has been agreed with Leeds to support Max Fax patients and the contract for the Locum working in Dermatology has been extended to February 2018 , until the new Consultant starts work at the Trust. Long wait patients are reviewed weekly and prioritised through theatre planning and bed meetings.

Specialty	Performance	Breaches	Main Provider
Thoracic Medicine	80.20%	119 of 601	110 YTH
Plastic Surgery	82.21%	29 of 163	15 LTH 6 HEY
Urology	82.93%	157 of 920	136 YTH
Ophthalmology	85.30%	380 of 2585	355 YTH
General surgery	87.08%	252 of 1950	221 YTH
Dermatology	87.35%	146 of 1154	142 YTH
Neurosurgery	87.50%	1 of 8	1 Other
Cardiothoracic Surgery	90.00%	1 of 10	1 Other
Gynaecology	90.68%	75 of 805	67 YTH
T&O	91.69%	130 of 1564	53 LTH, 48 YTH
All	89.24%	1,663 of 15,451	1,362 YTH

DNA rates have improved in October down to 6.1% following the introduction of text reminder services and concerted work across Directorates, with the York locality DNA rate down to 5.1% and Scarborough 7.8% .

95% of requested theatre lists have gone ahead year to date, however the total number requested remains 19% lower than the lists identified in the service level agreement with Directorates to meet planned demand this year. This is due to a combination of annual leave, consultant vacancies and nurse staffing issues.

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

PERFORMANCE PLANNED CARE: CANCER

14 Day Fast Track

62 Day 1st Treatment (GP)

62 Day 1st Treatment (SS)

CCG	DoT	Targ.	CCG	DoT	Targ.	CCG	DoT	Targ.
86.8%	↓	93%	72.5%	↓	85%	88.9%	↓	90%

14 Day Fast Track

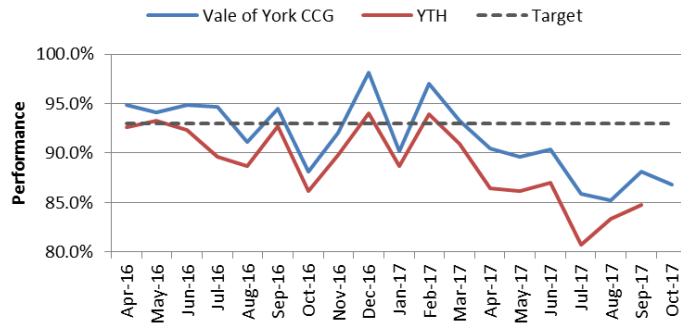
- Vale of York CCG achieved 86.8% in October 2017 compared to 88.1% in September. York Trust (one month behind) achieved 84.8% in September 2017, an un-validated data shows an improved performance of 86.4% in October and 92.9% in November 2017.

There were 131 x 2WW breaches for VOYCCG patients in October 2017. 110 breaches related to suspected skin cancer and the majority of these delays were due to inadequate outpatient capacity. 8 breaches related to suspected lower gastrointestinal cancers and all breaches were due to patient cancellations. Patient cancellations account for 13% of all 2WW FastTrack breaches and 80% of the delayed patients did NOT have cancer.

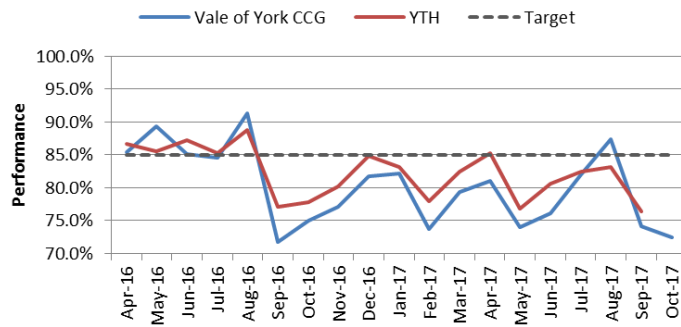
Dermatology recovery work continues at YTH and the locum Consultant's contract has been extended until February 2018 pending the start of the new permanent Dermatologist in February 2018. Immediate action has been taken to ensure that all children are flagged on the weekly PTL and a review of all children's cancer performance is under way. The new 'one stop' model of care opened at Malton Hospital in mid-November and this will enable more patients to be seen and provide a better patient experience as all diagnostic tests will be undertaken on the same day and there is free car parking.

There is on-going colorectal 2WW improvement work focused on piloting FIT testing with SHIELD practices in 2018 which should capture 70,000 patients over 6 months.

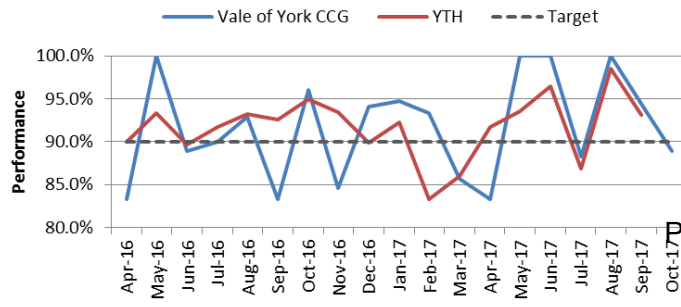
Patients seen < 14 days of an urgent suspect Cancer referral



Patients seen < 62 to First Definitive Treatment after GP Ref.



Patients seen < 62 days to First Definitive Treatment after Screening Service Referral



62 day waits first treatment - Vale of York CCG achieved 72.5% % in October 2017 against 85% target. York Trust (one month behind) achieved 76.45% in September 2017. Un-validated data for October showed a further drop in performance to 74% in October but in November 2017 this improved to 86%.

VOYCCG had 30 x 62 Day cancer breaches in October 2017 :-

7 Urology, 6 Skin, 4 Lung, 4 Lower Gastro, 3 Breast, 2 Haematological, 1 head & neck, 1 Upper Gastro and 2 Other. The main reasons for the delays were:- access to diagnostics, elective & outpatient capacity, patient cancellations and late referral dates.

YTH have asked the NHSI Intensive Support Team to work with them to review 62 Day performance during January 2018. YTH Cancer Board has been reconfigured with 4 work groups focused on: timed pathways, diagnostics, quality surveillance and patient outcomes, living with and beyond cancer. Individual recovery plans are being completed for each tumour site not meeting the 62 Day Standard.

PERFORMANCE PLANNED CARE: DIAGNOSTICS

Test	Performance	Activity	Provider
Non Obstetric Ultrasound	1.68%	15 of 895	8 YTH 4 STH
MRI	1.85%	12 of 648	11 YTH
Cystoscopy	12.12%	8 of 66	8 YTH
Echocardiography	4.67%	7 of 150	7 YTH
CT	1.10%	6 of 544	5 HEY
Colonoscopy	3.80%	6 of 158	5 YTH
Gastroscopy	2.19%	5 of 228	4 YTH
All Tests	98.4%	68 of 3,409	52 YTH

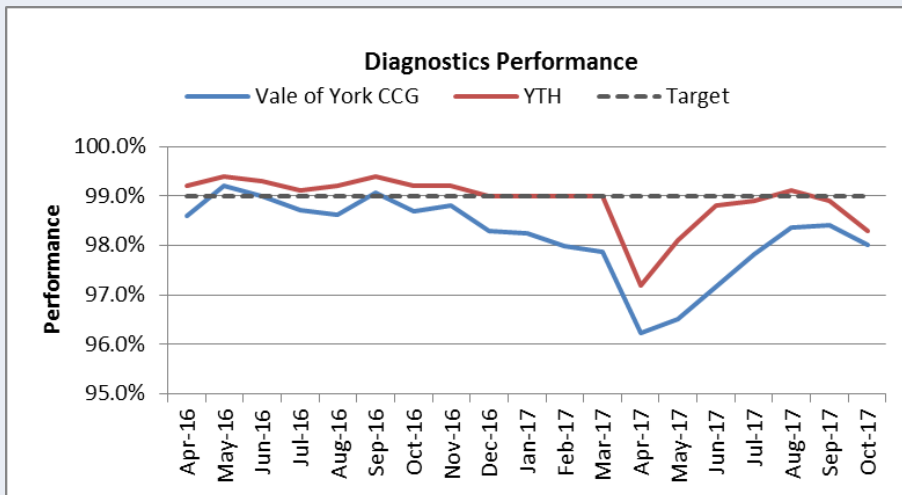
Vale of York CCG achieved 98.4% against the 99% target for patients waiting less than 6 weeks for a Diagnostic Test in October 2017. There were a total of 68 breaches out of 3409 on the waiting list.

The number of CT breaches continued to reduce with 6 in October, 5 at Hull.

The largest number of breaches was in MRI, with 12 patients waiting over 6 weeks. The majority of these patients are waiting for GA clinics and York Hospital don't currently have a resolution date. MRI capacity is impacted by urgent and ED patients taking priority and workforce pressures on routine work.

York Teaching Hospitals performance was 98.32% in October 2017. This equated to 92 breaches from a cohort of 5,469 patients. Echocardiography performance was impacted by unplanned Consultant leave and the situation will be rectified in November 2017.

Capacity and demand work continues for cystoscopy and MRI as part of recovery and sustainability plans in Diagnostics.





Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
<p>RTT – No</p> <p>Cancer – No</p> <p>Diagnostics –No</p>	<p>RTT: Annex</p> <p>Cancer:</p> <ul style="list-style-type: none"> • YTH have asked the NHSI Intensive Support Team to work with them to review 62 Day performance during January 2018. • YTH Cancer Board has been reconfigured with 4 work groups focused on: timed pathways, diagnostics, quality surveillance and patient outcomes, living with and beyond cancer. • Individual recovery plans are being completed for each tumour site not meeting the 62 Day Standard. • Agreed timed pathway in place to meet all waiting time standards for lung and prostate 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 <p>Diagnostics:</p> <ul style="list-style-type: none"> • Capacity and demand work continues for cystoscopy and MRI as part of recovery and sustainability plans in Diagnostics.
Is there a trajectory and a date for recovery / improvement?	Is further escalation required?
<ol style="list-style-type: none"> 1. Cancer 62 day – off trajectory after October performance; need full recovery to 85% by 31st March 2018 2. RTT recovery – there is no joint system trajectory and no national trajectory requirement. YFT local trajectory not being met. 3. Cancer 2WW – no trajectory just continued work to address specialties breaching 	<ol style="list-style-type: none"> 1. Cancer Alliance 62 day recovery plan: 2. RTT recovery plan: 3. Cancer 2WW:

Programme Overview - Unplanned Care

Validated data to October (Month 07)

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

CONTRACTING : UNPLANNED CARE OVERVIEW

	Total	
Point of Delivery	Var	%
Accident & Emergency	89,583	1.66%
Non-Elective	(1,334,726)	(3.62%)
- PbR / Non PbR	(871,509)	(2.58%)
- Excess Bed Days	(463,217)	(15.15%)
Non-Elective Non-Emergency	(264,265)	(4.96%)
- PbR / Non PbR	(211,543)	(4.04%)
- Excess Bed Days	(52,722)	(62.56%)
Threshold Adjustment	(196,200)	8.55%
Re-Admission Adjustment	18,908	(1.85%)
Total Inpatient	(1,776,282)	(4.57%)
Ambulatory Care	24,583	5.46%
Best Practice	(16,013)	(2.84%)
Blocks	(19,804)	(2.22%)
Critical Care	209,509	6.23%
Maternity	144,889	3.84%
Rehabilitation	56,726	6.77%
Other	(38,132)	100.00%
Total Other PoD	361,758	3.68%
Total CQUIN	259,685	19.21%
Total	(1,065,257)	(1.92%)

Overview	£1.1m overspend for the year to date.
Accident & Emergency	The reported underspend is £89k, which includes a financial adjustment related to the ED Front Door at YTH. Further detail is available in the Contract Trading Report.
Inpatients	Over trading by £1.8m. This is a significant deterioration from last month due to the movement of the YTH position. An Observation Unit was opened in A&E during October which may explain some of the increase. YTH has been asked to investigate the reason why emergency activity has increased. Analysis will be undertaken by the CCG once the data is fully coded.
Other Points of Delivery	Continue to under trade by £362k, mainly driven by Critical Care and Maternity.
CQUIN	Under trading by £259k, largely in relation to the 0.5% national reduction for the non-achievement of financial balance in 2016/17.
Adjustments	The challenges applied relate to YTH. Further detail is provided in the Contracting Trading Report.
Please refer to the Contract Trading Report for further detail.	

QIPP: UNPLANNED CARE MONTH 08

Scheme Name	Planned start date	YTD		Forecast Outturn		Plan profile											Actual profile											Forecast profile																			
		Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar						
UNPLANNED CARE																																															
Community Podiatry	May-17	250	216	393	393	0	36	36	36	36	36	36	36	36	36	36	0	31	31	31	31	31	31	31				0	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	85
Review of community inpatient services - Phase I (Archways)	Apr-17	281	235	421	352	35	35	35	35	35	35	35	35	35	35	35	29	29	29	29	29	29	29	29				29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29
Wheelchairs service re-procurement	Apr-17	217	187	217	217	27	27	27	27	27	27	27	27	0	0	0	23	23	23	23	23	23	23	23				23	23	23	23	23	23	23	23	23	0	0	0	0	0	0	0	0	0	0	30
Community Equipment service re-procurement	Apr-17	418	119	418	102	52	52	52	52	52	52	52	52	0	0	0	15	15	15	15	15	15	15	15				15	15	15	15	15	15	15	15	15	0	0	0	0	0	0	0	0	0	-17	
Patient Transport - contracting review	Apr-17	11	11	11	11	11	0	0	0	0	0	0	0	0	0	0	11										11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Unplanned Care Programme (including urgent care and out of hospital care)	Jul-17	458	0	824	275	0	0	0	92	92	92	92	92	92	92	92											0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	92	92	92		
Integrated Care Team Roll-out (Central locality only)	Apr-17	504	135	756	756	63	63	63	63	63	63	63	63	63	63	63	17	17	17	17	17	17	17	17				17	17	17	17	17	17	17	17	17	17	17	17	17	17	17	17	17	17	571	
Review of community inpatient services - Phase II	Oct-17	67	0	200	200	0	0	0	0	0	0	33	33	33	33	33											0	0	0	0	0	0	0	0	0	0	0	0	0	50	50	50	50	50			
RightCare Phase 2 - Trauma & Injuries	Apr-18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0											0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Patient Transport project - re-procurement	Apr-18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0											0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

QIPP: UNPLANNED CARE MONTH 07

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 QIPP supplementary report: Annex to Finance report		

PERFORMANCE UNPLANNED CARE: EMERGENCY CARE STANDARD

Accident and Emergency

Ambulance Service

Type 1 Attendances

% seen within 4 hrs

Conversion Rate

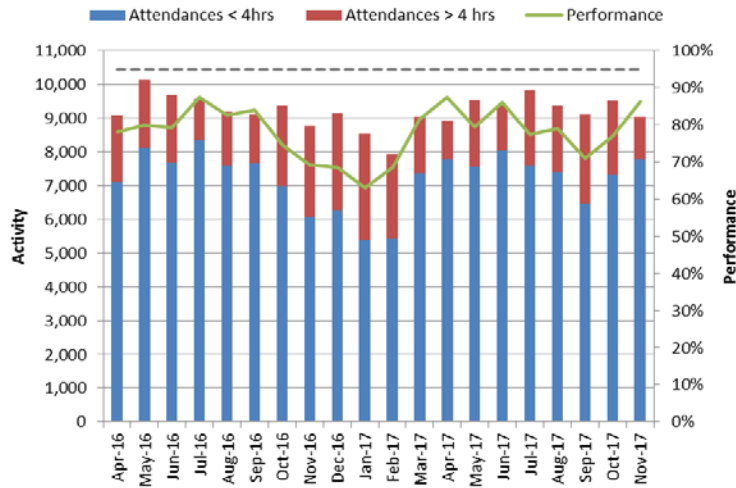
Cat. 1 Standard

Arrivals at Destination

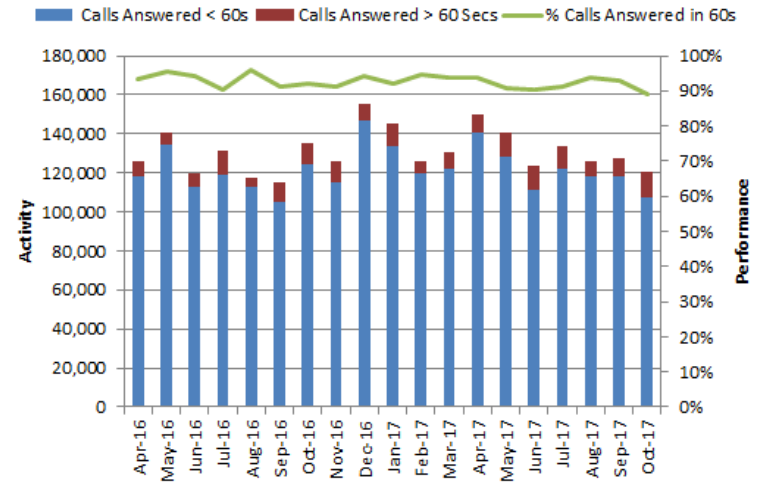
15 Min Handover

Sept	Oct	Nov	Oct	Nov	DoT	Oct	Nov	DoT	Sep	Oct	Std.	Sep	Oct	DoT	Sep	Oct	DoT
9.112	9,519	9,042	76.89 %	86.21 %	↑	37.67 %	39.64 %	↑	7m 14s	7m 11s	7m	3,880	4,097	↑	55.6 %	59.5 %	↑

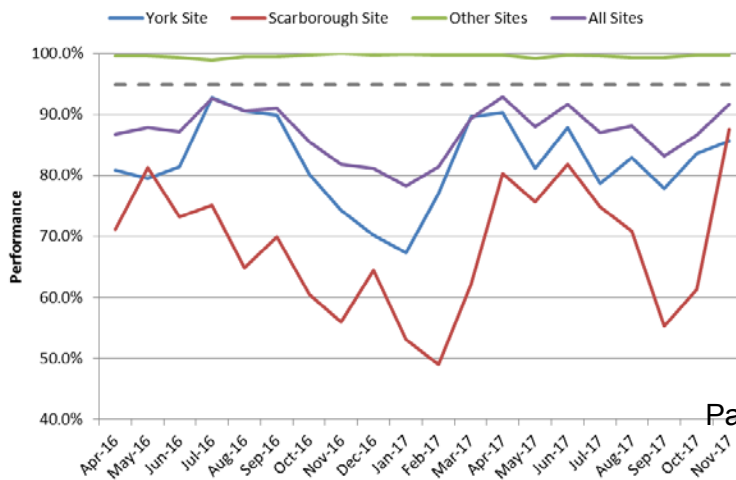
York Trust (All Sites) - Type 1 Attendances and 4 hr Performance



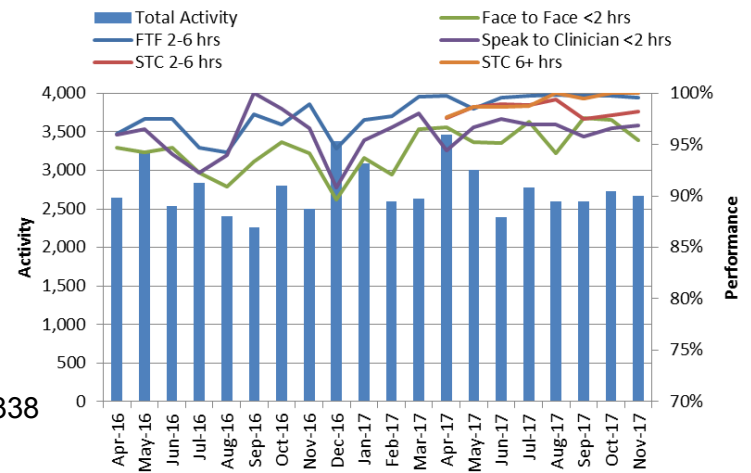
NHS 111 (Y&H)



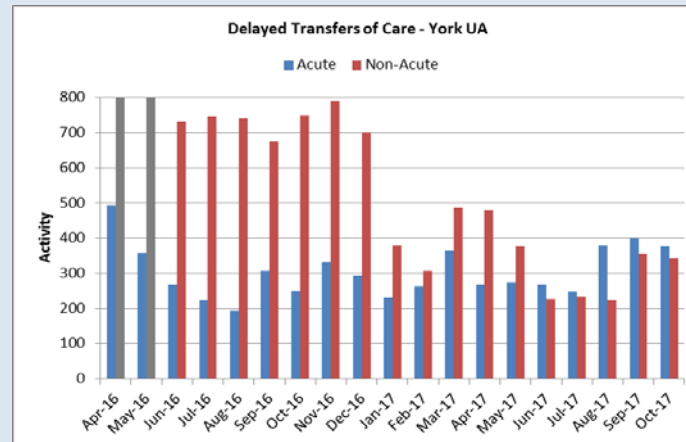
York Trust - AE 4 Hr Performance by Site



GP Out of Hours



PERFORMANCE UNPLANNED CARE: DELAYED TRANSFERS OF CARE



The number of DTOCs decreased in October 2017 to 377 bed days for acute (down from 399 in September) and 343 for non acute (down from 355 in September).

Common reasons for delay include:

- Poor patient flow at York Hospital results in discharges later in the day
- Shortage of Care Staff to provide home care packages
- Delays in putting packages of care in place to support people in their own home
- Difficulties in sourcing overnight care packages
- Continuing Health Care systems and processes are a contributory factor in delays
- Shortage of Dementia/EMI Nursing beds across the City of York and North Yorkshire
- Sourcing complex packages of care that can meet individual needs in a timely manner, especially at weekends
- Patient Choice - patients sometimes wait in acute beds for their preferred Care Home placement

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. Continuing health care – executive lead in place to direct a programme of work, including systems/process/capacity pressures. CHC nurses working with hospital to develop single discharge hub and discharge to assess bed funding agreed for CHC for VOYCCG
3. Care homes, packages of care – CYC market position statement being reviewed, High Impact Change self-assessment undertaken as part of BCF planning. CYC increased providers on framework. Work underway in CCG to develop an aligned contractual framework for domiciliary providers
4. Review of community beds – common recurring reasons for delay identified and alternative system solutions being developed by partner agencies
5. Patient choice – protocol agreed to support timely discharge

DTOCs is one of our key performance indicators and is reported monthly through UNIFY returns. There has been extensive review of the way DTOCs are calculated across the system following discussions of target setting over the summer. A model has now been designed which shows the target and current activity on a daily basis for operational teams to reference. The 10th trust DTC visit took place successfully and work continues on the priorities identified by the Complex Discharge Group, including CHC and Mental Health DTOCs.

KEY QUESTIONS : PERFORMANCE UNPLANNED CARE



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

- **4-hour standard:** Performance continued to be sustained at trajectory level in October and November
- **Ambulance Handovers:** Handover performance also continued to be good throughout October and November
- **YAS response times:** YAS have moved to ARP Phase 3 and are reporting against the YAS response standard pending further discussion at a regional level.
- **OOH GP:** services continue to perform well against quality targets. It has been agreed that the contract will be extended to the +2 years in the original procurement
- **EDFD:** the challenge around data has resulted in a day's audit of the service during December. Results are being analysed but significant numbers of patients appear to have been streamed; potentially above the figures reported by YTHFT
- **NHS111:** performance continues to be on target.
- **DTOC:** has slipped during October against target. Mitigating actions were discussed at the Complex Discharge Group at the start of November and December and pushed forwards where possible
- **Utilisation review:** increased focus continues – data is feeding the winter planning.

What mitigating actions are underway?

- **4-hour standard:** Currently the trajectory for the 4-hour standard is being met. Bids have been put in for additional winter funding against the Budget announcement, Mental Health specific schemes and Primary Care specific schemes – the outcomes of this are awaited.
- **Ambulance Handovers:** monitoring continues.
- **YAS response times:** monitoring continues.
- **OOH GP:** No mitigating actions required at present; monitoring continues.
- **EDFD:** Additional next steps paper is now being collated.
- **NHS111:** No mitigating actions required at present; monitoring continues.
- **DTOC:** Work continues at pace as part of the complex discharge group. CHC and MH work is being escalated. Support for mini-MADE events from LA partners is good.
- **Utilisation review:** individual actions from the AEDB are being escalated as required. The frailty team now have a regular presence at the front door of ED and pathways for timeliness of management of #nof are being mapped as part of the Trauma & Injuries Right Care work.

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

- **4-hour standard:** a joint trajectory has been agreed for achievement of 95% by March 2018. This has been revised by partners in the winter plan and is being met currently.
- **Ambulance Handovers:** current performance matches that seen regionally; monitoring over the next three months will continue.
- **YAS response times:** monitoring over the next three months will continue.
- **OOH GP:** not applicable at present.
- **EDFD:** ongoing discussions at CMB level, audit completed, paper with key themes currently being collated.
- **NHS111:** not applicable at present.
- **DTOC:** trajectory now agreed, actions underway.
- **Utilisation review:** not applicable at present.

Is further escalation required?

- **4-hour standard:** Escalation is underway. Response has been seen with increased focus on the cultural and process changes within YTHFT as well as ongoing support from system partners.
- **Ambulance Handovers:** No
- **YAS response times:** No
- **OOH GP:** No
- **EDFD:** Yes – paper being prepared
- **NHS111:** No
- **DTOC:** Escalation is continuing. Actions are agreed to support the work ongoing and exec and senior support are in place.



Programme Overview

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

Validated data to October (Month 07)

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

MENTAL HEALTH, LEARNING DISABILITY SERVICES, COMPLEX CARE & CHILDREN: CONTRACT MONTH 08

	Cumulative To Date (M8)			Forecast Outturn		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000	£000	£000	£000	£000	£000
Mental Health Services						
Tees Esk and Wear Valleys NHS Foundation Trust	26,432	26,420	12	39,524	39,506	18
Out of Contract Placements and SRBI	3,485	4,764	(1,280)	5,227	6,821	(1,594)
Non-Contracted Activity - MH	281	277	4	421	417	4
Other Mental Health	156	156	0	233	233	0
Sub Total	30,354	31,617	(1,264)	45,405	46,977	(1,572)

QIPP: MENTAL HEALTH, LEARNING DISABILITY SERVICES, COMPLEX CARE MONTH 08

Scheme Name	Planned start date	YTD		Forecast Outturn		Plan profile														Actual profile											Forecast profile																			
		Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar									
COMPLEX CARE																																																		
Continence Supplies	Apr-17	23	5	23	23	5	5	5	5	5	0	0	0	0	0	0	4	-7	20	-4	-8	0	0	0																								18		
CHC review 1 to 1 care packages	Apr-17	98	0	98	98	14	14	14	14	14	14	14	0	0	0	0	0	0	0	0	0	0	0	0																									98	
CHC review: Short Breaks	Apr-17	51	0	51	51	7	7	7	7	7	7	7	0	0	0	0	0	0	0	0	0	0	0	0																									51	
CHC review panel decisions (jointly funded packages of care)	Apr-17	83	0	83	83	12	12	12	12	12	12	12	0	0	0	0	0	0	0	0	0	0	0	0																									83	
Complex Care - CHC and FNC benchmarking	Oct-17	517	0	1,550	0	0	0	0	0	0	0	258	258	258	258	258							0	0																									0	
Recommission MH out of contract expenditure	Apr-17	200	0	300	200	25	25	25	25	25	25	25	25	25	25	25							0	0																										50

KEY QUESTIONS: MH LD CC QIPP

Are QIPP targets being met and are you assured this is sustainable?	What mitigating actions are underway?	Is further escalation required?
See Agenda item Finance Report with Supplementary QIPP Progress Report		

PERFORMANCE EXCEPTIONS: MENTAL HEALTH

Estimated Dementia Diagnosis Rate (QoF)

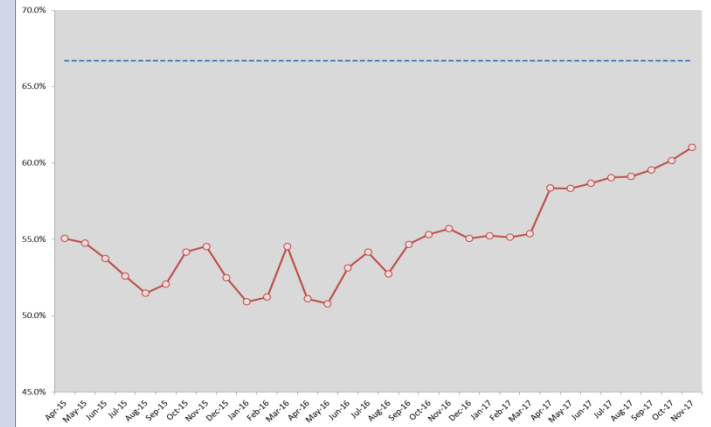
The proportion of people that enter treatment against the level of need in the general population. **Target – 66.7%**

Trend



Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	RAG
58.4%	58.3%	58.7%	59.2%	59.4%	59.5%	60.2%	61.0%	

Recorded Prevalence as a %age of Expected (Whole CCG)



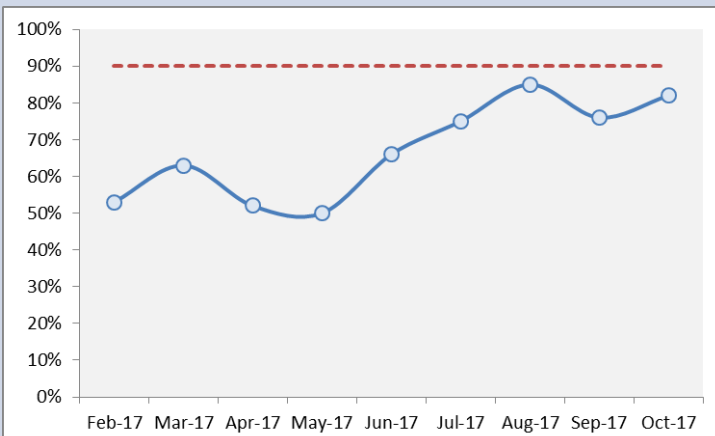
Child & Adolescent Mental Health Service (CAMHS) : % Assessments <9 weeks

The percentage of external CMAHS referrals assessed within 9 weeks. **Target – 90%**

Trend



Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	RAG
63%	52%	50%	66%	75%	85%	76%	82%	



Psychiatric Liaison Service: % seen within 60 mins of A&E referral

The percentage of Psychiatric liaison referrals from A&E seen within 60 minutes. **Target – 90%**

Trend



Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	RAG
72%	67%	88%	88%	87%	85%	88%	86%	

Provider Update:

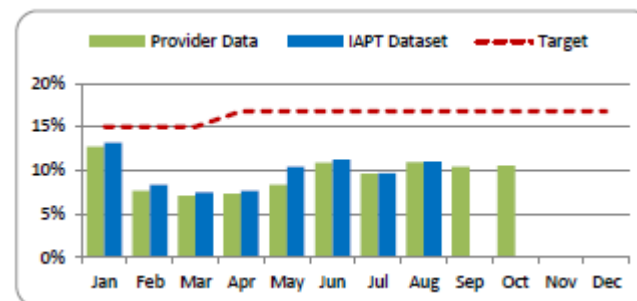
The position for October is 86.11% which is attributable to 20 breaches.

15 patients breached due to staff capacity issues at the time of referral. This occurs when more than one patient is referred at a time and there is only one member of staff on duty.

Recruitment has taken place to increase capacity of the service to prevent future breaches. Staff will commence in post in November 2017 and the service will be fully staffed by the end of November 2017. A twilight shift will be added to alleviate the issues around handover times as soon as possible and will be fully implemented when the service is fully staffed at the end of November 2017.

PERFORMANCE EXCEPTIONS: MENTAL HEALTH - IAPT

Improving Access to Psychological Therapies (IAPT) : Prevalence								
The proportion of people that enter treatment against the level of need in the general population. Target – 16.8% from April-17								Trend
								↑
Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	RAG
7.1%	7.3%	8.4%	10.9%	9.6%	10.9%	10.4%	10.5%	Red

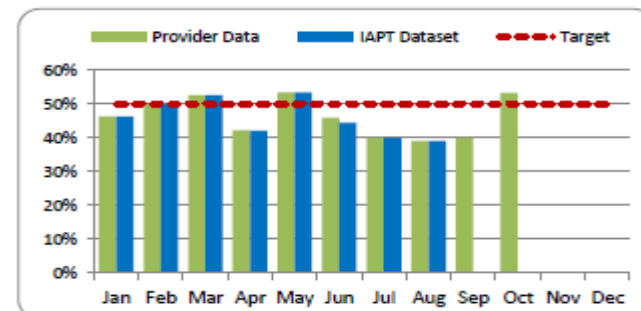


Provider Data

Source: TEWV

Monthly	2016-17				2017-18							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Referrals	466	400	571	325	383	326	375	349	346	465		
Number Entering Treatment	332	199	184	191	219	284	251	285	272	275		
Monthly Prevalence rate	12.7%	7.6%	7.1%	7.3%	8.4%	10.9%	9.6%	10.9%	10.4%	10.5%		
Rolling 3 month Prevalence rate	12.0%	10.2%	9.1%	7.3%	7.6%	8.8%	9.6%	10.4%	10.3%	10.6%		
Quarterly against target	Target	Q4	Var.	Target	Q1	Var.	Target	Q2	Var.	Target	Q3	Var.
Number Entering Treatment	1172	715	-457	1319	694	-625	1319	808	-511	1319		
Quarterly Prevalence rate		9.1%			8.8%			10.3%				

Improving Access to Psychological Therapies (IAPT) : Recovery								
Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session. Target – 50%								Trend
								↑
Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	RAG
52.7%	42.2%	53.4%	45.9%	40.0%	39.0%	40.0%	53.3%	Green



Provider Data

Source: TEWV

Monthly	2016-17				2017-18							
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number completing treatment	151	150	143	202	126	130	117	154	125	210		
Number moving to recovery	62	66	69	81	62	56	44	57	46	104		
Number not at caseness	17	18	12	10	10	8	7	8	10	15		
Monthly Recovery rate	46.3%	50.0%	52.7%	42.2%	53.4%	45.9%	40.0%	39.0%	40.0%	53.3%		
Rolling 3 month Recovery rate	48.7%	46.6%	49.6%	47.5%	48.3%	46.3%	46.6%	41.5%	39.6%	45.4%		
Quarterly against submitted plans	Plan	Q4	Var.	Plan	Q1	Var.	Plan	Q2	Var.	Plan	Q3	Var.
Number moving to recovery	197	197	195	199	4	195	147	-48	195			
Quarterly Recovery rate		49.6%			46.3%			39.6%				

PERFORMANCE EXCEPTIONS: MENTAL HEALTH - IAPT

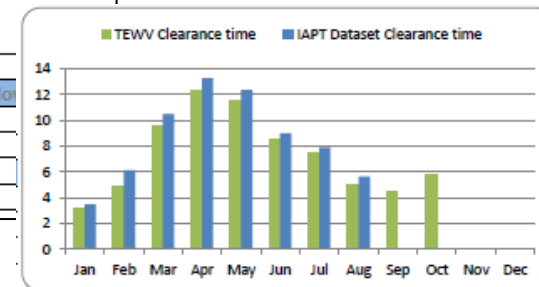
Clearance waiting times

The scale of patients waiting is often shown as Clearance Times in weeks. The clearance time is the number of weeks it would take to clear the waiting list if no further new referrals arrived i.e. the number of patients waiting divided by the weekly number of patients entering treatment. Clearance times therefore give an indication of the scale of the backlog to be cleared, irrespective of the actual numbers and the size of the service/waiting list.

It is the most useful measure for monitoring variation between different services/waiting lists or progress within a service/waiting list.

Source: NHS Digital/TEWV

Monthly	2016-17					2017-18					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
NHS Digital Clearance Times in weeks	3.5	6.1	10.5	13.3	12.4	9.0	7.9	5.6			
Waiting for treatment at month end (TEWV)	223	297	522	543	528	454	433	311	282	371	
Difference to nationally reported	-37	-98	-88	-82	-107	-76	-62	-49			
TEWV Clearance Times in weeks	3.1	4.9	9.5	12.3	11.6	8.5	7.5	4.9	4.5	5.8	

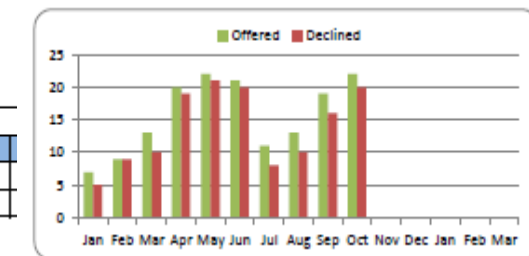


PERFORMANCE EXCEPTIONS: MENTAL HEALTH – PERSONAL HEALTH BUDGETS

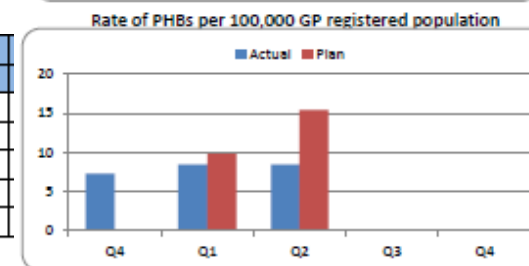
Vale of York CCG

Source: systmOne

Monthly	2016-17					2017-18					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Personal Health Plan Offered	7	9	13	20	22	21	11	13	19	22	
Personal Health Plan Declined	5	9	10	19	21	20	8	10	16	20	



Plan/Actual/Variance	Q4			Q1			Q2		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Quarterly Performance Against Plan									
Number of PHBs in place at the beginning of the quarter		24		20	26	6	35	30	-5
Number of PHBs that began during the quarter		2		15	4	-11	20	0	-20
Total Number of PHBs in the quarter (sum of above)		26		35	30	-5	55	30	-25
GP registered population (total number per CCG)		356,701		356,701	356,701		356,701		
Rate of PHBs per 100,000 GP registered population		7.3		9.8	8.4	-1.4	15.4	8.4	-7.0



Verbal update on Action Plan - Denise Nightingale

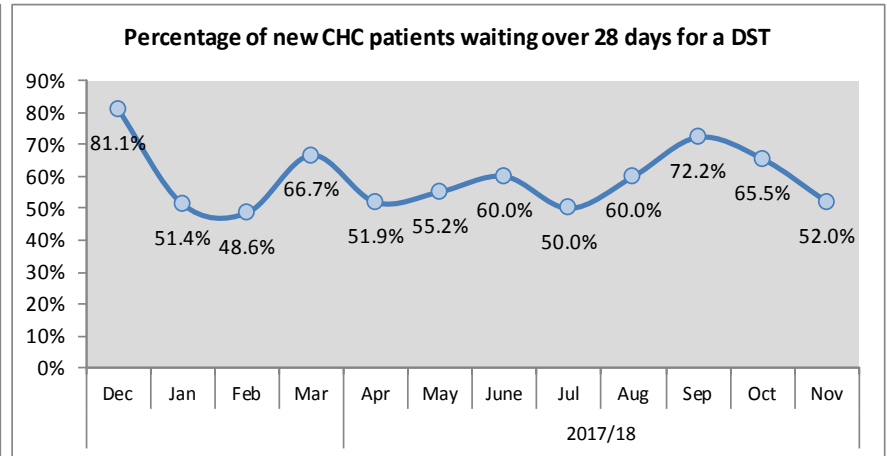
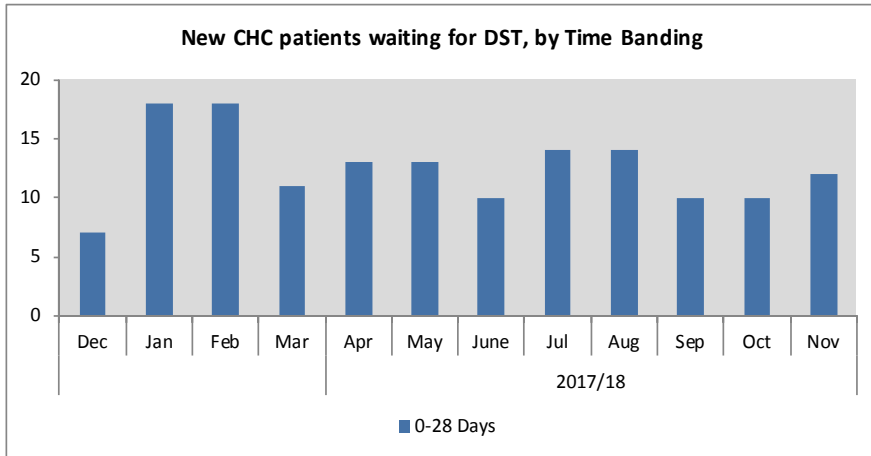
PERFORMANCE EXCEPTIONS: MENTAL HEALTH

CHC: Patients waiting for Decision Support Tool

New patients waiting for a DST (Decision Support Tool), Which should be completed within 28 Days

Source: SystemOne/QA/QAPlus

Monthly	2016/17				2017/18							
	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov
0-28 Days	7	18	18	11	13	13	10	14	14	10	10	12
Waiting over 28 Days	30	19	17	22	14	16	15	14	21	26	19	13
Overall	37	37	35	33	27	29	25	28	35	36	29	25
Percentage Waiting over 28 Days	81.1%	51.4%	48.6%	66.7%	51.9%	55.2%	60.0%	50.0%	60.0%	72.2%	65.5%	52.0%



Definitions:

1. CHC refers to Continuing Healthcare. This is a package of continuing care provided and solely funded by the NHS, for eligible patients with on-going healthcare needs. The NHS, and not the local authority or individual, pays for the total cost of that care.
2. Awarding FNC is a subset of the National Framework for Continuing Healthcare and is nationally set amount which supports individuals assessed as eligible for Funded Nursing Care in care homes under the framework.

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

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

IAPT : Performance remains below target for access at 10.5% (0.1% increase on last month) and the three month rolling average for access has increased to 10.6%. The recovery rate is now above target at 53.3%.

Dementia : Performance continues to improve and is now at 61.0% although it remains below the national target.

CAMHS : Performance remains below target. Current position is 82% having a second appointment in under 9 weeks. Eating disorder performance remains low against national standards. There is some initial un-validated data for autism waiting times as TEWV working through the DQIP to enable reporting from PARIS.

Psychiatric Liaison : Performance hovers just below the target at 86% but the reasons given for some of the breeches are clinically reasonable.

CHC : NHS England required a CHC Improvement Plan for DSTs in 28 days and work on-going to meet this.

What mitigating actions are underway?

IAPT : Work with TEWV and IST is on-going. Work continues in clearing backlog and implementing new pathways. TEWV held a rapid improvement event is planned by TEWV for week commencing 20th November. The CCG will monitor progress against this action plan at the CMB. The CCG has agreed to work on long term plans for achieving targets up until 2021.

Dementia : Progress is being made against the action plan. The CCG has responded to the findings and an action plan is being compiled in collaboration with other partners. Work is on-going with the next tranche of practices with the lowest coding rates.

CAMHS : Performance and progress on the action plan will be monitored by CMB.

Psychiatric Liaison : The CCG is evaluating the current level of activity and will continue to monitor the shortfall in performance at the monthly CMB. TEWV is progressing work to expand the service by recruiting additional staff.

CHC: continuing to validate each case from the 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. No NECS update received, as yet.

PHB: targets for increasing the numbers are not being met-review of opportunity and process underway. DSTs done out of hospital improving due to discharge to assess pathway & performance management.

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

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

Dementia : Yes – The tasks in the action plan support progress towards delivery of the national target of 66.7% and this will be reviewed regularly.

CAMHS : Work is on-going with TEWV to meet required performance targets

Is further escalation required?

IAPT : Verbal update to F & P Committee on 21st December 2017, as required.

Dementia : Verbal update to F & P Committee on 21st December 2017, as required.

CAMHS : Verbal update to F & P Committee on 21st December 2017, as required.

Psychiatric Liaison : No escalation required at this stage.

CHC : No further escalation at present.

Programme Overview

- Primary care



November 2017

Scheme Name	Planned start date	YTD		Forecast Outturn		Plan profile												Actual profile												Forecast profile																			
		Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar								
PRIMARY CARE																																																	
Dermatology Indicative Budgets	Apr-17	36	38	36	35	12	12	12	0	0	0	0	0	0	0	0	13	13	13																														
GPIT - NYNET	May-17	117	117	183	183	0	17	17	17	17	17	17	17	17	17	17	0	17	17	17	17	17	17	17																									
Roll out indicative budgets to other specialities	Jul-17	42	0	75	0	0	0	0	8	8	8	8	8	8	8	8																																	

Annex 1: Supporting performance reports

Validated data to October (Month 07)

ANNEXES



Public
Performance Report

Public Performance Report
York Trust overview of Performance.



Performance
Headlines

Performance Headlines
York Trust detailed Performance report. This covers key metrics such as the Emergency Care Standard, Cancer, RTT and Diagnostics.



Medical staffing
Update YTHFT Dec 2017

Update on Medical Staffing at YTHFT: December 2017



DTOCs reporting
Dec 2017

ADASS LGA and NHS letter: DTOC reporting Dec 2017



York DTOCs letter
Dec 2017

**Department for Communities & Local Government and
Department of Health - Letter: Dec 2017**

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	Multispecialty Community Provider (new model of care)
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: 12									
Name of Presenter: Michelle Carrington									
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group								
Report Title – Quality and Patient Experience Report									
Purpose of Report <i>(Select from list)</i> For Information									
Reason for Report To provide the Governing Body with an update from the Quality and Patient Experience Committee									
Key Messages <ol style="list-style-type: none"> 1. Changing Roles of the Child Safeguarding Board 2. Gaining additional assurance regarding Never Events (York Hospital NHS Foundation Trust) 3. Quality in Care Homes 									
Strategic Priority Links <table style="width: 100%; border: none;"> <tr> <td><input checked="" type="checkbox"/> Strengthening Primary Care</td> <td><input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care</td> </tr> <tr> <td><input checked="" type="checkbox"/> Reducing Demand on System</td> <td><input checked="" type="checkbox"/> System transformations</td> </tr> <tr> <td><input type="checkbox"/> Fully Integrated OOH Care</td> <td><input type="checkbox"/> Financial Sustainability</td> </tr> <tr> <td><input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> Strengthening Primary Care	<input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care	<input checked="" type="checkbox"/> Reducing Demand on System	<input checked="" type="checkbox"/> System transformations	<input type="checkbox"/> Fully Integrated OOH Care	<input type="checkbox"/> Financial Sustainability	<input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract	
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Emerging Risks (not yet on Covalent)									

Recommendations

To receive the report

Responsible Executive Director and Title

Michelle Carrington, Executive Director for
Quality and Nursing

Report Author and Title

The Quality and Nursing Team

NHS Vale of York Clinical Commissioning Group
Quality and Patient Experience Report
– December 2017

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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

Patient Story

The CCG's Engagement Lead brought a paper to the June's Quality and Patient Experience Committee which described Vale of York Clinical Commissioning Group's commitment to ensuring that the patient, carer and public voice is heard by the introduction of patient stories at committee meetings.

A patient story is an account of someone's experience of health and/or social care, and enables the organisation to understand the impact from their perspective. These stories bring an experience to life and help us to focus on the patient as a whole person rather than a clinical condition or outcome.

Stories can be used to highlight a need, to open a discussion, to share best practice and demonstrate success. They provide vital feedback and help to give us direction and identify areas for improvements and where changes can be made for the right reasons.

A parent carer was approached and was happy to be filmed and highlight their experiences of navigating a number of health and care services on behalf of her daughter.

The CCG gained the consent of the parent carer to record her story as well as being involved in reviewing the film before it was shared at the Quality and Patient Experience Committee.

The Deputy Chief Nurse will also ensure that Helen will receive feedback following the meeting.

City of York Safeguarding Children's Board

The draft update for the statutory guidance, *'Working Together to Safeguard Children 2018'* has been issued. The consultation period opened on 25 October 2017 and closes on 31 December 2017. As reported to previous QPEC meetings these revisions are being made largely to reflect the legislative changes introduced through the Children and Social Work Act 2017. The key changes relate to:

- The replacement of Local Children Safeguarding Boards (LCSB's) with Local Safeguarding Partners
- The establishment of a new National Child Safeguarding Practice Review Panel
- The transfer of responsibility for child death reviews from Local Safeguarding Children Boards to new Child Death Review Partners

The Designated Nurse attended a Department for Education consultation event in Sheffield and she will be leading the development of a North Yorkshire and York Health Provider and Commissioners Response. QPEC will continue to receive updates.

Quality in Primary Care

The Quality Lead for Primary Care has been visiting practices to introduce herself and better understand the successes and challenges in primary care. The Quality Lead for Primary Care arranged an informative session at York St John University about access to primary care, presented by a local GP. Other collaborative working includes presenting a Revalidation session to an audience of practice nurses, alongside the Senior Quality Lead.

Workforce Development

The Quality Lead for Primary Care and Senior Quality Lead will attend Support Staff Steering Group meetings. The aim of this group is to develop a sustainable framework that enables employers to attract, recruit, develop and retain health and social care support staff across Humber, Coast and Vale, to enable the delivery of high quality, efficient and cost effective care, whilst modernising and transforming service provision to meet the needs of its community. This work should be aligned to the recently published Multi-professional framework for advanced clinical practice in England (Health Education England, 2017).

Practice Nurse Forum

The CCG Practice Nurse Lead has recently left this post to undertake further study. The Quality Lead for Primary Care has assumed responsibility for the Practice Nurse Engagement and Practice Nurse Forum.

Learning Disabilities & Screening

Clinicians from the CCG attended an informative session at the Learning Disability Forum (LDF) Community Voluntary Service (CVS) on the 28th September 2017. A local GP delivered a presentation about women's health as data demonstrates poor uptake of screening and reduced health outcomes in this population. Following the interactive discussion at this meeting an action plan was devised to address the potential barriers and issues raised. The Quality Lead for Primary Care will provide an update at the LDF CVS in December 2017. The Quality Lead for Primary Care has been working with external partners to scope and develop these actions.

Collaborative plans are underway to scope practice level uptake data for this cohort of patients. The Cancer Research UK Facilitator has kindly offered to support with collating results, the GP Macmillan Cancer Lead within the CCG is also involved.

Infection Prevention & Control (IPC)

HCAI Surveillance

An update on the numbers of HCAI cases will be provided in the next report once all the data is available and has been collated at the end of quarter 3.

Antimicrobial Stewardship (AMS) Update

Vale of York CCG is represented by the Head of Quality Assurance and Maternity at the North Yorkshire Antimicrobial Stewardship Group (NYAMSG) which was established in October 2016 to oversee antimicrobial stewardship at scale across the North Yorkshire CCGs, including oversight of the implementation of NICE guideline NG15 which requires healthcare organisations to have systems and processes in place to enable safe and effective use of antimicrobials. This wider scale working is proving beneficial.

The AMS role includes

- Oversight of the monitoring of use of antimicrobials and flag issues with prescribers
- Lead and support antimicrobial policy and practice development within care settings
- Update and disseminate guidance relating to antimicrobials
- Lead antimicrobial action planning when required
- Dissemination of important information to appropriate colleagues
- Maintain oversight of programmes of education and training to support AMS
- Undertake the development and updating of the antimicrobial guidance for primary care in York and North Yorkshire
- Development of a programmes of AMS to support commissioners covering all care settings including the review of prescribing, hospital admission and resistance data, new drugs, education and training, patient safety, laboratory test reporting.

Summary of actions to date:

Topic	Outcome
Update of the NY CCG guidance particularly with respect to UTI management	Updated and reissued guidance
Oversight of primary and secondary care data; PHE data	Action via CCG MM teams
Review of Boots near patient testing plan for sore throats	Considered but on hold.
Consideration of pilot for CRP testing for respiratory infections	At scoping stage

Overview of UTI bacteraemia data	Review ongoing and also seeking to establish
Gentamicin – place in therapy and review of RAG status	Completed
Fidaxomicin – place in therapy and review of RAG status	Completed
Baseline assessment for each CCG in relation to NICE guidance	In progress

Methicillin-Resistant Staphylococcus Aureus Bloodstream Infections (MRSA BSI)

The MRSA trajectory remains zero however there have been 10 cases reported to date, 5 community cases and 4 York Teaching Hospital NHS Foundation Trust (YTHFT) apportioned following post infection reviews. 1 recent case is still awaiting review. Of the 5 pre cases 2 are assigned as third party. Issues identified from post infection reviews formulate action plans for the YTHFT, for example additional training on care of devices. Review of the existing equipment currently used to obtain blood cultures is underway as contamination has been a factor and other collection equipment is being considered.

Clostridium difficile (C diff)

The C diff objective for 2017/18 remains at 82 cases with YTHFT remaining under trajectory. The CCG continues to participate in the review of both hospital and community cases where agreement on any lapses in care is made. Whilst improvements in practices are evident recurring themes continue to be identified from these post infection reviews at YTHFT, such as inappropriate antibiotic prescribing, cleaning and fabric of the wards and occasionally delay in sampling or isolation. The Infection PC team have had challenges in gaining attendance from ward nursing and medical staff for these reviews due mainly to clinical workload. The Quality Lead for primary care now attends the review of community cases to support sharing of any learning across the locality.

Methicillin-susceptible Staphylococcus Aureus Bloodstream Infections (MSSA BSI)

MSSA BSI continues to be reported as per Public Health England (PHE) requirements. The number of these cases continues to rise and some seasonal variation is to be expected. Other local secondary care providers have also seen an increase in cases.

E. coli BSI

As of April 2017 the CCG objective for the reduction of Gram Negative BSI has been in place. A 10% reduction in cases is required based on the number of cases from January 2016 to December 2016. The CCG objective is 287 cases for 2017/18. The mandate is to achieve a 50% reduction in the number of E. coli BSI over 3 years based on 2015/2016 figures across all care settings. Agreement on the number of cases to be reviewed by both acute and community based staff has taken place with reviews to date identifying no discernible themes. In recognition of this it has been agreed to further refine the criteria of cases reviewed to over 65 year old patients.

It is acknowledged that reduction will be a huge challenge due to no clearly identifiable themes for e coli bacteraemias being evident. Urosepsis is believed to be a cause in a large number of cases but the local reviews are not demonstrating this. Despite this, improvement plans are underway to improve the quality of care and adherence to guidance to reduce urosepsis with the understanding that this may result in a reduction. However it is acknowledged that any reduction plans or projects are based on expert speculation combined with the need to improve standards and patient experience rather than robust evidence.

A pilot is currently under development to stop dip sticking urine in care home residents and instead focus on clear communication of clinical symptoms to primary care. When combined with support for proactive hydration and education, other areas have identified significant reductions in both hospital admissions and antibiotic prescribing.

Norovirus

Norovirus has remained a continued presence in YTHFT, and work continues to increase multi agency preparedness and resilience. The number of community outbreaks within the Vale of York to date has been low with the Community Infection prevention team continuing to be vigilant in their monitoring. The Stay Well this Winter campaign continues to focus on keeping visitors with any history of symptoms away from hospitals and education as well as on-going education about hand hygiene. The Community Infection Prevention team support care homes where concerns are raised about infection prevention and help to monitor the resultant action plans. The service specification for this shared service is currently under review to increase the proactive education and support to primary care and care homes.

Serious Incidents

Serious Incidents (SI's) provide valuable information into the safety and overall governance culture within an organisation. Whilst high levels of incident reporting can be indicative of a healthy organisational culture in recognising the importance of learning when things go wrong, failure to demonstrate learning by reporting similar themed incidents raises concerns. Detailed data relating to SI's with accompanying analysis will be provided in the next report. Changes to process have resulted in updating the SI policy which is underway. Following receipt of appropriately agreed actions Serious Incidents are closed on STEIS, the SI reporting platform. Additionally an assurance framework has been devised and is currently under agreement from providers and CCG colleagues.

CCG SI Assurance Framework

Assurance Method	Frequency	Data	Lead
Monitoring of recurrent incidents and appropriate action as required	Ongoing	STeIS reports SI reports Other intelligence	SI team CCG Quality team- Head of Quality Assurance

on situational basis			
Robust quality review of completed investigations and action plans	Monthly	SI reports	SI team Clinical reviewers Head of Quality Assurance
Scheduled planned Quality Site visits	As per agreed schedule	SI data from area Actions from SI action plans for area Patient relations intelligence Recurrent applicable themes	Head of Quality Assurance
CCG attendance at Trust SI panels	As invited	SI report Analysis of recurring trends and themes	Head of Quality Assurance
Assurance visits to Trust	Quarterly	Random number of SI's selected and audit of evidence of completion progress provided, eg ward visits, guideline updates, safety briefs	Head of Quality Assurance
CCG attendance at Falls and Pressure Ulcer panels	Monthly	Collation of themes and trends	Head of Quality Assurance

Key Issues from provider Trusts

York Teaching Hospital Foundation Trust

Never Events

Concerns regarding the number and similar type of Never Events reported by YTHFT have resulted in a joint letter to the Medical Director from Vale of York, Scarborough and Ryedale and East Riding CCG highlighting concerns. The letter requests assurance of evidence of learning, embedding of robust safety checks and actions to address procedural failings.

Since May 2017 there have been 4 Never Events, 2 at York District Hospital, 1 at Bridlington Hospital and 1 at Scarborough General Hospital. All four cases are related to surgical invasive procedures and three of the cases are related to incorrect identification of the patient and thus suggests that systems and process related to this aspect of patient safety are not embedded in the Trust.

Whilst the CCG acknowledge that there is significant work being undertaken related to the implementation of National Safety Standards for Invasive Procedures (NatSSIPs) and an action plan in progress it appears to lack the pace required to maintain patient safety. The latest Never Event occurred in October 2017.

To date, the completed Serious Incident reports identify overall themes as: not adhering to policy and procedure, process issues, training, communication, supervision, time pressure and human error.

Given the occurrences described and the lack of assurance from the previous communications the CCG have requested a meeting with appropriate representatives from the YHFT to discuss these Never Events and to agree a way forward. East Riding CCG, Scarborough and Ryedale CCG and VOYCCG will all be represented.

QPEC will receive an update about the outcomes of this meeting in February 2018.

Duty of Candour

YTHFT's compliance with the duty of candour standards for patient and families is improving with evidence in reports and conversations at the falls and pressure ulcer panels. Internal processes to identify cases where Duty of Candour is required are included on directorate quality dashboards which are reported through performance meetings where hospital directorates are held to account.

Pressure Ulcers and Falls

The number of falls with harm which fit the Serious Incident framework continues to decrease. However, similar themes and issues continue to be evident in cases reviewed. A meeting has taken place recently with the Deputy Director of Patient Safety to review progress against the organisations Strategic Action plan which details how YTHFT will support pressure ulcer and falls reduction. CCG Senior Nurse attendance at the Trust Falls and Pressure Ulcer panels continues to provide clear evidence of improvements, openness and insight. Neighbouring CCGs and providers have requested if they can attend the panels with a view to replicating this approach.

Evidence of pressure ulcers reduction is not as evident. Reviews of progress against the strategic project plan describe some improvements but the CCG and YTHFT recognise that there are more actions to embed.

SI Framework Compliance

Adherence to the scope of the current NHS SI Framework contributes to the number of Serious Incidents reported which is higher than neighbouring acute trusts. The Head of Quality Assurance and Maternity attended a YTHFT SI lead investigators training day to present what commissioners want from a Serious Incident report and explained the organisations overall position and the need to adhere to the framework. The number of requests for de-logs continues with the total number de-logged from April 2017 to date 26 CCG cases and 13 SRCCG cases. Any cases where de log is not agreed are discussed in person to ensure assurance is obtained.

CCG SI Team

There have been significant amendments and improvements in the CCG management of the Serious Incident processes since the CCG took over the responsibility of the North Yorkshire SI team. Meetings with providers to address outstanding queries are slowly becoming established. This allows earlier closure of cases as assurance is provided allowing providers to focus on embedding of learning and implantation of action plans. The assurance schedule for provider meetings has been shared with YTHFT and a response is awaited.

Tees, Esk and Wear Valleys (TEWV)

Key Issues

Following significant concerns regarding the lack of responsive reply to queries about SI reports and outstanding action plans a meeting was organised with the Director of Quality and Governance who explained the reasons for this. An agreement was reached for updates to be provided against queries and once received closure of old cases. This is progressing via monthly meetings being arranged with the Head of Patient Safety following the CCG SI panel to continue the timely dialogue and assurance process. Two Quality visits are scheduled to TEWV services, which include Huntington House in December and Lime Trees and the CAMHS service in early January. The aim of these visits is supportive fact finding by a multi-disciplinary team from the CCG to follow the patient journey, understand staff challenges and promote triangulation of all the information the CCG obtains. A summary of these visits will be presented to QPEC in January 2018.

Requests for extensions on completion of SI reports for all CCG's continue to be made by TEWV. The Director of Quality Governance updated us about significant capacity gaps within the Patient Safety team and that recruitment had taken place which included recruitment to the Lead Investigator team. The benefit of this is not yet evident and the Director has been asked to attend the planned joint CCG meeting with the Head of Patient Safety to provide further updates. No extensions to completion of SI reports have been requested for staffing reasons for CCG cases.

Outstanding actions from 2 SI reports from Leeds and York Partnership Foundation Trust have now been closed.

The CCG had raised concerns with TEWV about the robust processes for evidencing learning. The Director of Quality Governance has since shared the TEWV annual quality report which provided further evidence and the CCG's assurance schedule will support this. Amendments to the Contract Management Board schedule have taken place with a quarterly meeting assigned to quality which is viewed as positive.

The CCG management of the SI process has also improved. A senior mental health clinician employed by CCG is now reviewing all SI reports. This ensures that relevant issues are identified which are then triangulated with performance data and discussed at Contract Management Board. This function is currently being undertaken on behalf of other CCG's which may not be sustainable. Additionally, the Head of Quality Assurance dials into TEWV Director Panels and contributes to

robust discussions and scrutiny of SI reports. Identified issues are reviewed at the CCG SI panel.

12 Hour Trolley Waits - Review of Patient Safety Assurance Process

The process of reporting and providing assurance of patient safety and avoidance of harm for those patients waiting on trollies in the Emergency department for more than 12 hours has been reported previously. An updated process has now been developed which will address these issues.

Details of Serious Incidents from other providers will be provided in the next report. There have been no significant concerns to date and the Nursing and Quality team are committing to attend Contract Management Boards to allow closer scrutiny of quality, patient safety and patient experience.

CCG Incidents

Owing to a number of issues a CCG incident management system has not been implemented. In response, a system called Safeguard has been re-established which will provide this function and enable CCG staff to report incidents.

The RSS Serious Incident investigation is complete. Root causes were attributed to delays in appropriate referral with numerous administrative issues being identified as contributing factors. The GP practice and RSS have fully engaged with the process, made amendments to processes and embraced the learning. The GP shared the report with the patient who was satisfied with it and the recommendations. The RSS actions are also complete.

Maternity

STP Local Maternity system

Work continues in STP Local Maternity System in line with requirements. The plan is complete and was submitted to NHS England with the NHS England Clinical Network providing support and expertise to all working groups. Recruitment is underway for project managers including those with specialist midwifery expertise. Four task and finish groups have been established which include Safer Maternity Care, Improving Choice, Multi professional working and Governance and Perinatal Mental Health (PNMH). The Head of Quality Assurance and Maternity represents the CCG on 3 groups as well as the Executive Board. The commitment is significant, particularly as sub groups are now emerging to progress the work. A summary of the detailed plan was presented at Governing Body which included the risks to both the STP and the CCG.

Key risks to the CCG from this work

- Detailed financial information not yet available
- Challenges in maintaining existing service provision whilst transforming service delivery
- Lack of specialist maternity commissioning resource and capacity within the CCG to ensure the CCG is involved and population need is reflected
- Local demographic not representative at STP level
- Financial impact of developing and sustaining a PNMH service

The CCG commissioning statement for maternity services is being developed which includes an update of the service specification as well as mapping to the Better Births report. The maternity Key Performance Indicators also require review.

The regional dashboard describes YTHFT having the lowest stillbirth rate. YTHFT have reduced this by a third through implementation of the Stillbirth bundles, adherence to the customised growth charts and raising awareness of the importance of foetal movements.

Rates of Smoking at Time of Delivery

Numbers of women smoking at the time of delivery appears to have deteriorated slightly although a higher number of maternities did not have their status recorded. Reasons for this are being investigated with maternity services. It is thought that the number of women in York smoking at time of delivery is low overall however specific locations in the city identified by City of York Council (CYC) are significant outliers. CYC have updated that smoking, not only in pregnancy but in the population as a whole has been proposed as a priority focus for public health along with other public health outcomes. CYC smoking cessation teams have been targeting areas of highest prevalence and working closely with midwives to increase the profile of the service, as well as accessible local venues where women can get support. Referral services from midwives have been improved which were disrupted temporarily when the stop smoking service transferred into the council last year. An opt out approach to referral into the yorwellbeing service for behavioural support and medication is being used.

Midwives have been updated on the national on-line training programmes available through the NCSCT website to keep midwives updated in the skills of brief advice to their clients as well as updates on the most recent research findings, strongly linking miscarriage, still birth and other neo natal problems to smoking plus the need for strong accurate advice to stop.

CYC smoking cessation officers are visiting Time and Space for pregnancy groups run in children's centres to make valuable contacts with pregnant women and consult with them on planned advertising campaigns. As the data highlighted such specific areas visits are scheduled to the Avenues centre, Hob Moor and Clifton children's centre as these displayed highest prevalence of smoking at times of delivery. A multimedia publicity campaign with new posters and leaflets is planned for the New Year.

Perinatal Mental Health

Preparatory meetings have taken place to prepare for details of NHSE funding for the development of perinatal mental health services. It is recognised that the lack of a comprehensive service is a risk to the CCG and plans are being developed through the LMS. Proposals have been prepared collaboratively and include valuable themes from service user information will support the plans.

Patient Experience Update

Vale of York CCG Complaints

7 complaints were registered in the CCG during September and October:

- 3 complaints related to communication and information regarding the BMI/smoking threshold policy.
- 2 complaints were about communication and performance of CCG staff.
- 1 patient was unhappy that a new glucose monitoring system is not currently prescribed in the Vale of York.
- 1 complaint related to a delay in being notified of the outcome of a CHC assessment.

62 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. This is available to the most vulnerable people in the community who are in receipt of specific benefits. The consultation period has been extended to 24 November as well as a drop-in session which was arranged on 22 November at West Offices. All feedback is being collected and will be considered in conjunction with the comments received via the on-line/paper survey.
- 12 contacts were from patients who were unhappy with or seeking clarification on the BMI/smoking criteria for elective surgery.
- 14 contacts were from a persistent contactor which required no further action.
- 3 contacts were 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 Medicines Commissioning Committee and a decision will be made before the end of this year.

The table below shows CCG activity for all types of contact during the two month period of September and October (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	7
	Communication/information	4
	Referral	1
Gluten Free Prescribing	Communication/information	2
	Commissioning decision	10
CHC	Communication/information	1
	Assessment	4
	Funding decision	1
Podiatry	Commissioning decision	3
CAMHS	Commissioning decision	1
Referral Support Service	Communication/information re appointment/referral	7
	Commissioning decision	2
CCG	Communication/information	2
Medicines Management	Prescribing	4
Community equipment	Prescribing	2
Respiratory rehabilitation	Commissioning decision	1
Persistent contacters	N/A	14
Individual Funding Requests	Funding decision	2
	Commissioning decision	1

Examples of actions arising from complaints and concerns:

- The CCG were contacted by 3 distressed patients who had been given a date for orthopaedic surgery but on attending their pre-operation assessment, were told the surgery could not proceed because of their BMI (which was over 30). All the patients said that at no point on had there been any discussion about BMI or a warning that surgery may be postponed.

On investigation, the patients had all been seen in the MSK clinic during a period of implementation of the optimising outcomes thresholds (BMI/Smoking policy for elective surgery). The MSK service reported there was uncertainty at that time as to whether BMI recording was required for orthopaedic surgical opinion. The MSK now understand that ALL patients should have their BMI measured on entering the service (and advice given and recorded where appropriate). The CCG arranged for the referrals to be reinstated for all 3 patients.

- The CCG were contacted by a resident who had a health check via the City of York Council's Health & Wellbeing Service. She was very upset at being told her risk of suffering a heart attack or stroke was very high and had been sent away without any support or consideration of how this news affected her.

A few days later she got an email from the service saying that actually her risk was very low and she had been misinformed.

The Assistant Director of Public Health contacted the resident, apologised and explained the measures that had been put in place to ensure this wouldn't happen again.

Other Organisation Complaints / Concerns

36 complaints/concerns were signposted to other organisations and these are detailed in the table below:

Provider/Service	Primary Issue	Contacts
GP	Clinical care	4
	Communication/information	1
	Staff attitude	1
	Access	
Other CCG		
CHC	Funding decision	1
BMI/Smoking policy	Local policy query	1
HEY		
Neurology	Discharge concerns	1
TEWV		
Mental Health adult services	Lack of support	2
CAMHS	Referral	1
YTHFT		
Cardiology	Appointment cancellation	1

Dermatology	Appointment cancellation	1
District Nursing	Care & treatment	1
Orthopaedics	Failure to arrange onward referral	2
	Failure to provide fit note on discharge	1
	Inappropriate discharge	1
	Referral issues	2
Occupational Therapy	Delay in assessment and equipment	1
Respiratory medicine	Services available	1
Specialist medicine	Failure to arrange onward referral	1
Patient Experience Team	Communication/information	1
Infection control	Query re use of gloves	1
Spire Hospital Leeds		
Standard hospital contract breach	Failure to provide timely clinic letter and onward referral	1
HDFT		
Podiatry	Appointment delay	1
Dental services	Referral issue	1
City of York Council		
Public Health	Communication/information	2
Yorwellbeing service	Communication/information	1
NHS England		
PCSE	Medical records	2
Dental	Access	1
IFR	Reproductive medicine	1

Other Sources of Patient Feedback

These include Healthwatch, Care Opinion and NHS Choices. Postings left about our providers are reviewed regularly 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	210
Scarborough	4	85
Selby Warf Memorial	5	22
Malton	4.5	28
St Helen's	2	1

Patient Engagement

Patient and Public Engagement Improvement Assessment Framework (IAF) 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.

The CCG have been assessed against each of these outcomes and the outcomes have been RAG rated amber, scoring eight out of a potential fifteen points.

Despite a range of evidence being submitted the assessment was largely based on the information available on the CCG website. Improvements to the current configuration of the CCG website are planned and it is recognised that whilst the information is available it can sometimes be difficult to navigate.

It was recognised that whilst some of the outcomes of this review were disappointing it did not fully consider the wide range of activities and evidence that the CCG have led with patients, public and staff. However the information is being used as a baseline for improvement into 2018/19.

Regulatory Inspection Assurance

Care Homes – Care Quality Commission Inspections and Concerns

The CCG maintain a record of care homes within the Vale of York area.

- Outstanding: 1 (Christmas Lodge)
- Good: 62
- Requires improvement: 14
- Inadequate: 1 (Stamford Bridge Beaumont nursing home)
- Not inspected: 2 (Chocolate Works Care Village and Tancred Hall Nursing Home)

Care Homes and Adult Safeguarding Update

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 (see Quality in Care Home section).

Yorkshire Doctors Urgent Care CQC Inspection – Rated Good Overall

CQC carried out an unannounced comprehensive inspection at their head office hub at Maple House and the Urgent Care Centre at York Hospital on 30 and 31 August 2017. All five domains of the inspection were rated good. Key findings included the following

- There was an open and transparent approach to safety and an effective system in place for recording

- Patients' care needs were assessed and delivered in a timely way according to need
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment
- There was a system in place that enabled staff access to patient records. The out-of-hours staff provided other services, for example the local GP and hospital, with information following contact with patients as appropriate.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

The CCG have congratulated Yorkshire Doctors on the outcomes of this inspection and look forward to continuing to work with them in the future.

Quality in Care Homes

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. It is hoped that by listening to the opinions of the staff and residents/ relatives the Care Home Work Plan will be representative of user's needs.

React to Red and Safety Huddles: A pressure ulcer quality improvement programme is being led by the Senior Quality Lead and supported by the React to Red Assistant Practitioner. This uses the NHS England 'React to Red' initiative and centres around a set of interventions known as the SSKIN bundle to support care home staff in the prevention and management of pressure ulcers. Although this work focusses on pressure ulcers the education and interventions promotes cross cutting themes such as mobility, nutrition and hydration which will contribute to the reduction of other avoidable harms.

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). Four care homes have been recruited into the first cohort where the methodology for implementation of 'React to Red' via the huddle will be tested before wider scale spread. Cohort 2 commences in December with another 5 care homes identified. A communication plan to GP's and nursing colleagues is under development to inform stakeholders of this important work.

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. Three care homes involved in Safety Huddle work have incorporated a focus on falls. This is important work as falls are known to account for the majority of reported patient incidents. 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.

International Stop the Pressure Day, November 16th 2017 successfully involved as many stakeholders as possible in raising awareness of pressure ulcer prevention. Care Homes across the Vale of York were invited to host their own events with one filming a news piece for That's York TV. A Team Leader from a local care home was supported to attend 'Wounds UK' in Harrogate following a 'React to Red' competition run by the Vale of York CCG in partnership with Direct Health Care Services.

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 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.

A pilot to support care homes not to dip stick urine is being planned in collaboration with the infection Prevention team. This aims to reduce the use of unnecessary antibiotics and promote appropriate antibiotic stewardship.

A QI project to use a technique that can be used to facilitate prompt and appropriate communication SBAR (Situation, Background, Assessment and Recommendation) and NEWS (National Early Warning Score) scores in care/ nursing homes is under discussion. Anticipated to build on work published by Wessex AHSN (Allied Health Science Network) it will focus on earlier identification of the physically deteriorating resident and the use of SBAR to improve communication and safety and include sepsis awareness.

Other programmes the CCG is currently involved with include a Delirium Toolkit and 'Undernutrition' work with the AHSN. The Red Bag initiative is still under consideration but these are longer term programmes of work which will feed into a care home work plan.

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 meeting to explore the opportunity has been arranged for December.

Supporting Carers: The 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 will provide training around a variety of issues important to carers including two to be delivered by the React to Red Team.

Care Home Bed State Tool: This is described as a 'web based capacity portal' developed by NECS (North of England Commissioning Support) in conjunction with NHS England North region, 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 Authorities. Following initial meetings, it is hoped implementation may be agreed in early December.

Winter Resilience: Two identified work streams relating to winter resilience have been identified

- A pathway to reduce the incidence of urosepsis amongst patients who have long term urinary catheters
- A process to support the use of subcutaneous fluids in nursing homes where appropriate to prevent admission into hospital.

Supporting care homes over the winter period with challenges as they arise is a priority for the Quality and Nursing team. Public Health messages such as the support for care workers to receive the flu vaccine have been communicated. All Care Managers are encouraged to contact the senior Quality Lead for any support they require with issues that the VOY CCG may be able to help resolve.

The Partners in Care forum: The November meeting had a full agenda and feedback will be included in the next QPEC report. Representation from those involved in District Nurse Services, CHC, Discharge Liaison and a GP supported and facilitated productive and positive conversation.

A 'Partners in Care Lessons Learned' (PICLL) bulletin specifically aimed at sharing learning from health and social care incidents within the CCG is currently under development and will be presented at the next Partners in Care Meeting.

Health and social care joint working: The Senior Quality Lead now accompanies 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 evidences joint working between health and social care, ensuring that appropriate interventions are facilitated. It is hoped this practice will extend to NYCC and East Riding for care homes across the CCG footprint.

Verification of Expected Death (VOED) in Care Homes: BMA guidance states that a GP is not required to attend a care home to verify an expected death. This can be performed by a 'competent adult'. The CCG is leading a response to issues raised at their Partners in Care meeting in relation to this. Feedback from care home and primary care staff has demonstrated a wide variation in practice and opinion on who and how VOED should be conducted. A follow on meeting has been convened in December with stakeholders from provider organisations, local authority to progress this work aiming to provide clarity and supporting guidance for care home organisations.

Update on Mattress Selection for Community: 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. This has been updated following a review of the mattresses available for use 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. In the first month spend reduced by approximately 44%, savings of £20K. This was an encouraging initial saving however figures from October indicate an increase in usage. Further training and support will be offered to clinical teams to help support them in selecting appropriate surfaces for patients. Further cost saving opportunities are being explored to include how staff order and particular categories of equipment where a review would be beneficial.

A case study into the benefits of using the Mercury Hybrid mattress within a Nursing Home will commence in early December. A care home setting has not published a trial like this as yet and it is hoped will help inform on best practice.

Research Agenda: The CCG continues to support the University of York to consider 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 CCG.

Cancer

Two Week Wait (2WW) for Suspected Cancer Pathway

Five breaches were reported by YTHFT for Children in August against the 2WW suspected cancer pathway. A further 2 are to be reported in September 2017. Ordinarily all suspected cancer referrals are sent to paediatrics at York and then onto to Leeds Teaching Hospitals (LTH). The only exception to this is the dermatology referrals which remain in York – hence the breaches.

YTHFT are providing us with full analysis of why the breaches occurred and what remedial action will be taken to avoid reoccurrence but are understood to be as a direct result of the wider issues re a lack of Dermatology Consultant capacity.

All referrals were seen within a maximum of 34 days and none of the breaches were diagnosed with cancer. Poor performance against the 2WW for suspected cancer and 62 day wait from referral to treatment remain a key priority for the CCG. The CCG's quality and nursing team will continue to work closely with the CCG's Assistant Director of Delivery and Performance and the Cancer Alliance to ensure that review of potential clinical harm is always considered when breaches are reported.

End of Life Care

Early discussions with the trust about My Right Care, an IT solution to aid communication of all those involved in End of Life Care is progressing with YTHFT. YTHFT are currently the custodians of 2 systems - CPD (hospital IT system) and System One (the hospital's Community Services IT system) and it is imperative that the CCG get access to System One to be able to affectively launch My Right Care. Further discussions will take place with senior managers in the Out of Hospital Directorate to affect the changes required.

The CCG's Head of Joint Programmes and Deputy Chief Nurse were invited by St Leonard's Hospice's Chief Executive to share the commissioning vision for palliative and end of life at their Board of Trustee's Vision Day. The presentation was well received and feedback was positive.

The Deputy Chief Nurse received feedback from the Lead Nurse for End of Life Care at YTHFT that clinicians were required to contact the CCG to authorise ambulance conveyancing for patients in receipt of End of Life care. Risks were identified for example patients being delayed when needing to be moved at home from upstairs to downstairs at a crucial time in their care pathway. In response, the Community Palliative Care team have been authorised to approve ambulance conveyancing as part of appropriate clinical assessment.

Mental Health

The CCG's Commissioning Specialist will be invited to QPEC from December 2017. This will ensure that important briefings from the transformation, complex care and mental health team are adequately represented and presented.

Dementia

The CCG has developed a draft action plan based on the NHS England's Intensive Support Teams (IST) recommendations and high level summary of key issues to improve dementia diagnosis and optimise the dementia pathway.

The IST recommendations have been sent to TEWV who will be adding their actions to the action plan. This co-produced plan for local implementation will be signed off by all partners through their own governance arrangements.

Concurrently, the CCG continue to regularly monitor the number of patients on dementia practice registers. Technical and clinical support is being provided to targeted GP practices to improve coding and increase performance.

In addition, the CCG and the clinical network are offering training to GPs and care home staff in the use of the dementia diagnosis tool (DiADeM) and GP case finding tools (DeAR). This aims to establish clear protocols for accurate diagnosis and recording of diagnosis for all people admitted to and residing in care homes.

There has been an increase in dementia diagnosis rates from 58.4 to 60.2%.

Children and Young People

CAMHS

There is a focus on bringing together all action plans and performance data for CAMHS autism assessments and community eating disorders (CEDs) into a single recovery plan to address the sub-optimal performance in managing waiting lists across all three services; this will be monitored at TEWV's Contract Management Board (CMB) Performance Sub-group. There is improvement in the time waiting for CAMHS assessments, which is currently at 78% within 9 weeks. The recent Healthwatch report on CAMHS waiting times has been reported to the local Health and Well Being Board (HWBB), and the recommendations are included in the CCG's

refreshed Local Transformation Plan for CAMHS <http://www.valeofyorkccg.nhs.uk/data/uploads/publications/local-transformation-plan-2017/local-transformation-plan-2017-submission-31-oct-2.pdf>

Autism Waiting Lists

We are still awaiting data on autism waiting times, which is due at end quarter 3, although unconfirmed data states that 163 children and young people are awaiting assessment, and the average wait is around 53 weeks. The CAMHS recovery plan addresses the issue, and Executive Committee is sighted on this as well as work being undertaken on options to manage down the backlog of referrals. In November, a deep dive into autism, with City of York Council looked at ways of improving communication across agencies to improve the experience of families with children coping with autism or suspected autism. A number of actions have been identified which will feed through into action planning for the City's All Age Autism Strategy.

Community Eating Disorders (CEDS)

Performance against national standards remains low. Further discussions with TEWV and NHS England have clarified the key underlying issues around performance. This includes the level of investment, training requirements and numbers of referrals. There is now a draft action plan for CEDS which will be discussed at the TEWV's CMB Performance Sub-Group, and Executive Committee is sighted on the position, with further work on service options being prepared for early 2018.

Special Educational Needs and Disabilities (SEND)

There is a focus from NHS England on the pathway and standards of care and support for children and young people up to 25 with SEND. The CCG has historically worked well with commissioners in local authorities, and providers, mainly TEWV and YTHFT. There is now local and regional support though the local SEND network and the regional SEND health commissioners network: this is highlighting CCG performance against NHS England Key Lines of Enquiry: the main areas for further work includes engagement with families, transitions into adult services, and evidencing single pathways of care across agencies.

Workforce


Student Nurse University Applications

It has been reported nationally that the numbers of people applying to study nursing at university has fallen following the removal of NHS bursaries. At a time when it has never been more crucial to recruit to nurse vacancies this is a significant risk to sustaining the nursing workforce.

Last year universities were twenty three percent down in total of those applying for nursing and midwifery degrees. Currently, universities are about two thirds of the way through the application window (UCAS applications opened in September and have to be submitted by 15th January). Across the sector there seems to be a year-on-year reduction of applications and this appears to be mirrored locally. This may increase with seven or so weeks to go, but at the moment numbers are considerably affected.

Attracting people to a career in nursing is understood to be a contributing factor as well as the impact of Brexit in recruiting students from overseas. In response NHS England is working with all commissioners and providers of education to understand the full impact. Health Education England are leading work locally with CCGs to build on new roles for both Registered and Non Registered staff that will have an impact on promoting nursing as an attractive career as well as retaining those already in post.

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Item Number: 13	
Name of Presenter: Michelle Carrington	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Report Title – Designated Professionals for Safeguarding Children Annual Report 2016-17	
Purpose of Report <i>(Select from list)</i> To Receive	
Reason for Report This annual report describes some of the key national safeguarding children issues which have arisen during the year and provides an update on progress against the Designated Professionals Strategic Plan.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> System transformations <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Financial Sustainability <input type="checkbox"/> Sustainable acute hospital/ single acute contract	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> City of York Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description
Emerging Risks (not yet on Covalent) N/A	
Recommendations N/A	

Responsible Executive Director and Title	Report Author and Title
Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse	Designated Professionals

Scarborough and Ryedale CCG

Hambleton, Richmondshire and Whitby CCG

Harrogate and Rural District CCG

Vale of York CCG

Elaine Wyllie and Karen Hedgley

Designated Nurses for Safeguarding Children

Dr Natalie Lyth and Dr Sarah Snowden

Designated Doctors for Safeguarding Children

Dr Sally Smith

Designated Doctor for Child Deaths

Jacqui Hourigan

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1. Introduction

- 1.1** This fifth report will describe some of the key national safeguarding children issues which have arisen during 2016-17 before going on to describe progress against the Designated Professionals Strategic Plan. In particular, the report will highlight ongoing developments in assurance processes between the CCGs, provider organisations and the continued progress made to support developments in safeguarding practice for Primary Care.
- 1.2** The report will also describe the challenges and opportunities for 2017-18 as well as including the revised Designated Professionals Strategic Plan for the coming year. Any outstanding actions from the 2016 – 17 Plan have been incorporated into this revision document.

2. National Context

- 2.1 Unaccompanied Asylum Seeking Children (UASC)** – following the ‘Dubs’ amendment to the Immigration Act in 2016 and the disestablishment of the ‘Calais jungle’, the UK received a number of unaccompanied asylum-seeking children. This was in addition to and separate from the Syrian Refugee Resettlement Plan and was not associated with any additional funding. In total, 32 children and young people were placed in North Yorkshire and York – the majority in the Harrogate area. This placed particular challenges on both provider and commissioning organisations.
- 2.2 The Children and Social Work Act** - in January 2016, Alan Wood (CBE) was commissioned by HM Government to undertake a fundamental review of LSCBs, including processes for Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOP). The report and the Government’s response were published in June 2016. The report made 34 recommendations in total – 19 around LSCBs, 10 around SCRs and 5 in respect of CDOPs. With regard to LSCBs, the fundamental change that was proposed:

“To require the three key agencies, namely health, police and local authorities, in an area they determine, to design multi-agency arrangements for protecting children, underpinned by a requirement to work together on the key strategic issues set out in this report.”

The subsequent Children and Social Work Act received royal assent on 27.04.17. The statutory guidance accompanying this new legislation is yet to

be published. However, both NYSCB and CYSCB have facilitated preliminary discussions between partner agencies to consider the implications of this new legislation.

2.3 Inspection Frameworks – a number of inspection frameworks across the safeguarding children agenda have continued over the past year. The CQC has continued its single agency CLAS (Children Looked After and Safeguarding) Reviews. In December 2016, CQC undertook a CLAS review across City of York, and in February 2017 CQC returned to undertake a CLAS Review across North Yorkshire. At the time of writing this annual report the final reports arising from both reviews are outstanding.

In November 2016 City of York received an Ofsted inspection of local authority services for children in need of help and protection; children looked after and care leavers. This inspection also included a review of the effectiveness of CYSCB (see section 4.2.4).

Additionally, in January 2016 the inspection framework for Joint Targeted Area Inspections (Jay's) was published. The four inspectorates are Ofsted, CQC, HMIC and HM Inspectorate of Probation, the aim of the framework is to look at the arrangements and services for children in need of help and protection in local authority areas in England. Each set of JTAI's considers a different aspect of safeguarding practice such as Child Sexual Exploitation (CSE), Domestic Abuse and Neglect. Neither North Yorkshire nor York has received a JTAI during this financial year.

Ofsted and CQC launched a programme of joint inspections in 2016 to see how well health and local authorities fulfil their responsibilities for children and young people with special educational needs and/or disabilities (SEND). In July 2016 North Yorkshire was one of the first areas in the country to receive an inspection. The Designated professionals supported health providers, the Partnership Commissioning Unit and the CCGs during the inspection process, providing evidence regarding health care provision for children and young people in care who have SEND.

3. Statistical Information

Table 1: Summary of National and Local Statistical Information Table

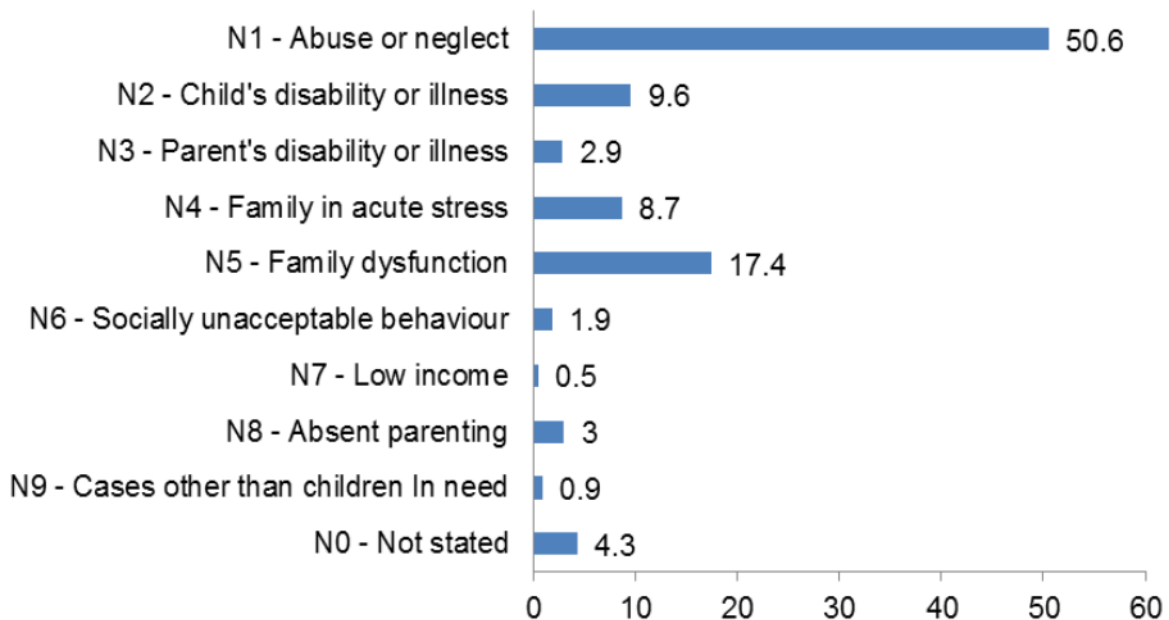
Category	England		North Yorkshire		City of York	
	2016-17 national data set not available until Oct 2017		As of 31.03.2017 As of 31.3.2016 (as 31.03.2015)		As of 31.03.2017 As of 29.2.2016 (as 31.03.2015)	
	14-15	15-16	2016 2015	16-17	2016 2015	16-17
Total number of children and young people	No data		118000	117,119	36,331	36,669 *
			(130,000)		(36,331)	
Number of children subject to Child Protection Plans	49,700	50,310	279 (410)	432 *	135 (124)	171 *
Prevalence of children with child protection plans/10,000 child population	42.9	43.1	23.6 (31.5)	36.9 *	38 (34.2)	46.2 *
Children in receipt of Child Need services	390,960	394400	2574 (2,015)	2,596 *	986 (1033)	Figures not available
Prevalence of children receiving child in need/10,000 child population () = 2014-15	337	337.7	218 (155.0)	221.7 *	273.8 (286.9)	Figures not available
Looked After Children () = 2014-15	69,540	70,440	415 (448)	425 *	191 (193)	204 *
Prevalence Looked After Children/ 10,000 child population () = 2014-15	60	60	35.3 (34.5)	36.3 *	53 (55)	55.1 *
Care Leavers 17-21	26290	26340	186	154 *	100 (80)	107*

* 2016/17 figures are unvalidated until Aug 2017

3.1 Key Points from National Data

- The number of children in need at 31st March has increased from 390,960 in 2015 to 394,400 in 2016, an increase of 0.9%.
- The number of children in need at 31st March has remained relatively stable over the last seven years.
- The number of children who were the subject of a child protection plan at 31st March has increased from 49,700 in 2015 to 50,310 in 2016, an increase of 1.2%.
- The number of children who were the subject of a child protection plan starting, and a child protection plan ending in the year, both continued to increase

Figure 1: Percentage of children in need at 31 March 2016, by factors identified at the end of assessment (England, 2015-16)



- The number of looked after children has continued to rise; it has increased steadily over the last eight years. There were 70,440 looked after children at 31 March 2016, an increase of 1% compared to 31 March 2015 and an increase of 5% compared to 2012. The rise this year reflects a rise of 1,470 in unaccompanied asylum seeking children, compared to a rise of 970 in all looked after children.
- In 2016 the number of looked after unaccompanied asylum seeking children increased by 54% compared to last year's figures, up to 4,210 children at 31 March 2016 from 2,740 in 2015 and up from a low of 1,950 in 2013.
- At 31 March 2016, unaccompanied asylum seeking children represented 6% of the looked after children population.

3.2 Key Points of Note from Local Data

- The number of children in receipt of Child in Need services has remained stable in North Yorkshire (numbers for York not yet available) and remains below the national average.
- The number of children and young people in receipt of a Child Protection Plan has increased from last year in both North Yorkshire and York which matches the national trend.
- The number of looked after children has increased slightly in both North Yorkshire and York but the prevalence remains below the national average in both localities. The national picture is of a rising prevalence.

4. Progress against Designated Professionals Strategic Priorities (2016-17)

4.1 Strategic Priority 1: To continue to develop and embed robust assurance processes in relation to safeguarding children arrangements in CCGs and provider organisations.

4.1.1 The Designated Nurses have worked with colleagues in the CCGs and Partnership Commissioning Unit (PCU) to embed the reporting against the Safeguarding Children Local Quality Requirements (LQRs), via the various contract reporting structures between the CCG and all NHS Providers across North Yorkshire and York.

4.1.2 The Designated Nurses now attend these quality meetings to offer expert advice and support to commissioners and providers, as well as expert challenge where this is felt necessary.

4.1.3 A key challenge this year has been in ensuring all providers report against all safeguarding children LQRS as per contract. It is expected that this work will fully complete by the 1st Quarter of 2017-18.

4.1.4 The Designated Nurses have worked with colleagues in the PCU and CCG to ensure that standard baseline safeguarding children LQRs, which were developed in 2016-17, are used in the development of all new contracts and service specifications.

4.1.5 The Safeguarding Children Policies for all four CCGs have been updated to include new responsibilities regarding PREVENT.

4.1.6 The CCGs Managing Allegations Against Members of Staff Policies have been updated and are now available on all four CCGs public facing websites.

4.1.7 In July 2016 NHSE undertook a safeguarding assurance visit to the CCGs across North Yorkshire and York. It is of note that the report found “*Excellent evidence of robust safeguarding arrangements*”, together with ‘*lots of examples of good practice and innovative practice*’. There were a total of five recommendations to be addressed across both the safeguarding children and safeguarding adult’s agendas. This action plan arising from this report is monitored via the Designated Professionals quarterly meetings between the Designated Professionals and the CCG Leads for Safeguarding Children (Executive and Chief Nurses). Updates are also provided in the safeguarding children reports to the CCG quality structures.

4.2 Strategic Priority 2: To support and continue to develop strong multi-agency partnerships across North Yorkshire and the City of York

City of York Safeguarding Children Board (CYSCB)

4.2.1 The Chief Nurse and the Designated Professionals have represented Vale of York CCG at CYSCB throughout 2016-17.

4.2.2 Summary of CCG representation at CYSCB 2016-17:

City of York Safeguarding Children Board Attendance 2016-2017
--

Date	Chief Nurse	Designated Doctor	Designated Nurse
12/04/2016	✓	x	✓
22/06/2016	x	✓	✓
10/08/2016	x	✓	✓
19/10/2016	✓	✓	✓
14/12/2016	✓	x	✓
15/02/2017	x	✓	✓

4.2.3 **Embedding the new Board structure:** The Designated Professionals have provided ongoing support to embed the restructure of the CYSCB sub groups. The Designated Nurse has continued in her role as Chair of the Case Review Group (CRG).

4.2.4 **Ofsted Inspection of the Board:** In December 2016 the Designated Professionals supported CYSCB Business Unit in preparing for, and responding to, an inspection by Ofsted. The outcome of the inspection was very positive with the report concluding that the board demonstrates '*strong and highly effective multi-agency partnership working across the city. These partnerships are fundamental to the work of the CYSCB in sustaining the commitment to safeguarding children*'. The Board received a judgement of 'Outstanding', only the second LSCB in the country to receive such a judgement.

4.2.5 **Case Reviews:**

- The Ofsted Inspection noted that the '*Arrangements for case reviews have been significantly strengthened*' since the restructure of the Board with the revised terms of reference supporting increased rigour and scrutiny.
- There have been no Serious Case Reviews in York during 2016-17.
- A Learning Lessons Review involving a young child who had experienced significant neglect was completed during 2016. The final report and recommendations were endorsed by the Board in September 2016. The subsequent multi-agency action plan has been monitored via the CRG and actions are been taken forward within the agreed timescales.
- During 2016-17 a case involving the death of a young child was referred into the CRG for consideration for a possible SCR or other form of learning review. The Independent Chair for CYSCB considered the recommendation from the group and concluded that learning from this case would be best achieved via a separate review process led by NHSE. Chair of the CRG (Designated Nurse) will sit on this review panel to ensure any safeguarding children issues are identified and addressed.
- The CRG has received assurance from partner agencies that the actions arising from historical reviews are now complete.

4.2.6 The Annual Report for CYSCB will be accessible via the LSCB website: www.saferchildrenyork.org.uk

North Yorkshire Safeguarding Children Board

4.2.7 The Executive Nurse for Scarborough and Ryedale CCG and the Designated Professionals have represented the four North Yorkshire and York CCGs at NYSCB throughout 2016-17. One of the Designated Nurses continues to undertake the role of Vice Chair of the Board.

“As Chair of the North Yorkshire Safeguarding Children Board I welcome the active partnership we have with the Designated Professionals who provide us with a positive engagement with children's health services. It is complex for Boards to work effectively with the NHS 'architecture' - a task that would be impossible without the Designated Professionals. Whether it is concerns about individual children, or in relation to major policies issues, the Designated Professionals enable us to feel confident that we are offering the best possible service for the children and young people of North Yorkshire.”

Prof Nick Frost, Independent Chair, NYSCB

4.2.8 Summary of CCG attendance at NYSCB 2016-17

North Yorkshire Safeguarding Children Board Attendance 2016-2017

Date	Executive Nurse	Designated Doctor	Designated Nurse
20/06/2016	✓	✓	✓
19/09/2016	✓	✓	✓
05/12/2016	✓	✓	✓
20/03/2017	✓	✓	✓

4.2.9 The last twelve months has been a period of embedding new structures and processes within NYSCB, particularly the change to only two sub-groups - the Learning and Improvement Sub-Group, and the Practice Development Sub-Group which aim to progress the Board's vision to “listen to the views of children and young people and their families, and work together to ensure they feel safe and North Yorkshire is a happy place to live”.

4.2.10 The locality groups of the LSCB continue to meet across the county to progress the Business Plan and to address specific local operational issues.

4.2.11 Case Reviews:

- There have been no Serious Case Reviews commissioned by NYSCB over the last year.

- A Learning Lessons Review into the serious sexual assault of a teenage boy was commissioned during 2016. The final report will go to the Learning and Improvement Sub-Group; this group will then develop recommendations arising from the report and agree a plan for the dissemination of the practice lessons learned. A full report will be presented to the Board in June 2017.

4.2.12 The Annual Report for NYSCB can be accessed via the LSCB website: www.safeguardingchildren.co.uk

4.3 Strategic Priority 3: Children in Care

4.3.1 Action Plan for Looked After Children NHS England Assurance Process and Action Plan: in 2015-16, NHS England North undertook a benchmarking exercise to map CCG arrangements for children who are looked after against the revised statutory guidance (2015). A summary of the findings was presented in June, 2016 and as reported in the previous Annual Report, the NYY CCGs performed well against other CCGs in the Northern region. Actions arising from the benchmarking are being taken forward by the Designated Professionals and updates against this plan have been provided to NHSE.

4.3.2 Introduction of Health Passports for Children in Care (York): the Designated Professionals have continued to lead on the staged introduction of health passports for children in care across City of York. The aim of this initiative is to support children, young people and their foster carer's understanding of their past medical history and ongoing health issues, ultimately to support better health outcomes for this vulnerable group of children. Health passports are now issued to all children who have come into the care of the local authority and to children under the age of 5 when they attend for their RHA. There has been a delay in issuing the passports to children and young people from 5-19 years due to capacity issues in the Healthy Child Service, during the transition into the local authority and reconfiguration of the service. This delay has been escalated to the strategic partnership for children in care.

4.3.3 Service specification for Specialist Nursing Team for LAC – work around disaggregating the HDFT Safeguarding Team and Specialist Nursing Team for LAC continues, alongside revision of service specifications to reflect new ways of working.

4.3.4 No Wrong Door – the award-winning No Wrong Door project in North Yorkshire continues to be supported by the HDFT Specialist Team for LAC. Formal evaluation of the health element of the project has been undertaken by

Loughborough University and provides robust evidence of improved physical and mental health outcomes. Additionally, work undertaken by the communication workers in the project has shown that a significant proportion of young people in the project had communication problems (this represented 65% of the young people in the project who were also looked after). The finding has led to some collaborative working between the Specialist Team for LAC, NYCC, Designated Professionals and the 0-19 service to develop more sensitive ways of screening for communication problems at entry into care.

4.3.5 Complex Needs Pathway – a ‘Pathway to Support Initial Health Assessments for Children and Young People who have Complex Care Needs’ was developed several years ago. However, because its presentation was very complicated, it had not been fully implemented. In conjunction with partner agencies, the pathway has been revisited, simplified and re-launched. The pathway recognises that there are three groups of children within this overarching heading:

- Children and young people who have complex needs, who have become looked after because they have become accommodated under Section 20 of the Children’s Act (voluntary accommodation);
 - Children and young people who have been placed in care by a Court order (Care Order);
- These two groups of children will have their Initial Health Assessments (IHA’s) by a paediatrician who is experienced in carrying out Initial Health Assessments, who will seek advice from the child’s usual paediatrician.
- The third group of children are children and young people with complex needs and disability, who are voluntarily receiving short breaks and respite care of more than 75 days a year. The focus for the IHA for these children is around their current health needs, to ensure that the health needs can be met within this setting. For these children, the request for an IHA will be sent to the child’s usual paediatrician, who will complete it, taking advice and support from a paediatrician who is experienced in undertaking IHA’s, if required.

4.3.6 Training – children in care and care leavers will form one element of the GP ‘Hot Topics’ Level 3 Safeguarding Training Programme 2017/18, as it was recognised that many GPs have limited knowledge and experience in this area. The training includes messages taken from consultation with care-experienced young people, reflecting what they would like from primary care services. Practices will be encouraged to support a consistent approach whereby whenever possible; children and young people in care see the same practitioner.

4.3.7 Supporting young children and young people to engage with their health assessments – The Designated Professionals have been working with colleagues in the local authority and the LAC Team for HDFT to develop a suite of information for children and young people and their carers which aims to support children and young people’s understanding of the benefits to them of accessing their health assessments. This work is being undertaken in consultation with children and young people. This builds on the work undertaken in 2015-16 to develop an IHA video clip which was launched in the early part of 2016-17.

4.3.8 Timeliness of Statutory Health Assessments for Children in Care

- A further audit of timeliness of completion of IHA’s in North Yorkshire was carried out in July 2016. This showed that there had been an increase in the timeliness of receiving initial paperwork from the local authority. Unfortunately, there had been a decrease in the number of looked after children who had their IHA completed within 20 working days of being looked after, from 44.6% in 2015 to 39.7% in 2016. The causes of this are multi-factorial, and further work is being done to try to improve the timeliness
- The audit of timeliness of Review Health Assessments in North Yorkshire has shown year-on-year improvement for the last three years. In 2013, 42.17% of assessments were completed within the target time; in 2014, this had increased to 54.66% and in 2016, to 79.87%. The target we have set for this year is 90% and work is ongoing
- The audit of timeliness of health assessments for City of York children has identified significant challenges throughout 2016-17. On average, less than 50% of IHA’s and RHA’s were completed within statutory timescales. Analysis of the data has identified that the key reason for such delays is most frequently due to delays in health receiving notifications and associated paperwork from colleagues in the local authority. This issue has been escalated to the Strategic Partnership for Children in Care by the Designated Professionals. An action plan has been agreed between the LA, HDFT, YTHFT and the Healthy Child Service (CoY Public Health). VoY CCG are receiving detailed updates regarding this issue via the Quality Patient Experience Committee

4.3.9 Quality of IHA’s - there has been a three-pronged approach to improving the quality of Initial Health Assessments:

- Training for all paediatricians who carry out IHA’s (as outlined in 4.3.8 above);
- Local authorities have a responsibility to undertake Strengths and Difficulties questionnaires for all children and young people coming

into care – these form an assessment of mental and emotional wellbeing. Starting in North Yorkshire, we are working to ensure that the results of these questionnaires are made available to the paediatricians carrying out IHA's/. Guidance on how to interpret these results has been provided for the paediatricians. In City of York, an action plan towards developing the use of Strength & Difficulties questionnaires is being developed via a Task & Finish subgroup of the Strategic Partnership for Children in Care. The group intends to meet regularly following the initial meeting scheduled for June 2017.

- Two quality reviews of IHA's have been carried out across North Yorkshire and York. The initial quality review outlined areas of focus for improvement. These were shared with the paediatricians who carry out the IHA's. A second quality review did show an improvement in practice. This work will be ongoing.

4.3.10 Training of paediatricians - IHA training has continued throughout 2016/17.

This year, we have provided two different types of training: the standard training for paediatricians new to carrying out IHA's which includes the background around the importance of the different areas of health that need to be assessed, together with the areas that need to be considered in the care plan that is produced at the end of an IHA. This training was provided to a group of paediatricians at the Friarage Hospital and one-to-one in the other provider settings. Specific one-to-one sessions have also been provided for paediatricians working with Unaccompanied Asylum Seeking Children to ensure they are aware of the particular needs of this group and of the bespoke paperwork that has been developed to support assessment processes. A workshop is also planned for October 2017 which will bring together the paediatricians who carry out IHA's across North Yorkshire and York for some joint learning.

4.3.11 UASC - A significant amount of work has been undertaken to ensure that the health needs of young unaccompanied asylum seekers are effectively assessed and plans put in place to meet those needs. Work has included:

- Use of specially adapted Initial Health Assessment (IHA) forms which reflects potential health needs of this vulnerable group of young people
- IHA's being undertaken by one specialist paediatrician at the residential centre where the initial groups of young people were accommodated
- Agreement with local GPs that IHA's will replace routine New Patient Checks
- Development and distribution of briefing paper for all GPs regarding potential health needs of UASC

- Agreement with HDFT regarding screening and treatment for TB
- Active membership of the North Yorkshire and York multi-agency group for UASC

“Here at North Yorkshire County Council, we have always encouraged a joined up approach to working with all partners involved in delivering services to Children and Young People and particularly with the Designated Professionals. Their advice and input is extremely valuable to us for both delivery and improvement of our services and especially in regard to our children in care. As Lead Member for Children’s Services I very much appreciate and value their contribution and the long term relationship we have built together.”

Cllr Janet Sanderson, Lead Member Children’s Services, NYCC

Strategic Priority 4: Supporting Safeguarding Practice across the Health Economy in North Yorkshire and York

4.4.1 Multi-agency practice guidance on managing injuries to non-independently mobile children (NIMC) - the Designated Professionals have led on the development of multiagency practice guidance to support effective identification and response to indicators of physical abuse in NIMC. This guidance has now been adopted across North Yorkshire and York.

4.4.2 Safeguarding Supervision – In line with national guidance (RCPCH, 2014), the Designated Nurses and Nurse Consultant for Primary Care continue to provide reflective safeguarding supervision to safeguarding professionals across the local health economy. A total of 45 supervision sessions have been delivered during 2016-17.

Peer supervision continues in partnership with colleagues from East Riding, North Lincolnshire, North East Lincolnshire and Hull, supported by a robust supervision contract and documented outcomes.

The Designated Nurses and Nurse Consultant for Primary Care also continue to support NHS Provider organisations across North Yorkshire and York to develop supervision resources by providing supervision skills training. As accredited trainers they have facilitated four two-day courses – one of which was undertaken as an income generation initiative at the request of the Head of Safeguarding at Newcastle Hospitals.

- 4.4.3 **Peer Review processes YTHFT** - Peer review for Paediatricians within York Teaching Hospitals NHS Trust is a priority for development. It is currently scheduled to take place within the context of monthly Clinical Governance meetings on the York Hospital site, although there is the opportunity for additional ad hoc meetings with the Named Doctor and/or Named Nurse for Safeguarding if required at other times. Currently, complex safeguarding cases are discussed, although all inpatient safeguarding cases are discussed at weekly Grand Round handover meetings. On the Scarborough site, the Named Doctor and Named Nurse for Safeguarding Children have a programme of peer review planned. On both sites, there are plans for involvement from the Departmental Paediatric Liaison Psychiatrist to attend to provide additional support and input.
- 4.4.4 **Peer Review HDFT** – the Peer Review for Paediatricians is now well established at HDFT under the leadership of the Designated Doctor. Peer review meetings are held at least every three months, but are held more frequently, if required. Every child who has a Child Protection medical under the care of HDFT is reviewed in these Peer Review meetings. The meetings are well attended by the paediatricians, which has led to an increase in the quality and consistency of the child protection reports.
- 4.4.5 **ALSG** - the Designated Nurses and Nurse Consultant for Primary Care continue to support Safeguarding Children Recognition and Response Training for specialist doctors. They are also involved in the updating of this national course.
- 4.4.6 **Multi-Agency Public Protection Arrangements (MAPPA)** – in response to the findings of the ‘Child Ava’ Serious Case Review undertaken in Durham LSCB, the Designated Nurses and Nurse Consultant for Primary Care have been working with MAPPA co-ordinators for North Yorkshire and NHS providers to identify the most robust way of sharing information and responding to identified risk in individual cases considered via MAPPA processes. Interim arrangements are currently in place, whilst formal agreements are developed between MAPPA and individual providers, including primary care. MAPPA has also been included as part of the ‘Hot Topics’ training programme to increase awareness of MAPPA processes and implications for primary care practitioners.
- 4.4.7 **Domestic Abuse notifications** - the Designated Nurses, North Yorkshire Police and NHS provider organisations have worked together to agree a new information sharing process whereby colleagues in midwifery and the 0-19 services receive notification of domestic abuse incidents attended by North Yorkshire Police, where children and/or unborn babies are part of the

household. The aim of this process is to ensure that relevant health professionals are fully aware of domestic abuse incidents, which then facilitates comprehensive assessment of risk to children and young people. Further work is planned regarding similar information sharing with Primary Care. This work is very much aligned to the North Yorkshire and York Domestic Overview Strategy, 2014-18, Working Together to Safeguard Children (HM Government, 2015) and NICE Guidance (2014).

- 4.4.8 **Peer Review** – it is of note this year that one of the Designated Nurses was asked to support the formal peer review process of a Designated Professionals Safeguarding Team in the south of England. Learning from this process will be used to develop local work in North Yorkshire and York.

4.5 Strategic Priority 5: PREVENT

- 4.5.1 The Designated Nurse and Nurse Consultant for Primary Care have successfully negotiated with NHS provider organisations (including primary care) to ensure there is appropriate representation at the North Yorkshire Channel Panel meetings. This ensures there is relevant and proportionate information sharing, and assessment regarding individuals thought to be at risk of radicalisation and an agreed multiagency response. Additionally, provider representatives at the Channel Panel are also responsible for raising awareness regarding the Prevent agenda and acting as a single point of contact within their organisation providing advice and guidance to colleagues. (See 4.6 re PREVENT Training for CCG and PCU staff)

4.6 Strategic Priority 6: Ensure all CCG staff are aware of their roles and responsibilities with regard to safeguarding children and have a raised awareness of the role and responsibilities of the Designated Professionals Team

- 4.6.1 During the early part of 2016 a review of the safeguarding children training packages, available to CCG and PCU staff, identified a number of issues regarding the quality of this online training. Additionally, there was a 'gap' in terms of availability of the appropriate level of PREVENT training. In response the Designated Nurses offered an interim solution of 'face to face' training across North Yorkshire and York. Ten sessions were open to the CCGs and PCU staff throughout 2016-17. The training was very well attended and evaluated with attendees paying particular reference to the training providing them, with a greater understanding of their role and responsibilities with regard to safeguarding children, as well as the role of the Designated Professionals Team.

4.6.2 The Designated Nurses have since worked with the training provider to ensure future on line training is in line with national guidance (RCPCH, 2014) and meets the training needs of CCG employees.

4.6.3 The Designated Nurses have led on the development of a CCG Safeguarding Children Training Strategy. This supports all CCG staff's understanding of their individual training requirements with respect to safeguarding children and how this training can be accessed. The training strategy is in line with national guidance (RCPCH, 2014).

4.7 **Strategic Priority 7: Continue to develop safeguarding arrangements in primary care.**

4.7.1 **Training** – due to the success of the Hot Topics training events in 2015-16, this structured training programme was replicated in 2016-2017 with 28 sessions completed and 600 Primary Care staff trained on domestic abuse, recognition of sexual abuse, human trafficking and modern slavery as well as Prevent. These training sessions have continued to receive positive feedback and have evaluated well:

"Engaging speakers and presentation" "Excellent"

"Useful yearly update, keep it going" "It exceeded my expectations"

"The links to documents for further reading and learning will be useful"

A Primary Care Training Strategy in line with Safeguarding children and young people: roles and competences for health care staff, has been developed in conjunction with the Named GPs, and agreed with the Local Medical Committee. This strategy identifies the training requirements to enable Primary Care staff to meet their statutory, regulatory and contractual responsibilities. This document aims to provide guidance on the content and timetable for safeguarding children training for all staff who are employed by GP practices.

4.7.2 **Named GP Forum and Safeguarding Practice Leads Forums** - the Nurse Consultant chairs a quarterly North Yorkshire and York Named GP forum for all four Named GPs from NYY. The Named GP for Bradford is also invited to these meetings. The aims of the Named GP forum is to share knowledge and expertise, develop a joint strategic action plan to address risks and gaps and strengthen safeguarding practice in Primary Care, also to provide a forum of peer support.

The Named GP's and Nurse Consultant hold quarterly Safeguarding Leads forums in each CCG. These forums, established in November 2015, are now well established and have regular attendance by the GP safeguarding leads within each practice. The aim of the forums are to provide a resource to Safeguarding Practice Leads, in order that they can remain abreast of both local and national issues, that might better inform practice and safeguard vulnerable people. The recent CQC CLAS review reports in City of York and North Yorkshire commented that these structures optimise opportunities to share learning and improve practice. These meetings have been reviewed to ensure that they are meeting the needs of the Safeguarding Practice Leads via a Survey Monkey, the results identified that they are a positive and valuable resource.

Education and teaching on specific things really helpful, also really supportive to meet other leads.

All areas covered to date have been useful, whether child protection, domestic violence, data recording, as in a small practice these cases are quite rare and so major systems have not tended to exist and this helps towards generating protocols

4.7.3 Named GP Conference - the Named GPs and Nurse Consultant hosted a successful and well-evaluated Northern Safeguarding Named GP conference in November 2016, which aimed to provide level 4 educational updates, showcase and share innovative GP Safeguarding Practice, and develop Named GP support networks. Following this first successful conference, the Nurse Consultant and Named GP's approached NHS England for funding for a further conference and they have agreed to fund and contribute to organising a conference for Named GP's for the Northern region in 2017.



4.7.4 Primary Care Strategic Development Plan - the Primary Care Strategic Development Plan 2016-17 addressed specific high risk issues within Primary Care and aimed to develop more effective multi-agency partnership working.

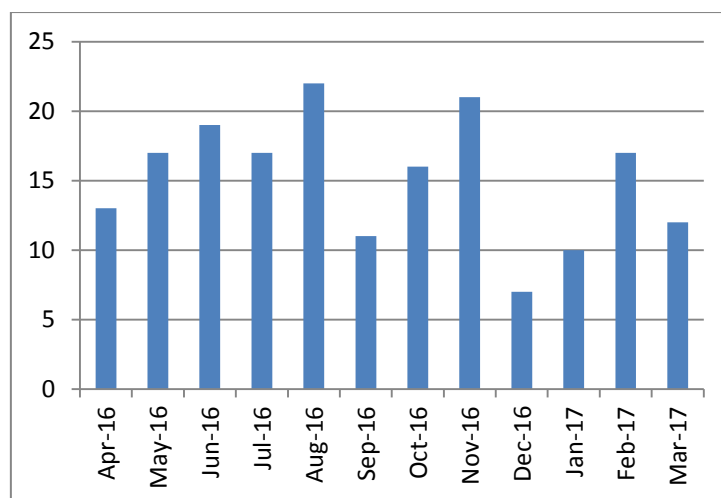
During the past year, practices have been encouraged to adopt and complete the NHS England Safeguarding Standards Self-Assessment Tool, in order to enable benchmarking of current safeguarding arrangements and identify areas for further development.

Local coding guidance has been developed and is supporting administration teams and health professionals using electronic records to identify and improve identification of vulnerabilities for children, young people and their families. The recent CQC CLAS review for City of York asserted that *“in all cases examined we saw that it would be difficult for a user of electronic record not to be made aware of specific risks that had been shared with the GP”*.

Work on developing pathways of information flow between General Practice and the Domestic Abuse Multiagency Risk Assessment Conference (MARAC) processes have been undertaken. All practices now receive MARAC minutes and have a process for managing this information. It is intended that this process will be extended next year to include practices being informed of MARAC’s prior to the meeting, to enable relevant information to be shared with multi agency partners.

Child ‘Was Not Brought / DNA’ guidance between the acute Trusts and Primary Care has been developed and disseminated to practices for use.

4.7.5 Provision of expert advice and support – the Nurse Consultant and Designated Nurses continue to provide support and advice to North Yorkshire Primary Care practitioners in relation to individual cases. There has been a steady increase in the number of calls to the Team throughout 2016-17 – this is believed to be in response to additional training and heightened awareness of possible safeguarding concerns.



4.8 Strategic Priority 8: Child Death Overview Process:

- 4.8.1 The Designated Doctor for Child Deaths continues to offer 'Rapid Response Training' on a multiagency basis across North Yorkshire and York. Training this year has taken place in Scarborough and York. Training is planned in the coming months for the Harrogate locality and Middlesbrough (James Cook University Hospital).
- 4.8.2 Introduction of the SUDI box has been successful in York – Scarborough continues to use its own well-established SUDI box –and implementation is imminent in Harrogate. Feedback from doctors using the box has been positive, minor amendments to the contents are planned following the feedback, also in order to comply with new national guidelines.
- 4.8.3 Rapid response meetings continue to be well attended and are invariably multi-agency in nature. Phase 1 meetings are usually held within 48 hours as per “working together” guidelines - 83% in 2016/17. Some notifications to CDOP were delayed (often due to cross boundary issues) and 100% phase 1 meetings took place within 48 hours of notification to CDOP. Phase 3 meetings are often considerably delayed as we await post mortem reports. Concerns have been raised with pathologists and coroners regarding this, and a meeting with the designated doctor for Child Deaths and the coroners is planned for June, in which potential solutions may be discussed.
- 4.8.4 A Memorandum of Understanding (MOU) has been developed by York and North Yorkshire CDOP, and shared with CDOPs throughout Yorkshire and Humber. This outlines what we expect to happen if a child resident in York or North Yorkshire dies outside our area, and also outlines our response to children resident outside our area, who dies in York or North Yorkshire. This was developed due to concerns about an inconsistent approach to rapid response procedures within different CDOP areas. It has been well received, and all 14 CDOP areas within Yorkshire and Humber plan to adapt the MOU for local use, in order to assist communication and consistency of response.
- 4.8.5 A regional SUDIC event is jointly planned by North Yorkshire and York, East Riding and Hull, planned to take place in autumn 2017.

5. Challenges and Opportunities for Forthcoming Year

5.1 Sustainability and Transformation Plans (STP's) – STP's form a key part of the NHS Five Year Forward View (2014). Across North Yorkshire and York there are three proposed STP's or commissioning partnerships. It is of note that these partnerships are not co-terminus with local authority boundaries – this is of particular relevance when taking into consideration that such boundaries are the footprint upon which services for children and young people are arranged and delivered. The additional layer of complexity around commissioning arrangements in the NHS could potentially form a barrier to effective multi-agency planning, commissioning and evaluating the impact of key services for our children and young people. The Royal College of Paediatrics and Child Health has undertaken a review of the 44 published STP's and in a recent position statement, has highlighted their concerns around the *'lack of profile given to infants, children and young people (who comprise 25% of the UK population) by the majority of STP...'* The deficiencies cited in the statement include *'Lack of a life course approach; lack of recognition of the needs of infants, children and young people; Limited engagement with clinicians and the public; and workforce shortages.'* Over the coming year, there will be a real need to maintain a county-wide sustained focus on the needs of our child population, specifically including their safety and welfare.

5.2 Responding to Multiple Recommendations from Inspections, Reviews and Assurance Processes – As described in 2.3, 4.1.7 and 4.2.4, the Designated Professionals have led the CCG, and where appropriate NHS providers, response to a number of different inspections, reviews and assurance processes throughout 2016-17.

A key challenge for the Designated Professionals Team during 2017-18 will be to develop and take forward the subsequent recommendations for the CCG via a robust overarching action plan. This action plan will form the core aspect of the Designated Professionals Strategic Plan 2017-18. It is anticipated that the subsequent reporting of progress against this action plan, via existing quality structures within the CCGs, will enhance current assurance to the CCGs that they are fulfilling their statutory responsibilities with regard to safeguarding children and children in care. Additionally, the Designated Professionals will continue to offer support, expertise and where appropriate, challenge to NHS provider organisations with regard to their action plans.

5.3 Children and Social Work Act 2017 – as noted in the introduction to this report (2.2) the introduction of the Children and Social Work Act earlier in 2017 will change the face of multi-agency child safeguarding arrangements in this country. With little detail yet available, it is hard to define exactly what this may mean in terms of statutory regulation, governance, accountability, agency roles, resources, funding, Case Review and Child Death processes. Again, sustained focus on robust inter-agency work to safeguard children will be required – it is well-documented that the risk to children can increase at times of organisational change and re-structure. The recent triennial analysis of serious case reviews 2011 – 2014 stressed: *‘It is crucial that effective systems are maintained through periods of change, and that arrangements are made to ensure continuity and coherence.’*

5.4 Modern Slavery and Human Trafficking – one of the fundamental features of safeguarding practice is that it is a continually changing, dynamic phenomenon as we recognise different ways in which the safety and welfare of our children and young people may be compromised. As safeguarding professionals and front-line practitioners, the continual challenge is to respond to emerging issues with informed understanding and appropriate actions to protect our most vulnerable population. Over the past year, the issues of Modern Slavery and Human Trafficking have been brought into sharp relief following the Modern Slavery Act, passed in March 2015. This Act established the issue on the political agenda and introduced associated policy and practice changes.

Human Trafficking is clearly linked to Modern Slavery and specifically in terms of child safeguarding, with the issue of Child Sexual Exploitation (since a child moved from one place to another for the purposes of sexual exploitation is deemed to be a victim of Human Trafficking). These key issues have formed part of the ‘Hot Topics’ training programme over the past year, with the aim of ensuring that practitioners have an awareness of the issues and understand their role and responsibility in terms of reporting and safeguarding. Horizon-scanning to ensure practitioners remain aware of these and other emerging issues will continue to form a significant challenge for the team.

5.5 Healthy Child Service, City of York - In April 2016 the Healthy Child Service, (formerly known as the 0-19 child health service), was taken ‘in house’ by City of York LA Public Health. Subsequently the service has undergone a significant reconfiguration and the Designated Nurse has offered expert advice regarding the revision of safeguarding arrangements specific to this service. During 2017-18 the Designated Nurse will continue to support developments in the information sharing pathways between the HCS and NHS provider organisations. The Designated Professionals will also offer expert advice to

leaders of the service as they respond to areas of challenge which were identified in the December 2016 York CLAS Review.

5.6 Challenges for the Designated Professionals Team – it was highlighted in the NHS E Safeguarding Assurance Tool that the team are under-resourced according to agreed national formulas. Additionally, the workload for the team has expanded, particularly with the development of primary care practice and the introduction of a strengthened MAPPA management process across both county and city. The team strive to balance competing demands on time to deliver a robust service to all four CCGs, both LSCB's, and provider organisations as described in the Accountability and Assurance Framework (2015). We will need to continue to review this position throughout the coming financial year.

**North Yorkshire and York CCGS
Designated Professionals Safeguarding Children/ Nurse Consultant for Primary Care
Safeguarding Children Strategic Plan 2017-18**

Strategic Priority 1:

To further develop and embed robust assurance processes in relation to safeguarding children arrangements in CCG provider organisations

Objective	Associated Delivery Plan	Person(s) responsible / expected date of completion	Evidence	Progress
1.1 NYY CCGs will have assurance that provider organisations are delivering services which safeguard the welfare of children and young people in line with statutory national guidance and local requirements.	Where safeguarding children LQRs/KPI's are agreed, to continue to support embedding of the reporting arrangements to NYY CCGs and to provide expert oversight and monitoring.	Designated Nurses (September 2017)	CCG/Provider Sub CMB Minutes	

	To map non-NHS provider organisations with view to developing robust safeguarding children assurance mechanisms.	Designated Nurses (March 2018)	CCG/Provider contract monitoring processes	
	To identify relevant commissioning leads within the NYY CCGs in order to support robust commissioning processes with regard to safeguarding children.	Designated Nurses (December 2017)	Notes from 1:1 meetings with relevant commissioners	

Strategic Priority 2:				
To support and continue to develop strong multi-agency partnerships across North Yorkshire and the City of York				
Objective	Associated Delivery Plan	Person(s) responsible / expected date of completion	Evidence	Progress
2.1 The Designated Professionals Team will support the development of new multi-agency arrangements in line with revised statutory guidance (Children and Social Work Act, 2017)	Designated Professionals will provide health expertise and leadership to LSCB's in York and North Yorkshire during negotiations to develop revised multi-agency partnership arrangements.	Designated Nurses and Designated Doctors (March 2018)	Revised LSCB structures reflected in Board minutes	
2.2 The Designated Nurse will work with NHS providers and	Regular 1:1 meetings with relevant leaders in the Healthy Child Service and NHS providers.	Designated Nurse (December 2017)	Notes from established 1:1 meetings	

<p>Healthy Child Service (City of York Public Health) to support the development of robust pathways and processes for information sharing in relation to safeguarding children.</p>	<p>Designated Nurse to facilitate Task and Finish Groups to develop agreed pathways for information sharing.</p>	<p>Designated Nurse (December 2017)</p>	<p>Agreed written pathways supported by robust Information Sharing Agreement</p>	
<p>2.3 The Designated Professionals Team will work with CCG commissioners and lead managers to support continued engagement with multi-agency partnerships in light of potential changes in NHS commissioning arrangements,</p>	<p>Regular 1:1 meetings with Exec/Chief Nurses to ensure clear line of sight in relation to safeguarding children in any proposed changes to NHS commissioning arrangements.</p>	<p>Designated Nurses and Designated Doctors (March 2018)</p>	<p>Clear representation from NHS organisations on LSCB or other multiagency partnerships reflected in Terms of Reference</p>	

Strategic Priority 3:				
To further support robust arrangements across North Yorkshire and York in order to improve health outcomes for Children in Care				
Objective	Associated Delivery Plan	Person(s) responsible / expected date of completion	Evidence	Progress
3.1 The CCGs will be assured that their responsibilities towards children in care are fulfilled in line with national statutory guidance.	To agree new reporting arrangements to the four NYY CCGs regarding timeliness of Initial and Review Health Assessments (previous function of PCU).	Designated Nurses and lead commissioners for children's services (December 2017)	Notes from 1:1 meetings with relevant commissioner	
	To develop revised format of quality reports to CCGs to reflect IHA/RHA performance.	Designated Nurses (December 2017)	Reports to CCG quality structures and associated minutes	
	Continue to work with commissioning leads in HaRD CCG to finalise the Service Specification for Specialist Nursing Team for Children in Care (HDFT).	Designated Nurses/Commissioning leads HaRD CCG (March 2018)	Agreed and signed Service Specification	

	<p>Work with Specialist Nursing Team for LAC in HDFT, local authorities and relevant providers in York and North Yorkshire to improve both timeliness and quality of Initial and Review Health Assessments.</p>	<p>Designated Nurses and Designated Doctors</p> <p>(March 2018)</p>	<p>Performance reports from HDFT</p> <p>Des Profs reports to CCG quality structures</p> <p>Relevant IHA and RHA audits</p>	
	<p>Work with Specialist Nursing Team for LAC in HDFT to develop and implement information leaflets for children and carers to support improved engagement with Health Assessments.</p>	<p>Designated Nurses</p> <p>(December 2017)</p>	<p>Minutes of the North Yorkshire and York Children in Care Health Professionals Group</p> <p>Information leaflets for children, young people and their parents/carers</p>	

Strategic Priority 4:				
Supporting Safeguarding Children Practice across the health economy of NYY				
Objective	Associated Delivery Plan	Person(s) responsible/expected date of completion	Evidence	Progress
4.1 To continue to provide expert support in order to develop safeguarding children practice across the health economy in NYY.	Work closely with North Yorkshire Police to implement the process for notification of domestic abuse incidents to midwifery and 0-19 services.	Designated Nurses (December 2017)	Process established and notifications being received by health practitioners. Reports to LSCB's and minutes of associated meetings	
	Work closely with NYY MAPPA service to establish an improved process for the sharing of sensitive MAPPA information relative to safeguarding children across primary care and relevant provider organisations.	Designated Nurses/Nurse Consultant for Primary Care (December 2017)	Agreed pathways for management of relevant MAPPA information with primary care and provider organisations	
	Lead on the development of revised multi-agency guidance for the management of Fabricated and	Designated Nurses (December 2017)	Revised guidance published on	

	Induced Illness in children and young people.		LSCB websites	
	Support provider organisations to undertake audits in order to establish the impact of safeguarding supervision	Designated Nurses (March 2018)	Completed supervision evaluation reports provided to Safeguarding Children Health Professionals Network	
	In association with provider organisations, agree a Development and Mentorship Programme for specialist safeguarding children nurses.	Designated Nurses (December 2017)	Written Programme agreed and nurses recruited to commence development activities.	

Strategic Priority 5:				
Responding to recommendations arising from CQC CLAS Reviews and any other review processes				
Objective	Associated Delivery Plan	Person(s) responsible/expected date of completion	Evidence	Progress
5.1 The CCGs to be assured that recommendations arising from CQC CLAS Reviews (York and North Yorkshire) are being progressed within CCGs and relevant provider organisations.	City of York – develop SMART action plan to address recommendations specific to VoY CCG.	Designated Professionals/Nurse Consultant (August 2017)	VoY CCG QPEC meeting minutes	
	City of York – provider action plans to be submitted to Designated Professionals.	Designated Nurses (April 2017)	Collated action plan submission to CQC	
	City of York – monitoring of progress against CCG action plan to be submitted bi-monthly to QPEC.	Designated Nurses (March 2018)	VoY CCG QPEC meeting minutes.	
	City of York - provider action plans to be submitted to Designated Professionals on quarterly basis and to CCG contract monitoring structures.	Designated Nurses (March 2018)	Updated collated action plan submitted to CQC Minutes of contract monitoring meetings.	

	North Yorkshire – develop SMART action plan to address recommendations specific to NYY CCGs.	Designated Professionals/Nurse Consultant (September 2017)	Minutes from NYY CCGs quality meetings	
	North Yorkshire – provider action plans to be submitted to Designated Professionals.	Designated Nurses (September 2017)	Collated action plan submission to CQC	
	North Yorkshire – monitoring of progress against CCGs action plan to be submitted to CCG quality structures.	Designated Nurses (March 2018)	Minutes from NYY CCGs quality meetings	
	North Yorkshire - provider action plans to be submitted to Designated Professionals on quarterly basis and to CCG contract monitoring structures.	Designated Nurses (March 2018)	Updated collated action plan submitted to CQC Minutes of contract monitoring meetings	
5.2 Assurance to be provided to NHS England that actions arising from LAC and Safeguarding Assurance processes	Progress against outstanding actions arising from these assurance processes to be reported to NHS E as requested.	Designated Professionals (March 2018)	Assurance reports to NHS E Update reports to CCG quality structures	

have been addressed.			Minutes of Designated Professionals meetings	
Strategic Priority 6:				
Continue to develop safeguarding children arrangements in Primary Care				
Objective	Associated Delivery Plan	Person(s) responsible/expected date of completion	Evidence	Progress
6.1 The Nurse Consultant will develop safeguarding children assurance processes around primary care in conjunction with the Named GPs.	Support all practices in the completion of NHS England self-assessment/assurance tool for primary care, which measures practice against expected safeguarding standards. Support practices in the completion of safeguarding-associated recommendations following Primary Care CQC inspections	Nurse Consultant for Safeguarding Primary Care (NCSPC)/Named GP's /Practice Leads (Ongoing)	Database of completed Practice visit assessments NHS England Safeguarding standards self-assessment tools and associated action plans	
6.2 The Nurse Consultant will establish Reflective Safeguarding Supervision for	Support introduction, training and development of Reflective Safeguarding Supervision for the Named GPs across all four CCGs.	NCSPC/Named GPs (March 2018)	Record of supervision sessions and associated documentation	

the Named GP in all four CCGs across NYY.				
6.3 In conjunction with the Named GPs, the Nurse Consultant will promote quality safeguarding children practice across NYY.	Establish robust information sharing processes between 0-19 Practitioners and Primary Care across NYY.	NCSPC/Named GPs (September 2017)	Agreed 0-19 /GP communication standard between City of York practitioners and GP Practices Evidence of completion of audit of 0-19 / GP Liaison meetings across NYY	
	Establish robust information sharing processes between midwifery services and Primary Care across NYY.	NCSPC/Named GPs (December 2017)	Agreed midwifery / GP information sharing process across NYY	

	Further develop MARAC information sharing processes so that GPs are informed of the pending MARAC meetings.	NCSPC/ /Named GPs (December 2017)	Evidence of completion of audit of GP involvement in MARAC assessment process	
	Standardise the process that GP's are invited to attend or contribute to child protection case conferences across NYY by establishing a secure electronic email process between local authorities in CoY and NY, and GP practices.	NCSPC (August 2017)	Database of agreed GP Practice secure email addresses	
	Support practices with the management of safeguarding children information within individual practices.	NCSPC/ Named GPs (March 2018)	Further development of coding guidance to include WNB and MAPPA Completion of specific admin staff training to support management of safeguarding information	

	Support the development of information sharing pathways between GP practices and the multi-agency VEMT process NYY.	NCSPC (December 2017)	Agreed information sharing process across NYY to enable GP's to fully contribute to the VEMT process	
6.4 The Nurse Consultant for Primary Care will support and promote quality safeguarding children practice within the services Northern Doctors provide across NYY.	Support with the introduction of CP-IS within Northern Doctors NYY. Develop effective information sharing processes between Northern Doctors and 0-19 service NYY.	NCSPC (December 2017)	CP-IS 'live' within Northern Doctors services in NYY Effective information sharing pathways established between Northern Doctors and 0-19 services NYY	
6.5 The Nurse Consultant will explore and scope the support required to ensure Dental Services across NYY have safe and effective safeguarding	Establish and develop links with the North Yorkshire Local Dental Committee to promote effective safeguarding practice. Establish links with dental services NYY.	NCSPC (March 2018)	Database of local dental service NYY Agreed offer of support by Nurse consultant to Dental services NYY	

children processes in place.				
Strategic Priority 7:				
CDOP				
Objective	Associated Delivery Plan	Person(s) responsible/expected date of completion	Evidence	Progress.
7.1 Explore ways in which the timeliness of PM reports could be improved	Review process with local coroner to determine possible options.	Dr Sally Smith (December 2017)	CDOP meeting minutes can evidence that PM reports received in timely manner to support professional discussion and decision-making	
7.2 To respond to revised statutory guidance re arrangements for CDOP processes (expected early 2018).	Respond to likely consultation process around revision of WTSC. Working with colleagues in relevant partner agencies to establish new processes in line with revised guidance. Ensure that CCGs and provider organisations across NYY are kept fully aware of implications of	Dr Sally Smith (April 2018)	Revised CDOP processes reflected in LSCB procedures CCG quality structure reports Minutes from SCHPN meetings	

	new guidance via reporting processes.			
7.3 Development of the Memorandum of Understanding for CDOP to be implemented regionally and potentially nationally.	Discussion with regional CDOP's and adjustment of MOU as necessary to allow them to take up use of the MOU	Dr Sally Smith / Ali Firby (April 2018)	Implementation of York and North Yorkshire MOU across Yorkshire	

Appendix (i)

References:

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DfE (2016) “*Wood Report: review of the role and functions of local safeguarding children boards*” available at: <https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards>

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HM Government (2015) “*Working Together to Safeguard Children*” available at: www.gov.uk/government/publications

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Modern Slavery Act (2015)

NHS England (2015) “*Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework*” available at: <https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf>

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North Yorkshire and City of York Domestic Abuse Overview Strategy 2014-2018

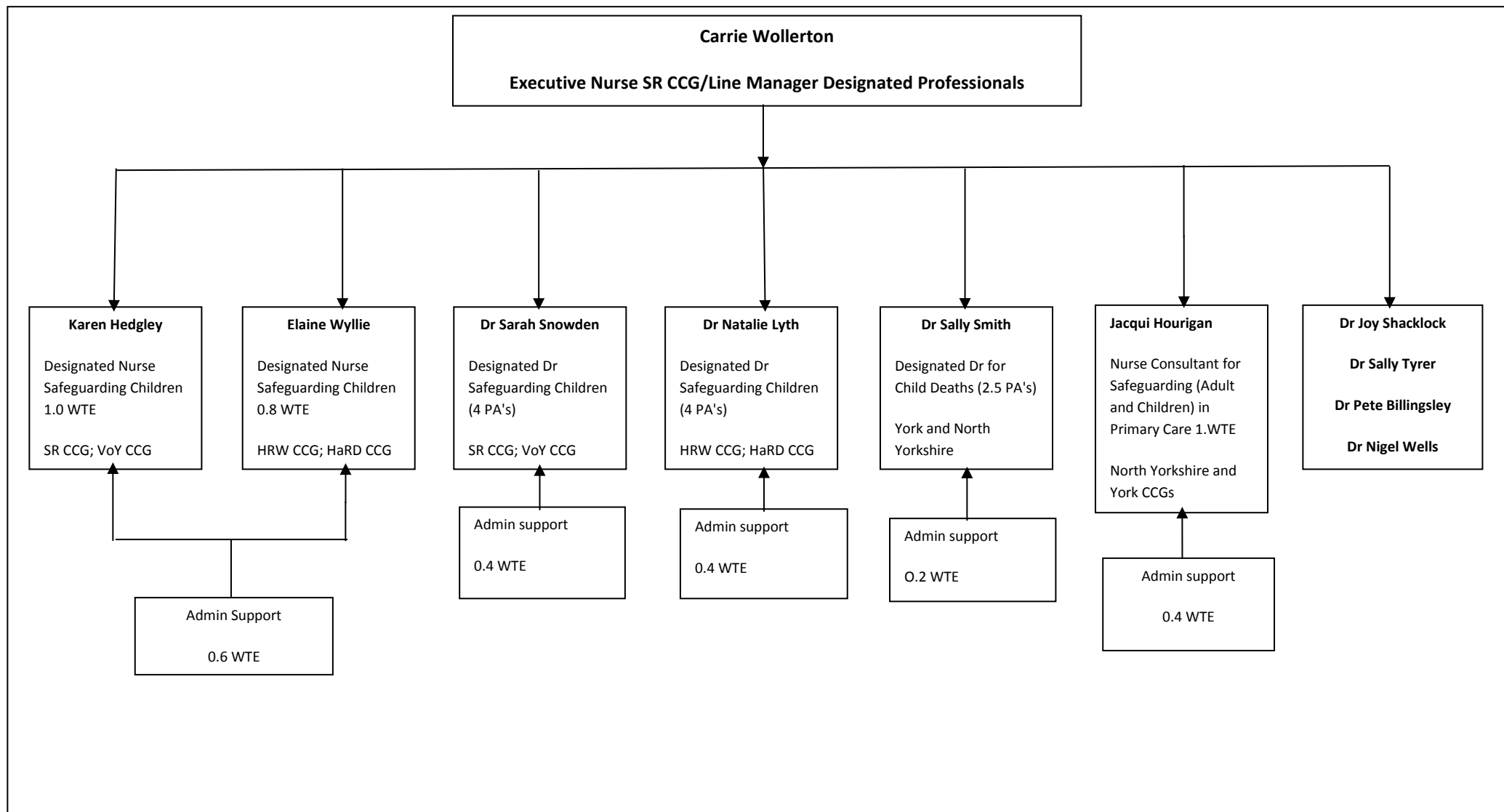
RCPCH (2014) “*Safeguarding Children and Young People: roles and competences for healthcare staff*” available at: < <http://www.rcpch.ac.uk>

RCPCH (2017) *“Lack of focus on health and wellbeing of children in majority of STPs ‘major cause for concern’”* available at: <http://www.rcpch.ac.uk/news/lack-focus-health-and-wellbeing-children-majority-stps-%E2%80%98major-cause-concern%E2%80%99>

Serious Crime Act 2015

Appendix (ii)

Structure of CCG Safeguarding Children Team (hosted by SR CCG)




Appendix (iii)

Abbreviations used in this report:

BAAF	British Association for Adoption and Fostering
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CLAS	Children Looked After and Safeguarding
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CQC	Care Quality Commission
CYC	City of York Council
CYSCB	City of York Safeguarding Children Board
HaRD CCG	Harrogate and Rural District Clinical Commissioning Group
HRW CCG	Hambleton, Richmondshire and Whitby Clinical Commissioning Group
HDFT	Harrogate and District Foundation Trust
IHA	Initial Health Assessment
LAC	Looked After Children
LAC SNT	Looked After Children Specialist Nursing Team
LMC	Local Medical Committee
LSCB	Local Safeguarding Children Board
LYPFT	Leeds and York Partnership Foundation Trust
MAPPA	Multi-Agency Public Protection Arrangements
NSPCC	National Society for the Prevention of Cruelty to Children
NYCC	North Yorkshire County Council
NYSCB	North Yorkshire Safeguarding Children Board
PCU	Partnership Commissioning Unit
RHA	Review Health Assessment

SCR	Serious Case Review
SR CCG	Scarborough and Ryedale Clinical Commissioning Group
STHFT	South Tees Hospitals NHS Foundation Trust
SUDI	Sudden Unexpected Death in Infancy
TEWV	Tees, Esk and Wear Valley NHS Foundation Trust
UASC	Unaccompanied Asylum Seeking Children
VoY CCG	Vale of York Clinical Commissioning Group
YTHFT	York Teaching Hospitals NHS Foundation Trust

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Item Number: 14	
Name of Presenter: Louise Barker	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Report Title – Tees, Esk and Wear Valleys NHS Foundation Trust – Two Years On	
Purpose of Report <i>(Select from list)</i> To Receive	
Reason for Report Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has taken the opportunity to reflect on the last two years of the contract with the CCG to look at what has worked well for:: <ul style="list-style-type: none"> • Mental health and older people • Mental health and learning disabilities • Mental health and adults 	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> System transformations <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Financial Sustainability <input type="checkbox"/> Sustainable acute hospital/ single acute contract	
Local Authority Area <input type="checkbox"/> CCG Footprint <input type="checkbox"/> East Riding of Yorkshire Council <input checked="" type="checkbox"/> City of York Council <input checked="" type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description
Emerging Risks (not yet on Covalent) N/A	

Recommendations

N/A

Responsible Executive Director and TitleLouise Barker
Clinical Director**Report Author and Title**Information provided by colleagues at
Tees, Esk and Wear Valleys NHS
Foundation Trust

TEWV - Two Years On in Mental Health Services for Older People (MHSOP)

Headlines:

- Services within MHSOP are CQC rated as 'requiring improvement' which is below our expected standard however it is representative of the significant progress we have made in a relatively short time as the previous rating across services in 2015 was 'inadequate'.
- All services within MHSOP have seen some level of development since TEWV with significant investment in new or refurbished buildings; and Quality Improvement System (QIS) work in both inpatient and community services.
- TEWV took the key decision to disaggregate the Adult and MHSOP directorate to create stronger individual specialties.

What we have done:

- We have developed new community hubs at Acomb in the west and Huntington in the north with further plans to develop similar services in Selby in the south.
- We have worked with the CCG to bid for and achieve funding in the first wave for CORE 24 mental health liaison services within York District Hospital. In the last year we have extensively recruited to the service and our current advanced practitioner has developed the Liaison Nurse Competency framework and local induction for new staff.
- The Care Home and Dementia Team have been providing support to service users in Care Homes in the Vale of York locality since 2013 - there are 46 residential and nursing care homes across the locality provided privately or by local authority. The team now operates from 9:00am to 9:00pm seven days a week and work closely with the local community mental health teams. The Care Home and Dementia team provides extra input in addition to, rather than instead of, this established support.
- Inpatient wards - all of the inpatient wards have developed Purposeful Inpatient Admission (PIPA) processes with daily report outs to ensure that every patient is reviewed by a multi-disciplinary team. The work has enabled teams to reduce length of stay by removing unnecessary waits.
- In parallel, we have also undertaken work to address delayed transfers of care (DToC). This work, hosted by TEWV and in collaboration with all sector partners, has been particularly successful and has yielded a 50% reduction in DToC across the inpatient wards.

Service issues:

- Out of Area Placements – we inherited a significant cohort of people who are placed 'out of area' and we have systematically reviewed all individuals within this cohort and have reduced the number of out of area placements by over 55% repatriating people to York wherever possible. This work continues to progress and will be maintained going forward as a key work stream.
- MHSOP male dementia inpatient beds continue to be in high demand with a significant proportion of the occupied beds being DToC due to the lack of suitable accommodation in nursing or residential placements.
- Memory services continue to experience high demand however work to eliminate the historical waiting list issue has yielded excellent results with positive trajectories and an expected 81% reduction by the end of October 2017.

Commitment to Quality:

- TEWV has a robust Quality improvement Programme which has two key elements:
 - Purposeful InPatient Admission (PIPA)
 - Purposeful and Productive Community Services (PPCS)
- These programmes have revitalised and focussed the respective teams on their processes, outcomes for patients, key performance indicators, and embedding quality into everyday practice. We have seen improvements with training compliance, appraisal and supervision and have woven into these processes the new ThinkOn methodology which is a thinking effectiveness framework based on a classic coaching route way.

Innovation:

- In MHSOP we are developing a dementia pathway which builds on existing work and reflects the outcomes and recommendations of a recent Intensive Team Support via NHS England.
- Tewv have established a Transformation Board of senior operational and clinical staff to consider transformation requirements and to identify the actions necessary to ensure that our services evolve to ensure high quality care delivery and best clinical practice. The board is set up to explore a transformation agenda across all of our services, involving clinical interventions, workforce development, improvements in care environments and increased partnership working.

Working in Partnership:

- TEWV recognises that working in partnership is essential in developing services that meet local needs and expectations.
- Listening to feedback and supporting service changes remains important to us but we have also made significant progress in engaging and involving service users and carers in helping to transform the way services are delivered and to design new services and clinical pathways.
- TEWV have committed to supporting various information and signposting guides provided by voluntary sector partners like Healthwatch. Communication with key stakeholders and partners is essential and we are committed to engaging with all groups especially the Service User Network (SUN) and York Carers Group.

Challenges:

- Maximising the throughput of patients from inpatient beds with the scarcity of available/suitable placements
- Understanding and managing the demand across teams in a changing and unpredictable system
- Recruitment and retention of nursing staff
- Maintaining the level of quality improvements in a challenging financial envelope

TEWV Two Years On in Learning Disability Services

Overarching headline is that Learning Disability Services are rated GOOD by CQC with no 'must do' actions

White Horse View closed ensuring the Transforming Care bed trajectories are being met. No staff redundancies were made but staff were redeployed to existing services

The TEWV values are Commitment to Quality, Respect, Innovation, Wellbeing and Teamwork

All too often Trust values are meaningless statements however TEWV values are meaningful and 'lived'

Commitment to Quality

TEWV has introduced a robust Quality improvement Program

Examples in Learning disabilities are the introduction of the Purposeful Inpatient admission (PIPA) at Oak Rise this has led to:

- average length of stay reducing from 134 days to 92
- A 63% improvement in getting the right people to meetings
- Over 90% of admissions having a person centred formulation meeting at 72 hrs post admission
- Less delayed discharges
- And an efficiency gain of 10 hours per admission of nurse time
- There is a clearly defined patient journey

Purposeful and Productive Community Services program means that

- The amount of patients seen within 28 days has improved from 22% to 78% and 100% seen within the CCG target of 9 weeks. Reasons for breaching this are nearly always DNA or patient choice
- Data quality is much improved with no missing NHS numbers or ethnicity
- All new patients referred to the team receive a welcome pack which includes information on how to get an Annual Health check and health passport
- All new patients are now on the new Core LD pathway
- All staff have technology to support mobile working, meaning more efficient and contemporaneous record keeping
- All patients have a Safety Summary and compliance is monitored via a monthly audit

Other quality improvements are in training compliance there is 95% compliance with core 7 training and 90% compliance with role specific training

Through the Transforming Care Program we have implemented a crisis team telephone support line via Oak Rise and have a two year Crisis intervention practitioner in post North Yorkshire wide who has successfully prevented admissions to hospital

Performance monitoring is open and transparent and ensures that teams are held to account

Respect

There is a robust feedback loop that ensures any feedback received via the friends and Family test is both listened to and acted upon.

An example is that service users and carers complained that having an answerphone at lunch time was difficult for people with learning disabilities
Now the telephone is always answered during office hours

In October 98% of people that used the service reported they were treated with respect

Staff receive positive feedback via the e-bulletin, being eligible for team of the week and being nominated for the Trust annual awards

Inpatient staff are now compliant with working time directive, enabling them to have a comfort break during their shift

The environments at both Oak Rise and Systems House have been improved
Systems house has been decorated and new carpets throughout

Oak Rise now has dedicated dispensing areas for medication, a proper staff office and staff room a small 1:1 therapy room and a quiet area for service users. There is new flooring throughout and new furniture and furnishings. A staff alarm system has also improved the safety of staff

Innovation

TEWV support innovation and new ways of working
In Learning Disability Services the Positive Behaviour Pathway is now embedded in both the community team and inpatient services ensuring patients are supported to receive high quality care in their home environment

During the recent upgrade of Oak Rise an assertive outreach model was trialled which meant service users were assessed and treated in their homes, high quality independent behavioural observations were carried out to inform formulation and patients were treated under greenlight arrangements

Wellbeing

Staff well-being is paramount with TEWV and staff have access to a wide range of supportive services and processes
Mindfulness is offered to both patients and staff

Teamwork

Learning Disability services now have stronger links with mainstream mental health services than before

There is much improved greenlight working

Training in Learning Disability awareness has been delivered to Adult Mental Health Services and GPs

People with learning disabilities are seen by crisis liaison and home based treatment teams and when appropriate are admitted to Adult Mental Health wards

The challenges

Our challenges remain the Transforming Care agenda

Meeting the bed trajectory

Inpatient provision needs to be reviewed both in light of TCP and in light of providing a service for the complex patient group that will continue to require inpatient care.

Oak Rise continues to have many environmental issues and is isolated when there is a crisis on the ward.

The community team will need investment to ensure service users can be treated in their own homes and avoid hospital admission

The Care and Treatment reviews are not available in a timely way


There remains no clear forensic service for people with Learning disabilities

TEWV - Two Years On in Mental Health Services for Adult Services

- Safe Haven Development set to launch 31st October in development with Mental Health Matters.
- Brought EIP back into the NHS to maximise the oversight of service delivery and flexibility around workforce
- Developed a community rehab & recovery team with a focus on re-patriating service users to the locality.
- Integrated Personality Disorder Clinical Network into community services to share and disseminate specialist learning throughout teams.
- Implemented Purposeful & Productive Community Services across community services.
- Developed a full programme of DBT
- Developed a new Access & Brief Intervention Service which also 'bridges the gap' between primary and secondary services.
- Plans to develop a new perinatal service
- Provided innovation funds – working with the VCS to create additional mental health and wellbeing opportunities for patients
- Expansion of the Discover Hub with York St. Johns University
- Moves to Huntington House & Acomb Campus to enhance the level and quality of patient facing community facilities
- Re-opening of adult inpatient services at Peppermill these wards have developed Purposeful Inpatient Admission (PIPA) processes with daily report outs to ensure that every patient is reviewed by a multi-disciplinary team. This has seen a reduction in length of stays, reduction in violence and aggression and also a reduction in out of locality admissions
- Re-structuring of crisis team currently meeting gatekeeping and four hour breach targets as well as increasingly positive feedback from patient and carer feedback.
- Overall recruitment improved significantly, no long-standing vacancies or 'hard to recruit' areas within adult services.
- Challenges continue with IAPT picture locally in keeping with national picture.
- Worked with carers and supported carers video as part of Recovery College on line development to further enhance the recovery offer.

- Contributed to the Student Mental Health work streams
- Led Learning Sets and Symposium to stimulate thinking around new models of care, working with International Mental Health Collaborating Network (IMHCN), engaging partners, patients and carers
- Progressing volunteering into wards and Huntington House
- Revised pathways to align with TEWV processes with a focus on recovery
- Increased and enhanced working with Police via Street Triage and Force Control
- Contributed to the CYC Housing Workshop in September 2017.

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Item Number: 15	
Name of Presenter: Sheenagh Powell, Audit Committee Chair	
Meeting of the Governing Body Meeting Date: 4 January 2018	 Vale of York Clinical Commissioning Group
Audit Committee Annual Report	
Purpose of Report To Receive	
Reason for Report This report reviews how the Audit Committee (the Committee) has met its Terms of Reference and fulfilled the its role in relation to the financial year ended 31 March 2017. It is designed to inform the Governing Body of the wide range of work undertaken in the financial year and to provide assurance that key areas of organisational risk are being escalated.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description
Emerging Risks (not yet on Covalent)	

Recommendations

N/A

Responsible Executive Director and TitleTracey Preece
Chief Financial Officer**Report Author and Title**Michael Ash-McMahon
Deputy Chief Finance Officer

Audit Committee Annual Report 2016/17

1. Purpose of the Report

- 1.1 To review how the Audit Committee (the Committee) has met its Terms of Reference and fulfilled the role set out in relation to the financial year ended 31 March 2017.

2. Background

- 2.1 The Committee is established in accordance with NHS Vale of York Clinical Commissioning Group's (the CCG) constitution.
- 2.2 The Audit Committee membership is constituted from lay/independent members.
- 2.3 The Audit Committee has delegated responsibility from the Governing Body for the oversight of:
- Integrated Governance, Risk Management and Internal Control
 - Internal Audit;
 - External Audit;
 - Other Assurance Functions - Reviewing the findings of other significant assurance functions;
 - Counter Fraud;
 - Management - Reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management internal control and quality;
 - Financial Reporting;
 - Auditor Panel Provisions.
- 2.4 It is the responsibility of the CCG's Senior Management Team, now Executive Committee, to establish and maintain proper processes for governance. The role of the Audit Committee is to provide the Governing Body with independent assurance on systems and processes through challenge and scrutiny of internal audit, external audit and other bodies.

3. Governance, Risk Management and Internal Control

Membership

- 3.1 Mrs Sheenagh Powell, Lay Member and Chair of the Audit Committee, was in place throughout the financial year.

- 3.2 Mr David Booker, Lay Member and Chair of the Finance and Performance Committee, was in place throughout the financial year.
- 3.3 Dr Arasu Kuppaswamy, Secondary Care Doctor Member, was in place throughout the financial year.
- 3.4 Mrs Tracey Preece, Chief Finance Officer, was in attendance throughout the financial year.
- 3.5 Mrs Rachel Potts, Executive Director of Planning and Governance, was in attendance throughout the financial year.
- 3.6 Mrs Michelle Carrington, Executive Director of Quality and Nursing, was in attendance throughout the financial year.

Governance

- 3.7 In response to the 'not assured' rating for CCG leadership in Spring 2016, an in-depth review of the governance arrangements commenced in the Summer under the direction of the Interim Accountable Officer. This included a review of all decision making meetings within the CCG. The review was subsequently further developed in response to Legal Directions in September 2016 issued under Section 14Z21 of the National Health Service Act 2006. A response to this was included in the Improvement Plan submission in October 2016.
- 3.8 The Legal Directions focus on five key areas:
 - the production of a revised Improvement Plan;
 - the strengthening of the financial leadership of the CCG;
 - a financial recovery plan that ensured the CCG achieved an in-year deficit of no greater than £7m in the financial year 2016/17;
 - that NHS England will determine the process for making the new Interim Accountable Officer appointment;
 - that NHS England will be involved in the process to make any new appointments to the Executive Team and the next tier of management.
- 3.9 In response to these directions, the CCG developed an Improvement Plan, and it continues to work closely with NHS England to deliver against the agreed actions.
- 3.10 The CCG has a series of financial controls to ensure appropriate governance arrangements are in place and these were subject to review via Internal Audit with significant assurance opinions provided for Conflicts of Interest, Joint Commissioning, QIPP, Referral Management, Budgetary Control and Reporting and Key Financial Controls, Financial Forecasting, Governance, Information Governance Toolkit and PCU Information Governance Toolkit.

- 3.11 The CCG had policies in place regarding conflicts of interest and business conduct, and published the declarations of interest for Governing Body members.
- 3.12 The Audit Committee continued to review its terms of reference and work plan taking account of the Healthcare Financial Management Association NHS Audit Committee Handbook.

Risk Management

- 3.13 A robust Risk Management Framework was in place throughout the year, with risk, performance and financial issues being reported weekly to the Senior Management Team, monthly to the Quality and Finance Committee and to each Governing Body meeting, via the minutes of the Quality and Finance Committee.
- 3.14 The CCG continued to embed the Covalent system for recording and reporting of risk. An escalation process in Covalent was agreed to escalate risk to the Corporate Risk Register. The Corporate Risk Register was reviewed by the Governing Body at each meeting. The Governing Body was well sighted on the risks facing the organisation, including the financial risks identified and which materialised during the year, through the Corporate Risk Register and via the Quality and Finance Committee.
- 3.15 Risk training sessions were provided to the CCG to both raise awareness and improve identification and assessment of risk.
- 3.16 The CCG has strengthened working links between the Quality and Finance Committee and the Audit Committee throughout the year and this has been evidenced by the issues escalated which have resulted in the Audit Committee commissioning Internal Audit work.

4. Internal Audit

- 4.1 During the year the internal audit service was provided by Audit Yorkshire following the merger of North Yorkshire audit services and West Yorkshire Audit consortium. Audit Yorkshire is hosted by York Teaching Hospital NHS Foundation Trust.
- 4.2 The work of Internal Audit has continued to focus on the progress being made in designing, implementing and embedding core processes to underpin the delivery of the CCG's strategic objectives. As such the audit plan was structured around the following key responsibilities:
- Governance (incorporating assurance and risk management)
 - Securing Improvements in Quality
 - Commissioning and Contract Management
 - Partnerships
 - Financial Governance
 - Information Governance

4.3 A total of 120 days were allocated for this work, of which 10 were for the Management of Audit, 4 for Follow Up of Audit Recommendations and 10 available for Client Directed work. A total of 117 days were delivered in relation to the internal audit plan. The PCU governance audit was deferred at the request of the CCG. A total of 3 days were therefore carried forward to 2017/18 as a result.

4.4 In May 2017 the Committee received the Head of Internal Audit opinion relating to the financial year 2016/17. This opinion confirmed that significant assurance could be given that there is a 'generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and / or inconsistent application of controls put the achievement of particular objectives at risk'. Where weaknesses have been identified, an action plan is in place to address the issue. The Head of Internal Audit Opinion was given in the context of the following:

The current position: The Accountable Officer reported to the Governing Body at its meeting on 2 February 2017 that the CCG continues to work on implementing the Improvement Plan with regards to capability, capacity, financial leadership, governance, mobilising change and financial recovery. An assurance review of the design of the revised governance arrangements was completed, and provided Significant Assurance on the design of the arrangements.

The design and operation of the Assurance Framework and associated processes: During 2016/17 the CCG's arrangements for managing risk and providing assurance to the Governing Body have focussed on the mandated areas of NHS England's Improvement and Assurance Framework. The Governing Body and the Audit Committee have reviewed the Improvement and Assurance Framework and associated risk registers for the mandated areas at each of their meetings:

- Better Health
- Better Care
- Sustainability
- Leadership

4.5 The Audit Committee in September 2016 discussed whether the Improvement and Assurance Framework fulfilled the function of providing assurance that key corporate and strategic risks were being managed and mitigated. A revised risk management framework based on the CCGs strategic priorities has been developed to provide assurance on management of risks to the priorities. The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year and detailed in paragraph 4.5 below.

4.6 The outcome of the audit reports presented to the CCG from the 2016/17 audit plan are summarised below.

Strategic Objective	Audit	Overall Opinion
Well led organisation with the skills and capacity to deliver statutory functions.	Conflicts of Interest	Significant
	Commissioning Support Contract Management	Limited
Effective clinical and quality assurance improving the quality and safety of commissioned services.	Prescribing and Medicines Management	Advisory review
Transforming local healthcare services	Primary Care Commissioning (Quality)	Limited
	Joint Commissioning	Significant
Financial sustainability supported by effective financial management.	QIPP	Significant
	Referral Management	Significant
	PCU QIPP	Limited
	Contract Management	Significant
	Budgetary Control and Reporting and Key Financial Controls	Significant
	Financial Forecasting (PCU* Expenditure)	Significant
Mental Health Act s117 Continuing Healthcare	Limited	
Audit Areas Relating to Other Corporate Functions	Governance	Significant
	Information Governance Toolkit	Significant
	PCU* Information Governance Toolkit	Significant

* Note: The PCU is a hosted organisation established by the CCGs in North Yorkshire to undertake commissioning activities on behalf of all four organisations. This includes Continuing Health Care, Children Services Commissioning, Mental Health Commissioning and Adult Safeguarding. As part of each internal audit plan a number of audit days are allocated to the audit of systems and controls at the PCU in order to provide assurance to all four CCGs. A detailed audit plan for the PCU for 2016/17 was agreed to provide assurance in relation to the commissioning activities undertaken on behalf of the CCGs.

5. External Audit

5.1 Mazars LLP are the External Auditors for all the North Yorkshire and York CCGs with Mr Mark Kirkham as Partner and Mrs Catherine Andrew as Senior Manager, managing the CCG contract and attending each Audit Committee meeting. They also hold regular liaison meetings with the Accountable Officer, Chief Finance Officer and Executive Director of Planning and Governance.

- 5.2 The fee to External Audit for work undertaken included auditing the CCG's financial statements, which incorporated a review of the Annual Governance Statement, Annual Report and auditing certain sections of the Remuneration report; and assessing arrangements for achieving value for money in the use of resources.
- 5.3 The audit fee was £60k plus VAT for 2016/17. There were no additional pieces of work commissioned from the External Auditors during 2016/17.
- 5.4 Mazars LLP carried out the audit in accordance with the Local Audit and Accountability Act 2014 and the Code of Audit Practice for NHS bodies as issued by the Audit Commission and delivered all expected outputs in line with the timetable established by the Department of Health and NHS England.
- 5.5 Mazars LLP Independent Auditor's Report to the CCG made the following findings:

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Vale of York CCG as at 31 March 2017 and of its net expenditure and income for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

- 5.6 However, they also issued a modified regularity opinion and qualified (adverse) value for money conclusion, relating to the failure of the CCG to meet its statutory duties under:

- Section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2016/17; and
- Section 223I(3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in the Direction.

Except for the incurrence of expenditure in excess of the specified targets, the opinion of the External Auditor was that in all material aspects the expenditure and income reflected in the financial statements were applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

- 5.7 On the basis of their work, having regard to the guidance issued by the C&AG in November 2016, Mazars LLP were not satisfied that, in all significant respects, NHS Vale of York put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

6. Local Counter Fraud Service (LCFS)

- 6.1 The Committee approved the 2016/17 plan which included 8 days allocated as follows:

- Strategic and Governance – 3 days
- Inform and Involve – 1.5 days
- Prevent and Deter – 2.5 days
- Hold to Account – 6 days

6.2 A further 6 days were contracted for from Internal Audit for investigative Local Counter Fraud work, largely within the Hold to Account area.

6.3 In January 2017 NHS Protect issued the updated *Standards for commissioners – fraud, bribery and corruption* to LCFs and Chief Finance Officers. The standards are intended to outline an organisation's corporate responsibilities regarding counter fraud and the key principles for action. These are:

- Strategic Governance – this sets out the requirements in relation to the strategic governance arrangements of the organisation to ensure that anti-crime measures are embedded at all levels across the organisation.
- Inform and Involve - this sets out the requirements in relation to raising awareness of crime risks against the NHS, and working with NHS staff and the public to publicise the risks and effects of crime against the NHS.
- Prevent and Deter - this sets out the requirements in relation to discouraging individuals who may be tempted to commit crime against the NHS and ensuring that opportunities for crime to occur are minimised.
- Hold to Account - this sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes, and seeking redress.

The Counter Fraud plan for 2016/17 was structured and implemented in accordance with these principles.

6.4 The Local Counter Fraud Specialist, Mr Steven Moss, is a regular attendee at Committee meetings and provides regular updates on proactive and reactive counter fraud work in these areas.

6.5 In order for NHS Protect to derive a clear picture of the work conducted and assess compliance with the counter fraud standards every NHS commissioner is required to submit a Self Review Tool (SRT). The SRT is intended to enable the organisation to produce a summary of the anti-fraud, bribery and corruption work it conducted over the previous financial year. Organisations are required to complete the SRT annually and return it with the annual report to NHS Protect.

6.6 A review of the SRT identified that the CCG feels it has fully met 21 of the standards, partially met 4 of the standards and recorded a neutral / not applicable response against 2 standards resulting in an overall level of green. This represents an improvement on the CCG's 2015/16 submission, which identified that the organisation had fully met 19 of the standards, partially met 5 and was neutral / not applicable with 1. In 2015/16 the overall level of compliance was green.

- 6.7 The CCG recorded neutral in response to interviews under caution being conducted in line with the National Occupational Standards and the Police and Criminal Evidence Act 1964 as none were conducted on behalf of the CCG in 2016/17. The CCG recorded not applicable in response to the standard for maintaining appropriate anti-fraud, bribery and corruption arrangements and ensuring any recommendations made by NHS Protect are fully implemented as this did not apply to the CCG in 2016/17.
- 6.8 In regard to the Inform and Involve workstream, a number of fraud awareness bulletins and alerts were issued to relevant CCG staff.
- 6.9 In relation to reactive counter fraud work there have been five investigations which the CCG has complied with:
- PCU investigation
 - Unsolicited phone call to patients
 - Anonymous allegation concerning award of contract
 - Amendment to prescription referral
 - Procurement referral
- 6.10 Information was shared as appropriate with regards to these and within the information governance and data protection regulations.
- 6.11 The total number of days used was 14 as follows:

Area of Activity	Number of Days
Strategic Governance	3.75
Inform and Involve	1
Prevent and Deter	3.25
Hold to Account	6
Total	14

7. Other Assurance Functions

- 7.1 Assurances were received from the CCG's commissioning support provider eMBED Health Consortium in a letter format.
- 7.2 The scope of the letter covered the following business process areas for the CCG:
- IT
 - Business Intelligence
 - Corporate Services
 - Business Services
- 7.3 In respect of the Service Level Agreement (SLA) between the Partnership Commissioning Unit (PCU) hosted by NHS Scarborough and Ryedale CCG, NHS Harrogate and Rural District CCG, NHS Hambleton, Richmondshire and Whitby CCG and the CCG, the Committee acknowledged the work done to improve the systems and

processes that support delivery of services. However, as identified by Internal Audit, the Committee formally noted the significant areas of concern that will need continued monitoring and review.

7.4 Members of the Committee take the opportunity to have a separate discussion with the internal and external auditors without any officer of the CCG being present at least once a year and with both internal and external auditors prior to the year-end meeting. The purpose of the discussion is to ensure that there are no matters of concern regarding the running of the organisation that should be raised with the Committee.

7.5 As at the 31st March 2017 the CCG recorded the loss of a mobile phone (value £432) and one special payment in relation to a compensation payment to a member of staff from the Partnership Commissioning Unit who was found to have been unfairly dismissed (VoYCCG share £32,379). There had been no write offs of CCG debts.

8. Meetings and areas of note considered by the Audit Committee in 2016-17

8.1 The following table details the each meeting of the Audit Committee for 2016-17 and details areas of note from the Committee discussion.

Meeting Dates	Areas of Note from the Committee Discussion
28 April 2016	<ul style="list-style-type: none"> • Signed off approval of the request for waiver to tender for Attain project support • Following detailed discussion of the NHS Vale of York CCG Auditor Panel, membership was agreed as well as those in attendance • Noted the 2015/16 annual report and accounts would be presented for final approval at the 24 May meeting • Tracey Preece was liaising with External Audit regarding Accountable Officer sign off of the annual report and accounts
24 May 2016	<ul style="list-style-type: none"> • Noted the updated Audit Committee work plan and agreed meeting dates • Noted progress against the Internal Audit work programme • Noted the progress with the implementation of Internal Audit recommendations • Approved the Internal Audit Strategic Plan 2016/17 to 2018/19 and the Operational Plan for 2016/17 • Agreed that Internal Audit Charter and Working Together Protocol be an annual agenda item and that information about it be included in a Staff Briefing • Approved the Annual Report and Accounts 2015/16 • Noted the update on the end of year review meeting with NHS England

<p>6 July 2016</p>	<ul style="list-style-type: none"> • Requested that the PCU report to Senior Management Team be circulated to members • Noted the on-going work by the PCU to address the Limited Assurance Internal Audit Reports • Agreed that Head of the PCU would attend the Committee when relevant reports were being presented • Received confirmation of the outcome of the CCG's 2015/16 annual review meeting. This was an overall rating of 'Not Assured' as a result of: <ul style="list-style-type: none"> - Well Led Organisation: Not Assured - Delegated Functions: Limited Assurance - Financial Management: Not Assured - Performance: Limited Assurance - Planning: Not Assured • Noted the review also recognised positive areas of work and, whilst acknowledging the challenges faced by the CCG, emphasised the need for focus on turnaround in 2016/17 • Formal notification was awaited but expected the CCG to be rated as 'Inadequate' under the new NHS England Improvement and Assessment Framework • Ratified the revised terms of reference for the Information Governance Steering Group • Noted the Information Governance Work Programme • Noted the content of the Annual Audit Letter 2015/16 and the challenges highlighted for 2016/17 • Noted the update on the Internal Audit merger between North Yorkshire NHS Audit Services and West Yorkshire Audit Consortium
<p>28 September 2016</p>	<ul style="list-style-type: none"> • Noted the Counter Fraud Progress Report, in particular that the National Fraud Initiative for 2016/17 was taking place ensuring staff were appropriately informed and that the submission deadline of 30 September for the fair processing compliance return to the Cabinet Office would be met . • Recommended to the Governing Body approval of the Security Policy. • Received assurance that the action plan developed following the incident at month 2 financial reporting to NHS England had been completed. • Approved the amendments to the Detailed Scheme of Delegation with the exception of delegated authority for the appointment of consultancy support which should be in line with the requirements of the Legal Directions. • Detailed review and discussion of Financial Arrangements for Mental Health Out of Contract Budgets and Financial Procedures and Forecasting of Continuing Healthcare and Funded Nursing Care Budgets and Benchmarking.

	<ul style="list-style-type: none"> • Ratified the Policy on Primary Care Rebate Schemes subject to a number of amendments which would be incorporated prior to its presentation to the November Governing Body meeting. • Noted the requests for waiver to tender for consultancy support to the financial recovery plan, the Better Care Fund and Programme Management Office expressing concern at the cost and value for money consideration. • Noted the periodic report outlining progress against the Internal Audit work programme. • Approved commissioning an additional five days of security service for 2016/17 with a review of future requirements towards the end of the year. • Noted the update on the merger of North Yorkshire Audit Services and West Yorkshire Audit Consortium and the proposed changes to Internal Audit provision. • Confidence that the Assurance Framework and risk log provided an accurate reflection but lack of assurance that the organisation would be able to deliver. • Request for a regular report on the financial recovery plan and response to Legal Directions. • Concern was raised at the cancellation of Primary Care Commissioning Committee meetings and potential implications.
5 December 2016	<ul style="list-style-type: none"> • Head of PCU presented updates on two Internal Audit reports circulated, Partnership Commissioning Unit Financial Reporting and Partnership Commissioning Unit Continuing Healthcare. The Committee took partial assurance from the updates but recognised the need for further assurance through the change process. • Noted the results of a survey for the annual review of effectiveness of External Audit. Data analytics and benchmarking were suggested areas of improvement although they had been used for the first time and Mazars were externally accredited as 'good' for them. • Noted the Counter Fraud Progress Report. Data matches from the National Fraud Initiative would be available from January and reviewed by the CCG. The report highlighted the need for Audit Committee Chairs to ensure the development and implementation of an action plan. • Agreed that review of the progress of those carrying out counter fraud and security activity was delivered through regular reporting. • Noted the results of the Security Management Self Review assessment and five areas of non-compliance. Non-compliance was due mainly to the fact that security management services were still at an early stage and work was ongoing to achieve compliance. • Noted a report on the Annual Accounts preparation

	<p>and timetable and provisionally agreed a date for the Annual Accounts meeting.</p> <ul style="list-style-type: none"> • Noted the loss of a mobile phone on the Losses and Special Payments Register. • Noted a review of the financial policies and that they would be reviewed again in the New Year after changes to the executive structure. • Noted the challenges and ongoing work in respect of the 2017-19 Finance Plan; the draft of which was submitted at the end of November. The AC noted concerns regarding challenges for delivery. • Noted the current portfolio of risk and that reporting of risk was being reviewed as part of the new committee structure. The Executive Committee would actively monitor corporate risk. • Recommended that the Whistleblowing Policy be presented for approval by the Governing Body. • Noted a report on two Information Governance incidents and that relevant action had been taken. • Noted the periodic report outlining progress against the Internal Audit work programme and in particular the Contract Management Audit Report which had been assessed as Significant Assurance. • Discussed concerns around the Partnership Commissioning Unit Internal Audit Reporting Protocol. • Noted the Internal Audit recommendations status report and requested that further reminders be sent in respect of the outstanding recommendations.
<p>1 March 2017</p>	<ul style="list-style-type: none"> • The Committee received reports on the annual review of effectiveness of the Audit Committee and internal audit. • Requested a policy on non-audit work carried out by external audit. • Requested that regulatory reports be added to the internal audit work programme and brought to the Committee as appropriate. • Requested that internal audit review the CCG's new governance structure. • Requested that minutes of the Quality and Patient Experience Committee and Executive Committee be included on future agendas. • Agreed that all Executive Directors should receive audit briefs. • Agreed the arrangements for consideration of the draft annual accounts and associated documents. • Agreed that security be added to the Committee work plan and that counter fraud be reported at the March and August meetings with exception reporting in between if required. • Approved the Counter Fraud Plan for 2017/18.

	<ul style="list-style-type: none"> • Agreed that the Security Self Review Tool be completed in September 2017 unless further guidance received. • Accepted the draft accounting policies, including the deviations from the NHS England accounts template. • Noted the potential risk to the CCG's £28.1m forecast deficit position due to the £1.7m prescribing adjustment which was not supported by the external auditors. • Agreed that the annual accounts for 2016/17 be prepared on a going concern basis with information about the Medium Term Financial Strategy and the development of the Accountable Care System included. • Noted a potential special payment relating to support provided to a York Medical Group site following a fire. • Noted that a full review of the CCG's Constitution and associated financial documents was taking place and requested the Scheme of Delegation review be completed by 31 March 2017. • The month 9 draft accounts, which were submitted to NHS England in line with the national timetable, were received and noted by the Committee. • Received a report on the progress against the Financial Recovery Plan which included the Financial Plan, QIPP Programme and Medium Term Financial Strategy. The Committee expressed concern at the level of risk that remained with the CCG. • Agreed amendments to the Primary Care Rebate Schemes policy. • Received the Risk Register and the Conflicts of Interest quarterly assessment. • Received a progress report from external audit and agreed the Audit Strategy Memorandum. • Received the annual Value for Money risk assessment. • Noted the draft internal audit plan and received the internal audit periodic report. Internal audit also reported on the audit recommendations status report and the Committee expressed concern over the Partnership Commissioning Unit recommendations.
26 April 2017	<ul style="list-style-type: none"> • Agreed interim approval of the Constitution, Scheme of Delegation and Detailed Financial Policies subject to suggested amendments to improve clarity and consistency. Requested that the Detailed Scheme of Delegation be finalised and circulated. • Received an internal audit progress report and five finalised reports. The Committee expressed concerns over the limited assurance report for the Commissioning Support Contract Management. Deadlines were queried and it was requested that a

	<p>report be brought back to the next meeting.</p> <ul style="list-style-type: none"> • Received the internal audit recommendations status report in which nine recommendations were completed. The Committee expressed concern over the Partnership Commissioning Unit transition. • Approved the draft internal audit plan. • Received the draft Annual Accounts and Annual Report 2016-17 and approved them for audit. • Resolved that the Annual Report and Annual Accounts 2016-17 be presented at the May meeting for delegated approval along with a report from the external auditors on their findings and opinion.
24 May 2017	<ul style="list-style-type: none"> • Received the internal audit periodic report which confirmed that the 2016/17 audit plan had been completed. Members sought and received clarification on the completed audits which had all achieved significant assurance. • Requested that internal audit scope governance principles for joint working with NHS Scarborough and Ryedale CCG and York Teaching Hospitals NHS Foundation Trust. • Noted that feedback would be provided on the implications for social care resulting from the audit of management of commissioning of aftercare under section 117 of the Mental Health Act. • Received the Head of Internal Audit Opinion which was presented with significant assurance and requested two minor amendments. • Received the annual review of Internal Audit Charter and Working Together Protocol. The Committee requested that a 'user-friendly' version of the protocol be developed for circulation to CCG staff. • Received the annual Counter Fraud report for 2016/17 welcoming confirmation that no fraud had been identified at the CCG. The Committee also received the Counter Fraud Self-Assessment which identified 4 standards which were partially met and 2 standards which were neutral/not applicable, resulting in an overall level of green. Work to be undertaken to improve where assessed as partially compliant. • Approved the Annual Report and Annual Accounts 2016-17 subject to the incorporation of an additional paragraph in the Management Representation Letter. • Received the external audit completion report which anticipated an unqualified opinion on the financial accounts but a qualified opinion on the regulatory and value for money aspects. • Noted an update on amendments to the Constitution, Scheme of Delegation and Detailed Financial Policies and requested a summary version for meeting chairs. • Approved the Conflicts of Interest Policy subject to

	confirmation that the recommendations of the internal audit report had been incorporated.
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9. Future Plans

- 9.1 The Committee is constantly looking to develop the way that it works and improve the efficiency of the internal control systems across the organisation. In 2018/19 the Committee will continue to take particular cognisance of the financial, quality and performance challenges facing the CCG, the transformational changes required to deliver this and the system and individual organisational form and structure alterations to support these arrangements taking assurance from the Auditors and the Quality and Finance Committee.
- 9.2 The Committee will continue to closely monitor assurance arrangements for the Commissioning Support services from eMBED as well as those put in place following the transfer of responsibility for services previously provided by the PCU back to the CCG.
- 9.3 The Committee will continue to review their Terms of Reference and will constantly seek the assurances required of the organisation that the systems of internal control are documented, fit for purpose and complied with consistently.
- 9.4 The Committee will also continue to review the Scheme of Delegation to ensure it is up to date and covers all relevant areas including the Primary Care Co-Commissioning arrangements and finalise the list of complete Financial Procedure Notes.
- 9.5 The Committee will report to the Governing Body on a regular basis.


10. Recommendations

- 10.1 The Governing Body is asked to receive and note the Annual Report.

Audit Committee Members Attendance April 2016 – May 2017

Name	Committee Membership	Attendance
Sheenagh Powell – Chair	From April 2016	10/10
David Booker	From April 2016	8/10
Arasu Kuppuswamy	From April 2016	6/10

Includes Auditor Panel meetings in July and December, David Booker missed the latter.

Item Number: 16									
Name of Presenter: Andrew Phillips									
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group								
Report Title – Overview: Winter Planning Update									
Purpose of Report <i>(Select from list)</i> For Information									
Reason for Report Summary of key actions: as described. <ul style="list-style-type: none"> • Lead up to winter 2017-18 – recap of last year, learning, AEDB and planning meeting in August 2017 • Schemes highlighted for further work by different groups • Local and regional proposals • Agreed winter plan by partners and local costs • Delivery against winter plan including escalations and key themes so far 									
Strategic Priority Links <table style="width: 100%; border: none;"> <tr> <td><input checked="" type="checkbox"/> Strengthening Primary Care</td> <td><input type="checkbox"/> Transformed MH/LD/ Complex Care</td> </tr> <tr> <td><input checked="" type="checkbox"/> Reducing Demand on System</td> <td><input checked="" type="checkbox"/> System transformations</td> </tr> <tr> <td><input checked="" type="checkbox"/> Fully Integrated OOH Care</td> <td><input checked="" type="checkbox"/> Financial Sustainability</td> </tr> <tr> <td><input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> Strengthening Primary Care	<input type="checkbox"/> Transformed MH/LD/ Complex Care	<input checked="" type="checkbox"/> Reducing Demand on System	<input checked="" type="checkbox"/> System transformations	<input checked="" type="checkbox"/> Fully Integrated OOH Care	<input checked="" type="checkbox"/> Financial Sustainability	<input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract	
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Local Authority Area <table style="width: 100%; border: none;"> <tr> <td><input checked="" type="checkbox"/> CCG Footprint</td> <td><input type="checkbox"/> East Riding of Yorkshire Council</td> </tr> <tr> <td><input type="checkbox"/> City of York Council</td> <td><input type="checkbox"/> North Yorkshire County Council</td> </tr> </table>		<input checked="" type="checkbox"/> CCG Footprint	<input type="checkbox"/> East Riding of Yorkshire Council	<input type="checkbox"/> City of York Council	<input type="checkbox"/> North Yorkshire County Council				
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Impacts/ Key Risks <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input type="checkbox"/> Equalities 	Covalent Risk Reference and Covalent Description								

Emerging Risks (not yet on Covalent)

All risks are associated with the achievement of the 4-hour A&E standard across the local system. Each winter scheme has a number of partners who are responsible for the associated actions and delivery of the scheme as part of their rolling risk registers. Regional schemes have various local delivery and oversight boards that monitor risk.

Recommendations

N/A

Responsible Executive Director and Title

Andrew Phillips
Joint Medical Director

Report Author and Title

Becky Case
Head of Transformation and Delivery

Winter Funding and Unplanned Care: update 15th December 2017

- **Lead up to winter 2017-18**

As previously described there has been a review by all members of the A&E Delivery Board around the previous year's schemes; what could be evidenced to have had an effect, and what new ideas the system felt could be tested and progressed this winter. A workshop to pull all the ideas together was held in August 2017, and a draft winter plan was compiled. Separate communications were sent out to GPs to ask for their suggestions as to how improvements could be made to Unplanned Care. This plan was then shared with partners and there was further discussion at the A&E Delivery Board meetings and between stakeholders at the start of the Autumn. Similar discussions were held at the STP Urgent and Emergency Care Network group and two schemes were supported for implementation across the wider region.

- **Schemes highlighted for further work by different groups**

The schemes described all supported different aspects of the Unplanned Care pathways; from attendance and admission avoidance to improvement of flow within the acute care phase and support for discharge. Some of the schemes are standard expansions to current services; e.g. additional spot purchase beds for discharge, additional overnight support, provision of more acute staff to support flow etc. Others were more of a test to understand the impact of additional staff and resource on different parts of the system. 21 schemes were put forward across the York and Scarborough area.

Examples are shown below:

Hospital	Employment of Clinical Flow Practitioners	Implementation of 9 Clinical Flow Practitioners through internal appointment and backfill (6 - York site/ 3 - Scarborough site) - Acceleration of SAFER across both sites - Enhanced leadership of operational flow, discharge and stranded patients - Progress chasing on patients to support ECS delivery - Coaching ward staff to support flow and discharge - Key point of escalation
Community	Out of Hospital capacity	Implementation of home IV across York and Scarborough to reduce bed occupancy of patients who can receive IV treatments out of hospital. Bid covers drug and equipment costs. This provision is not commissioned in this area and would contribute to at least 9 acute beds released at any given time. This would significantly mitigate risk to deliver the 92% bed occupancy requirement.
Hospital	Medical and support Staff	Additional medical cover for ED to support overnight, supported by an ED tracker extended to the evenings to reduce evening delays. Evening and overnight contribute to the majority of our breaches, both non-admitted and admitted. This will significantly improve the the 'time to see a doctor' overnight and reduce non-admitted breaches.
Attendance and Admissions Avoidance	Access to primary care	This scheme includes additional access to GP appointments, UCP morning visits and ANP cover for Out of Hours team 24/7 to enable warm transfers from ED to primary care

Joint winter communications were also worked on between partners and a series of messages commenced in November 2017. Most schemes are now in place and being utilised, with the exception of the Community/Home IV work and the UCP morning visits. Both of these are being worked up to ensure appropriate governance and monitoring processes are in place. 22 of the 26 Vale of York partner practices have committed to providing additional sessions over winter; equating to approximately 4000 additional urgent appointments being available.

- **Regional proposals**

The Urgent and Emergency Care Network identified a specific plan around the provision of diversionary pathways in a number of clinical areas and it was agreed that the respiratory pathways were a priority. All areas also represented that they would want to support discharges and it was agreed that a request for additional overnight support would be appropriate.

The two schemes that were supported by NHSE/I for the STP area are:

<p>Providing overnight support for vulnerable patients (across UECN area)</p>	<p>- working with voluntary sector providers to establish capacity for evening and overnight support - establish a process for identifying patients (both admission avoidance and earlier discharge) and agreeing support requirements with patients</p> <p>£70k awarded across VoY and S&R area</p>
<p>Project work to support development of diversionary pathways for respiratory conditions with YAS (across UECN area)</p>	<p>- initial date for two day rapid improvement workshop agreed and data collection well underway - provision of workshop at end of October will provide rapid actions/pathway change - project manager availability will drive speed of progress with training/comms/actions to follow up</p> <p>£62k awarded across HC&V STP area</p>

Existing voluntary sector providers have been approached and discussions are ongoing as to the best way to utilise the funding via existing agreements. Project support has been obtained for the diversionary pathways work and commenced w/c 4th December.

- **Agreed winter plan by partners and local costs**

The schemes for support went to NHS Vale of York CCG Exec on 15th November and most of the operational schemes were approved for implementation. Those items that were not supported were requested to provide additional detail around implementation and cost effectiveness. A total of £328k was allocated towards additional winter support at this point.

Subsequent to this decision being made a number of opportunities arose to bid against specific and additional funding. It was announced in the Autumn Budget that there would be a national one-off provision of £350m to be shared across systems to support access to and delivery of urgent care. The system has since bid against the main tranche held by NHSE/I

and included extensions to schemes that were already planned for as well as reiterating the current financial pressures, bid against specific funds to support Mental Health services over winter, and bid against specific funds to support Primary Care access. It has not yet been reported if we have been successful in obtaining additional funds.

- **Delivery against winter plan**

Significant progress has been made against a number of these schemes: an update of actions is as shown below. Please note Scarborough specific schemes have not been included.

Out of Hospital	
Commissioning additional capacity to deliver support for step down facility for patients with restricted weight bearing capacity	YTHFT are supporting this independently of the winter plan.
Commissioning additional capacity to deliver support for Discharge to Assess for CHC assessment process	A number of block booked beds have been identified for CHC patients and two members of staff are now embedded in the joint discharge team.
Delivering home/community IV therapy	Discussions are ongoing about how best to support this; plans have been agreed that are cost neutral. Anticipated to commence in January 2018.
Providing overnight support for vulnerable patients	Supported regionally; discussions ongoing
Project work to support development of diversionary pathways for respiratory conditions with YAS	Supported regionally; project manager commenced 04/12
Additional Primary Care sessions	Commenced 12/12; 22 practices engaged
Additional PTS for same day discharge	Commenced 12/12
Additional ANP for OOH overnight period	Commenced 12/12 (3 nights per week)
Respiratory rescue packs	Communications commenced
Additional winter comms	Commenced November 2017
Expansion CRT – Community Response Team – both sites	YTHFT are supporting this independently of the winter plan.
In Reach to care homes	Ongoing work between all partners.
UCP morning support visits	Discussions ongoing; meeting 19/12
In Hospital	
Flow Capacity; additional site management support	Commenced December
Use of Orthopaedic Elective capacity - York	Commenced December
Use of surgical 23 hour ward over weekends-York	Commenced December
Work to extend opening hours of Acute Medical Assessment unit - York	Ongoing; expected to commence January 2018

- **Mini-MADE (Multi-Agency Discharge Events)**


As part of the winter system support it was agreed to hold an 8-week set of these events, with all system partners participating. Key themes emerging so far:

- More rapid escalation of complex patients supports more appropriate and timely outcomes
- Culture change around the emphasis on flow is gradually taking place
- Care home and acute hospital trust is still very fragile
- Weekend discharges need to have more emphasis to prevent the 'Monday' issues

- **Current performance:**

November 2017 performed at 90.9% against the 95% standard

December 2017 started well, but performance over the last 10 days has been in the region of 88%.

Item Number: 17	
Name of Presenter: Michelle Carrington	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Report Title – Equality, Diversity and Human Rights Strategy 2017-21	
Purpose of Report <i>(Select from list)</i> To Receive	
Reason for Report To update the previous Equalities and Diversity Strategy 2014-17 to take into account changes in legislation and practice.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description G.17.13-T The CCG fails to adequately discharge its Equalities and Health inequalities duties
Emerging Risks (not yet on Covalent) None identified	
Recommendations N/A	

Responsible Executive Director and Title	Report Author and Title
Michelle Carrington Executive Director of Quality and Nursing	Helena Nowell Planning and Assurance Manager

Equality, Diversity and Human Rights Strategy 2017-2021

Draft Strategy

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1. Foreword



We are pleased to launch the 2018-21 updated Equality, Diversity and Human Rights Strategy for NHS Vale of York Clinical Commissioning Group. The strategy sets out our commitment to taking equality, diversity and human rights into account in everything we do whether it involves commissioning services, employing people, developing policies, or engaging with our local communities.

The intention is that this strategy and action plan will help the Clinical Commissioning Group to focus on current health inequalities, to promote equality and fairness and establish a culture of inclusiveness that will enable health services across the Vale of York locality to meet the needs of all of its population.

The Governing Body commits to monitoring the CCG's progress and reporting regularly and openly on the developments set out in this plan. As leaders we acknowledge and accept our roles in supporting the strategy and will play our full part in making its aims a reality.

Phil Mettam
Accountable Officer, NHS Vale of York Clinical Commissioning Group

2. Accessibility

We are happy to consider requests for this information to be made available in alternative formats or languages



01904 555870



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Ten dokument zawiera informacje o tym, jak będziemy spełniać nasze obowiązki na rzecz równości. Jeśli informacje te są potrzebne w innym formacie lub języku, prosimy o telefon: 01904 555870 lub email valeofyork.contactus@nhs.net.

3. Executive Summary

This Equality, Diversity and Human Rights Strategy sets out the importance of equality and diversity to the CCG and its activities. It outlines the legislative basis that underpins equalities work, and the values that underlie human rights principles, as well as detailing the CCG's own values.

The focus in health inequalities is seen as key to improving the health of the population in the CCG's area, and the CCG will continue to work with its partners to develop activities that aim to prevent or improve health inequalities. The CCG has strengthened its approach to engagement and aims to ensure that as many groups as possible are represented in its work with patients and the public.

The CCG is working jointly with York Teaching Hospital Foundation Trust to deliver its EDS2 goals, as well as monitoring achievement against the current Workforce Racial Equalities Standard (WRES), and in future will work on the Workforce Disabilities Equalities Standard (WDES) to ensure that equalities considerations are embedded into current working practices.

4. Introduction

Vale of York Clinical Commissioning Group (CCG) recognises the need to act responsibly and fulfil our statutory and mandatory duties, such as the Equality Act 2010. We are committed to embedding Equality and Diversity into everything we do, both as a commissioner of services and as an employer. Our aims are to reduce health inequalities and serve our local population, ensuring we listen to and respect the voices of our diverse communities and staff and work in partnership to make services accessible and appropriate for all. We value and respect our staff and aspire to be an inclusive employer of choice. We see 'equality and diversity as the 'golden thread' that runs through all that we do and the way that we do it

This revised strategy sets out how we will deliver on our commitment and continue to meet our duties and responsibilities around equality and Human rights. This includes our revised equality objectives and action plan that we are currently finalising and will be available on our CCG website here <http://www.valeofyorkccg.nhs.uk/>.

5. About us

We are an NHS organisation led by clinicians who understand the needs of the community and the impact that local services have on patients' and local people's health.

We serve a population of more than 351,000 living in York, Selby, Tadcaster, Easingwold, Pocklington and the surrounding villages and rural areas.

Our footprint covers an area of approximately 857 square miles that runs broadly north to south through North Yorkshire. It is mainly rural with a number of small market towns and the main urban centre of York. It covers three local authority boundaries - North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council. The Vale of York is a comparatively affluent area but with pockets of significant deprivation in the York, Selby and Sherburn-in-Elmet areas. We have two local Universities with a significant, vibrant and diverse student population, with overseas students making up 17% of our student population¹.

There is a rapidly growing black and minority ethnic (BME) population in York, due in part to the continuing expansion of university and higher education facilities within the city. Another factor is seasonal work in York's tourism and agricultural industries.

Although the total number of BME people identified in the Census is lower than the UK average, the report *Mapping rapidly changing minority ethnic populations: a case study of York by the Joseph Rowntree Foundation*², reports that York has 78 different first languages spoken by its residents. In the City of York people of Chinese origin make up 1.2% of the population and are one of the most significant BME communities.

5.1 Our vision:

'To achieve the best in health and wellbeing for everyone in our community.'

¹ <http://www.york.ac.uk/admin/po/equality-students.htm>

² <http://www.jrf.org.uk/sites/files/jrf/ethnicity-population-change-york-full.pdf>

5.2 Our values:

Communication	Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
Courage	We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.
Empathy	We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.
Equality	We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality
Innovation	We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
Integrity	We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.
Measurement	Successful measurement is a cornerstone of successful improvement.
Prioritisation	We will use an open and transparent process to arrive at value driven choices.
Quality	We strive to be the best that we can be and to deliver excellence in everything we do.
Respect	We have respect for individuals, whether they are patients or staff colleagues; we respect the culture and customs of our partner organisations

6. Our Approach to Promoting Equality

6.1 Statutory Responsibilities - Equality Act 2010

Clinical commissioning groups have a legal responsibility to demonstrate compliance with the Equality Act 2010, specifically the Public Sector Equality Duty (PSED). In so doing, we must have due regard to three aims of the 'general duty' which states we must:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

The equality duty means we have to demonstrate how we will build consideration of equality into our work as commissioners and as an employer; we will need to understand how different groups are affected by our policies and practices, across the protected characteristics.

The protected characteristics groups covered by the Equality Act are:

- | | |
|--|---|
|  Age |  Race |
|  Disability |  Religion or belief |
|  Gender reassignment |  Sex |
|  Marriage and civil partnership |  Sexual orientation |
|  Pregnancy and maternity | |

In addition to the groups covered by the Equality Act, we also give consideration to carers and vulnerable groups, such as the homeless. We are particularly keen to address health inequalities experienced by those living in the lowest income groups, who are likely to experience poorer health.

6.2 Delivering a Human Rights Based Approach

Human Rights are rights and freedoms that belong to all individuals regardless of their nationality or citizenship. They are essentially important in maintaining a fair and civilized society.

A recognition that the principles of human rights apply to equality is important to us and is key a factor of this strategy. Taking this approach can only make for a better service for everyone, with patient and staffs experiences reflecting the core human rights principles of:

Fairness
Respect
Equality
Dignity
Autonomy

In practice, this means that NHS services should be provided in a non-discriminatory way and that services should be available for everyone.

Current Brexit developments have generated some concerns around the continued commitment to equality and human rights. As an organisation we want to clarify and

assure our local communities that protection under the Equality Act 2010 and the European Convention of Human Rights (ECHR) will continue. The ECHR protects the rights of people in countries that belong to the Council of Europe and is separate to the European Union (EU). The UK will remain signed up to the ECHR when it leaves the EU and in Britain our human rights under the ECHR are protected by the Human Rights Act 1998. Therefore, we remain committed to the FREDA principles as both an employer and commissioner of services.

6.3 Equality and Health Inequalities

“Health inequalities” are the differences in the health of different parts of the population. We are committed to addressing health inequalities and understand that some groups of people, including people with protected characteristics` experience different access, experience and outcomes when they use NHS services. The impact of this can be inequalities that affect broad groups of patients, families and carers. Being a member of certain groups e.g. those with a physical disability or a mental illness, Black and Minority Ethnic (BME) groups and the homeless also play a part, due to social marginalisation, poor access to services and likelihood of income deprivation.

The causes of health inequalities are complex, and include lifestyle factors, discrimination and also wider determinants such as poverty, housing and education. Health inequalities exist between socioeconomic groups, ethnic groups and between men and women.

Life expectancy and other measures of health can vary strongly between different geographical areas and York has two areas ranked in the 10% most deprived in England.

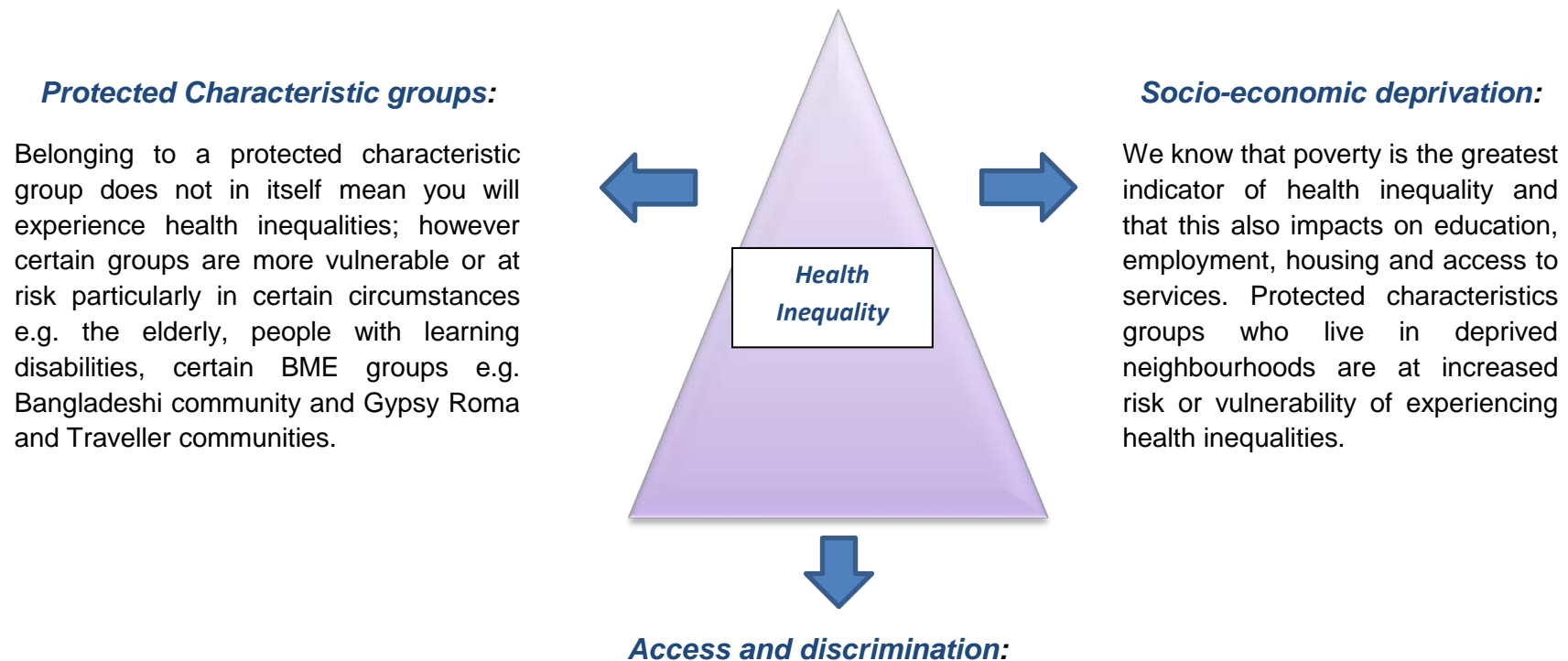
Our 2017 Public Sector Equality Duty report provides further demographic information for our population, and includes information on health inequalities experienced by protected groups. Please refer here for further information <http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/5-january-2017/item-11-annex-a-psed-report-2016-17.pdf>.

The Joint Strategic Needs Assessment (JSNA) also provides information on our local population and their health and we work closely with our Public Health colleagues to improve the quality of data we receive for the Vale of York. Further information on the York JSNA can be found at www.healthyork.org.

6.3.1 Health Inequalities Vulnerability Triangle

The health inequalities vulnerability triangle demonstrates how various factors, including belonging to a protected characteristic group, can contribute to an increased 'risk' of health inequality.

The more sides of the triangle that come into play the greater the risk or vulnerability to health inequalities. The triangle is equally relevant to other vulnerable groups, not covered by the Equality Act who may experience health inequalities e.g. homeless people



People with protected characteristics often experience discrimination based for example on age, gender, sexual orientation, disability, race or religion and belief. This can have a negative impact on both people's health and wellbeing and their access to and experience of using health and social care services and this can result in poorer health outcomes and further health inequalities

Promoting equality is not about taking away from one group to give to another. In the context of health, it's about ensuring that access to good quality and appropriate services are available to all groups in our population, not just a privileged few.

Whilst recognising that there are many causes and effects over which we do not have direct influence or control, we are committed to working in partnership with both our local communities and statutory providers and partners to ensure that different groups should not experience barriers to accessing services or, have less opportunity to live a longer healthier life due to factors beyond their control, specifically the nine protected characteristics.

The University of York is working with the NHS to develop how to measure health inequality and how this can be supported by the indices of deprivation.

6.4 Aligning engagement and equality

Promoting equality and effective community engagement should complement each other. Systematic community engagement is an essential element of partnership working to promote equality. The engagement and involvement of patients, carers, partners and other stakeholders, including local people is intrinsic to the commissioning and procurement of services

We are therefore, committed to being proactive about seeking the views of all groups in our community; this in turn will help demonstrate we are promoting equality.

We have created a range of engagement and involvement opportunities to gather the views of patients, service users and other stakeholders. This information is rich in personal experience and helps us to shape commissioning decisions, service specifications and improvement programmes.

Patients, carers and members of the public are represented through a number of channels including:

- Close partnership working with Healthwatch York and Healthwatch North Yorkshire and voluntary sector services
- GP clinical lead – providing a clinical overview and representing the patient voice at the clinical executive meetings
- Get involved section of our website – highlights the areas where patients and the public can become involved in the work of the CCG
- Attendance of voluntary and patient groups at committee meetings – such as the Maternity Services Liaison Committee (MSLC) and the Quality and Patient Experience committee (QPEC)

The CCG's engagement work is built upon the following strong foundations:

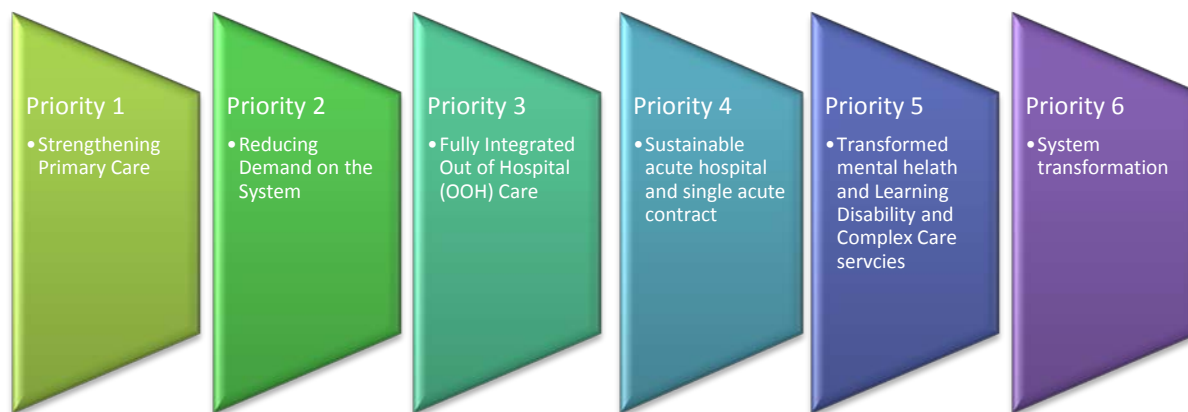
Inclusiveness	participation of all who have an interest in or are affected by a specific decision
Honesty and clarity	ensuring all involved understand how they can contribute and how decisions are made
Commitment	demonstrating a genuine attempt to understand and incorporate other opinions
Accessibility	different ways of engagement, ensuring people are not excluded
Accountability	respond within set timescales and report unambiguously on why contributions have/have not influenced outcomes
Responsiveness	open to idea of changing existing ways of working
Willingness to learn	those involved and those undertaking the engagement process must be willing to learn from each other
Productivity	at the start of any engagement process establish desired outcomes for improvement
Partnership approach	Where possible co-ordinate activities with other statutory and voluntary sector partners to engage efficiently and effectively and avoid any duplication.

You can find out more about [our engagement strategy and action plan here](#).

7. A Changing Landscape

The NHS and Social Services in England are facing unprecedented challenges due to demographic shifts and an extended period of financial austerity. Like other parts of the country, Vale of York have to find a way to deal with the twin challenges of rising demand for health and social care services within an increasingly restricted financial envelope.

We have a long history of working closely with health and social care partners to promote integrated care. In response to these challenges we have worked with our health and social care partners and identified the following priorities as our joint 'Local Place' programmes for 2017-2019



We will continue to work with our partners to respond to national, regional and local changes and commit to engaging with local people and being transparent about changes that may impact on them.

8. Delivering our strategy

8.1 Equality Delivery System 2 (EDS2)

The EDS2 programme is designed to support NHS commissioners and providers to work with local partners and people to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. There are four EDS2 Goals, which are:

- Goal 1: Better Health Outcomes
- Goal 2: Improved patient access and experience
- Goal 3: A representative and supported workforce
- Goal 4: Inclusive leadership

You can find out more about EDS2 at <https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf>.

We will continue to work collaboratively with our main provider York Teaching Hospital NHS Foundation Trust to assess and grade our progress against the EDS2 goals and outcomes. In November this year we held a joint event with local stakeholders. During this event we reviewed what we had done since the last event. This identified that we had made good progress on a number of priorities but that we still needed to do further work in a couple of areas and we will include these in the action plan being developed to support this strategy.

We also focused on EDS2 Goal 1- Better health outcomes for all and asked our local partners to assess and grade our joint progress against these outcomes.

This identified that there was a lack of evidence to show that we understand and meet the needs of the protected groups listed below, and we intend to look at ways to address this in our action plan:

- Lesbian, Gay, Bisexual and Trans (LGBT)
- Race / ethnicity
- Disability

We are currently, analysing the feedback from the event to identify key themes and shared priorities, with York Teaching Hospital NHS Foundation Trust and will use this to inform our action plan.

When this analysis is complete, you will be able to see a write up of the day including the assessment results and our action plan on the CCG website <http://www.valeofyorkccg.nhs.uk/about-us/>.

We will continue to work in partnership on our shared priorities and action plan and intend to continue to use EDS2 to measure our progress. As part of the analysis of this event we are also looking to review the best way to engage with local stakeholder as part of the assessment processes and the results of this will be reflected in our action plan. We are committed to assessing and grading our performance on a regular basis and plan to undertake our assessment and grading process on an annual basis.

8.2 Equality Objectives

This year we are reviewing our four year equality objectives to meet the revised publication date of March 2018. We are using the results of our EDS2 assessment event and EDS2 Goals to help us to identify our new equality objectives. We are keen to ensure our equality objectives demonstrate strong leadership and contribute to EDS2 goals that will address inequalities experienced by both staff and local people. Once finalised our equality objectives will be available on the CCG website.

8.3 Workforce Race Equality Standard (WRES)

The WRES has been developed to ensure employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The move follows recent reports that highlight disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst BME NHS staff.

NHS organisations need to demonstrate progress against nine indicators of workforce equality, including a specific indicator to address the low levels of BME

Board representation. Further information can be found at the NHS England website at <https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/>

As well as the CCG needing to give due regard to the WRES it also has a duty to ensure that it holds its providers to account in meeting their duties under the standard. Due to the small number of staff within the CCG and the risk of breaching confidentiality, the CCG is not required to publish statistical data for the WRES. However, the CCG is collecting and analysing this data to inform the ongoing development of its action plan.

8.4 Workforce Disability Equality Standard (WDES)

We will also need to demonstrate progress against the WDES which is due to become mandated in April 2018, when we will need to start to collect baseline data. The first WDES reports will need to be published by 1 August 2019. Like the WRES, the WDES has been developed to address the findings of the report published by Middlesex and Bedfordshire Universities on the '[Experience of Disabled Staff in the NHS](#)', alongside findings from research carried out by Disability Rights UK and NHS Employers '[Different Choices, Different Voices](#)', which found that disabled people had poorer experiences of working in the NHS in England than non-disabled colleagues.

The proposed standard will use data from the NHS annual staff survey and look at areas such as workforce representation, reasonable adjustments, employment experience and opportunities. When the metrics have been finalised we will assess our progress against these and develop an action plan.

8.5 Accessible Information Standard (AIS)

The Accessible Information Standard requires all organisations that provide health services (including GP Practices) or adult social care to identify record, share and meet the communication needs of patients who have a disability, impairment or sensory loss.

Although the CCG is exempt from delivering the standard, it is required to pay due regard and will make sure that when it communicates with the public it considers the requirements of the standard. We are also required to seek assurance from provider organisations, including GP practices of their compliance with the standard, including evidence of how they are planning to meet the standard. The CCG is currently working with the provider trust to agree how the standard will be implemented and monitored.

Further information about the accessible information standard can be found on the NHS England website at www.england.nhs.uk/accessibleinfo

8.6 Equality Impact Analysis (EIA)

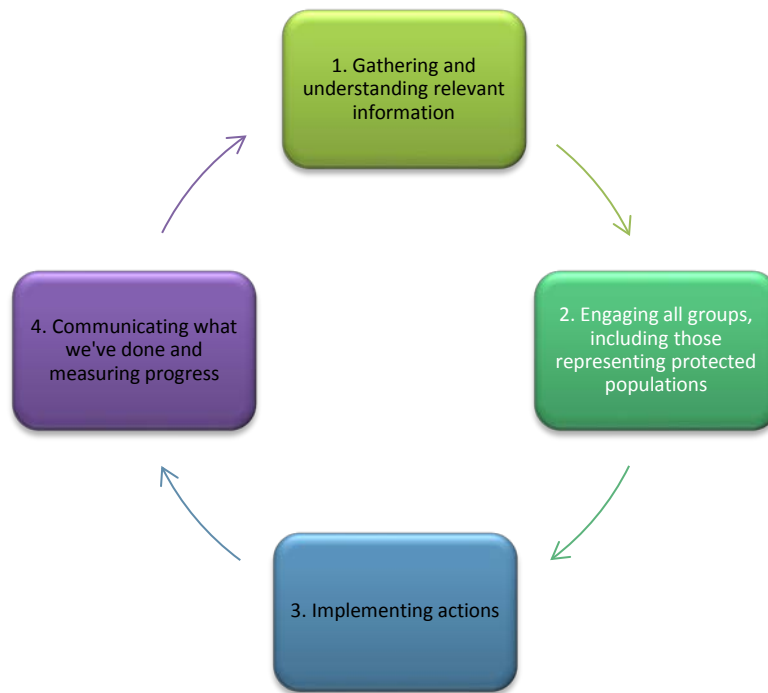
An equality analysis is a tool designed to help identify the potential impact (either positively or negatively) of policies, services and functions on staff, patients, carers, public and stakeholders.

Undertaking equality analyses both promotes good practice and provides evidence of compliance with the public sector equality duty. We have a comprehensive equality impact analysis template, which in addition to the nine protected characteristics, also includes assessment of carers and the opportunity to include the impact on other vulnerable groups such as the homeless or those living in the lowest economic groups or in rural communities.

In addition to promoting equality, equality impact analysis has huge potential as a tool for commissioners to tackle health inequality. It should be a natural part of our thought process in making decisions as an employer and as a commissioner of health services.

8.7 As Commissioners

The role of the CCG is primarily to commission health services and as such we need to consider how people from protected groups may be affected by our decisions. We do this by considering the impact at each stage of the commission cycle as shown below.



At each stage of the cycle, we should be able to demonstrate how we've considered equality. By being able to demonstrate that we've thoughtfully considered a few key questions at each stage, we not only meet our legal obligations, but even more importantly we are able to show how we deliver core business by commissioning services that meet the needs of our local population, using a robust evidence base.

9. Leadership and Governance

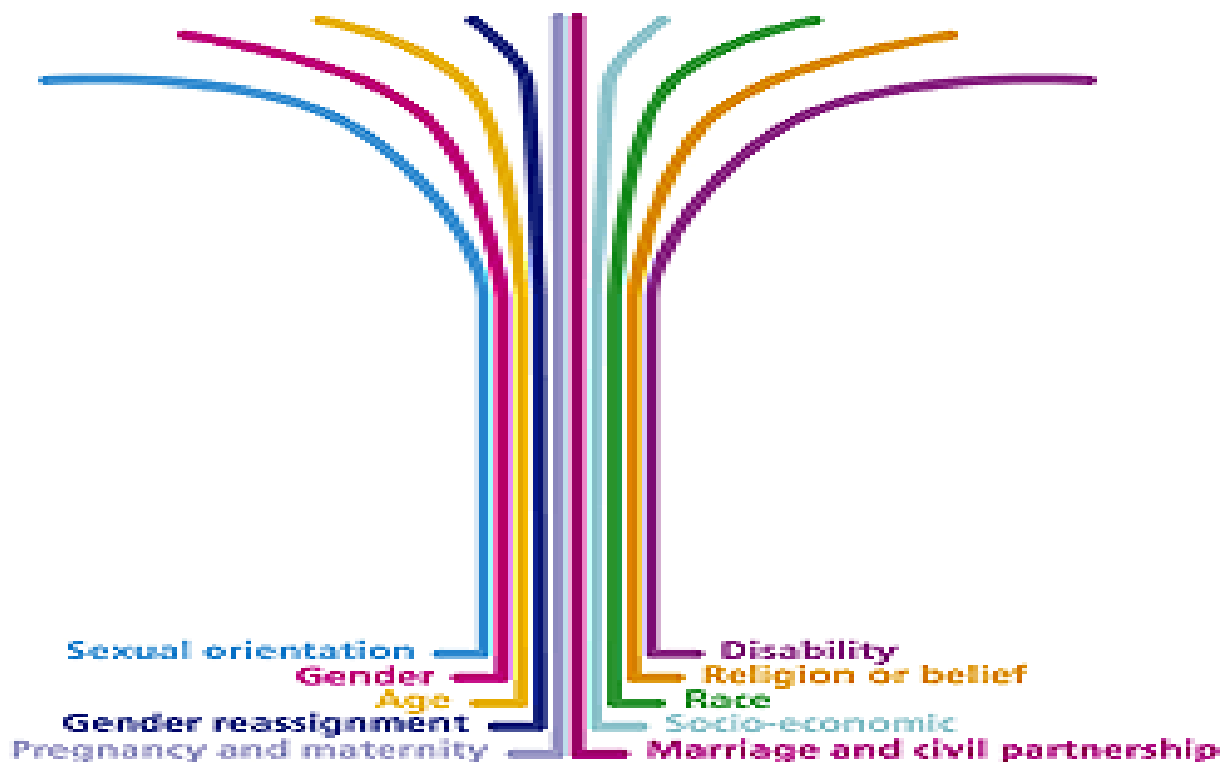
We recognise the importance of leadership in driving forward the equality agenda and that this is critical to our success as commissioners of local NHS services. We plan to use the Care Quality Commission (CQC) *Equally outstanding: Equality and human rights – good practice resource 2017* to help us embed equality into our mainstream work. The resource has been developed from the findings of CQC inspections of provider trusts and found that those rated outstanding had also developed practices that deliver equality and safeguard human rights for both the public and staff. This challenges assumptions that at times of financial constraints equality can be a distraction and instead demonstrates that a focus on equality and reducing health inequalities can improve the effectiveness and quality of services and improve health outcomes for local populations.

Although the report is primarily focused on provider trusts, the human rights principles of fairness, respect, equality, dignity and autonomy at the heart of good care provision is equally applicable to commissioning services that meet local need, focus on health improvement and reduce health inequalities.

The report highlights the importance of senior leadership commitment to equality and diversity and that this is reflected in organisational culture and practice. It identified the following factors for success:

- Leadership committed to equality and human rights
- Putting equality and human rights principles into action
- Developing a culture of staff equality
- Applying equality and human rights thinking to improvement issues
- Putting people who use services at the centre
- Using external help and demonstrating courage and curiosity.

We are looking at how we can build these factors into our equality objectives and organisational development plans.



11. References and supporting documents

	Title	Weblink
1.	York Joint Health and Wellbeing Strategy 2017-2022	https://www.york.gov.uk/downloads/download/3683/joint_health_and_wellbeing_strategy_2017_to_2022
2.	York Health and Wellbeing: A Joint Strategic Needs Assessment	http://www.healthyork.org
3.	North Yorkshire Partnerships: A Joint Strategic Needs Assessment	http://www.nypartnerships.org.uk/jsna
4.	Vale of York Public Health Report 2015	https://www.york.gov.uk/info/20125/health_and_wellbeing/957/director_of_public_healths_annual_report_2015
5.	City of York Council – Health and Wellbeing	https://www.york.gov.uk/homepage/44/health_and_wellbeing
6.	North Yorkshire Director of Public Health Annual Report 2017	http://www.nypartnerships.org.uk/dphreport2017
7.	Mapping rapidly changing minority ethnic populations: a case study of York by the Joseph Rowntree Foundation	https://www.jrf.org.uk/report/mapping-rapidly-changing-minority-ethnic-populations-case-study-york
8.	Accessible Information Standard	https://www.england.nhs.uk/ourwork/accessibleinfo/
9.	NHS Workforce Race Equality Standard (WRES)	https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
10.	NHS Workforce Disability Standard (WDES)	https://www.england.nhs.uk/about/equality/equality-hub/wdes/
11.	Sexual Orientation Monitoring Information Standard	https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/
12.	Equality Delivery System 2 (EDS2)	https://www.england.nhs.uk/about/equality/equality-hub/eds/
13.	Reducing Health Inequalities resources	https://www.england.nhs.uk/about/equality/equality-hub/resources/

14.	Health Profile for York 2017	http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000014.pdf
15.	Health Profile for Selby 2017	http://fingertipsreports.phe.org.uk/health-profiles/2017/e07000169.pdf
16.	Health Profile of North Yorkshire 2017	http://fingertipsreports.phe.org.uk/health-profiles/2017/e10000023.pdf
17.	Migration profile for Leeds City Region (includes York) June 2017	http://www.migrationyorkshire.org.uk/userfiles/attachments/pages/664/leedscityregionImp-summary-jun2017.pdf
18.	Stonewall 'Unhealthy Attitudes Survey'	http://www.stonewall.org.uk/sites/default/files/unhealthy_attitudes.pdf
19.	CQC - Equally outstanding Equality and human rights – good practice resource	http://www.cqc.org.uk/sites/default/files/2017_0913_equally_outstanding_ehr_resource_1.pdf
20.	Equality and Human Rights Commission (HMRC)	https://www.equalityhumanrights.com/en/about-us/who-we-are
21	Vale of York Public Sector Equality Duty Report 2017	http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/5-january-2017/item-11-annex-a-psed-report-2016-17.pdf .
22.	European Convention on Human Rights (ECHR)	https://www.equalityhumanrights.com/en/what-european-convention-human-rights
23.	The Human Rights Act 1998	https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Chair's Report: Audit Committee

Date of Meeting	29 November 2017
Chair	Sheenagh Powell

Areas of note from the Committee Discussion

- The Committee expressed continuing concerns about the Partnership Commissioning Unit.
- The Committee commended the progress on risk reporting.
- The Committee noted that the Annual Report would be presented to the January meeting of the Governing Body, subject to any comments forwarded to TP.
- The Committee expressed concern with regard to the delay in the revision of the CCG Constitution and requested that this be expedited.

Areas of escalation

- Delay in the revision of the CCG Constitution.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

**MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON
29 NOVEMBER 2017 AT WEST OFFICES, YORK**

Present

Sheenagh Powell (SP)
David Booker (DB)

Dr Arasu Kuppuswamy (AK)

Chair
Lay Member and Chair of Finance and
Performance Committee
Consultant Psychiatrist, South West
Yorkshire Partnership NHS Foundation Trust
- Secondary Care Doctor Member

In attendance

Michelle Carrington (MC)

Anne Ellis Playfair (AEP)
Pennie Furneaux (PF) – part
Steven Moss (SM) – for items 1 to 12
Stephen Nicholls (SN) – for items

Tracey Preece (TP)
Michèle Saidman (MS)

Executive Director of Quality and Nursing/
Chief Nurse
Audit Manager, Audit Yorkshire
Corporate Services and Assurance Manager
Local Counter Fraud Specialist
Local Counter Fraud Specialist / Local
Security Management Specialist
Chief Finance Officer
Executive Assistant

Apologies

Cath Andrews (CA)
Mark Kirkham (MK)

Senior Manager, Mazars
Partner, Mazars

There was no pre-meet of Committee Members with External Audit due to the apologies. There would be separate 15 minute pre-meets at the March meeting: External Audit at 1.00pm and Internal Audit at 1.15pm. The full meeting would start at 1.30pm.

The agenda was considered in the following order.

STANDING ITEMS

1. Apologies

As noted above.

2. Declarations of Interest

There were no declarations of members' interests in relation to the business of the meeting. Declarations of interest were as per the Register of Interests.

Unconfirmed Minutes

3. Minutes of the meetings held on 30 August 2017

The minutes of the meeting held on 30 August were agreed.

The Committee:

Approved the minutes of the meeting held on 30 August 2017.

4. Matters Arising

Annual Review of Effectiveness of Internal Audit – Action plan for proactive sharing of learning: AEP reported that processes for sharing and briefing were part of “business as usual”

Annual Review of Internal Audit Charter and Working Together Protocol: AEP advised that two draft leaflets were currently being reviewed by the Head of Internal Audit and would be circulated following approval.

Periodic Report and Internal Audit Reports: TP confirmed that most of the agreed actions from the review of prescribing and medicines management were being implemented but she would arrange for a written response to provide assurance. DB reported that he had not yet been able to discuss the role of pharmacists with the Joint Medical Director.

Report on Commissioning Support Contract Management: TP reported that contract management arrangements were being established with North of England Commissioning Support. She agreed to provide a written update before the Committee meeting when there would be a full report.

A number of matters were noted as agenda items, completed or still requiring action.

The Committee:

1. Noted the updates.
2. Noted that TP would provide an interim update on contract management arrangements with North of England Commissioning Support.

5. Audit Committee Work Plan

TP noted that the work plan had been updated in terms of Abigail Combes, Head of Legal Services and Governance, as the lead for Corporate Governance and Information Governance.

The Committee:

Noted the update to the work plan.

6. Audit Committee Terms of Reference

TP referred to the Committee’s terms of reference which were presented both to incorporate recommendations from the Internal Audit report on governance

arrangements and in line with changes within the organisation. In addition to the proposed amendments it was agreed that the Head of Legal Services and Governance be added to *Section 3 Attendance* and that a number of amendments proposed by SM be incorporated.

The Committee:

Approved the proposed and additional amendments to the terms of reference.

INTERNAL AUDIT

7. Progress Report and Internal Audit Reports

In presenting this report AEP noted the revised format, approved by the Audit Yorkshire Board, and invited feedback from members.

The report included a summary of performance against the agreed plan, including client requested amendments, and final audit reports for Contract Management and Business Continuity, both of which had received Significant Assurance. AEP noted that Internal Audit had met three of the four performance indicators to date; the one that had not been met related to management responses received within 15 days of the issue of draft reports. TP noted that she would reiterate the requirement for all managers to respond promptly to requests relating to recommendations.

Discussion ensued on members' concerns about issues that had arisen subsequent to presentation of Internal Audit reports to the Committee, for example relating to the Partnership Commissioning Unit and QIPP, which were both impacting the CCG's financial position and the ability to provide assurance to NHS England about information and data. Members felt that pressures now affecting the CCG could have been signalled through the audits and follow-up. SP noted that she and the CCG Chair were meeting with the Head of Internal Audit following similar discussion at the Finance and Performance Committee.

SN joined the meeting

In response to DB referring to the CCG's current review of risk management reporting, TP explained that there was a robust process in place for monitoring action on Internal Audit recommendations. SP highlighted that the concern was with the current Internal Audit methodology noting the need for a more dynamic system.

The Committee:

1. Received the Internal Audit Progress Report and Internal Audit reports.
2. Noted that TP would reiterate the requirement for prompt responses to requests relating to Internal Audit recommendations.
3. Registered concerns about the current Internal Audit methodology.

8. Audit Recommendations Status Report

AEP noted that the figures relating to progress with implementation of Internal Audit recommendations were incorrect for various reasons. She agreed to re-run the report and circulate the recommendations that exceeded the original target date with the reasons.

Members discussed a number of concerns relating to the Partnership Commissioning Unit recommendations but also noted that a number of these had been completed.

The Committee:

Noted that AEP would circulate revised information relating to recommendations that exceeded their target implementation date with reasons.

9. Partnership Commissioning Unit Transition Audit Plan

AEP presented the proposed audit plan to provide assurance on the Partnership Commissioning Unit transition arrangements as agreed with the four North Yorkshire CCG Chief Finance Officers and Chief Nurses. She noted the proposal to use the former Partnership Commissioning Unit audit days for this audit planned for quarter 4 and for any unused days to be carried forward into early 2018/2019 to support audits of processes identified as being high risk by the CCGs, or utilised as key risks arise during 2017/2018. AEP noted that the other CCGs were in the process of approving the plan and amendments already suggested would be incorporated.

The detailed scope of the audit would be determined through Internal Audit involvement in the project plan and early engagement with the CCG's Heads of Finance and Contracting. However, the scope would include: Financial governance, including delegation of authority and reporting arrangements, balance transfers, quality and continuity of service and SystemOne and QA cleansing process and updating of clinical records (Information Governance Toolkit).

In response to concern that this audit was proposed for quarter 4, TP explained this was primarily due to slippage of the final phase of the staff consultation. The aim of the Transition Programme Board was for the transition to be completed by 1 February therefore quarter 4 would enable a complete audit to be undertaken. TP noted that staff transferring to NHS Vale of York CCG on TUPE arrangements were doing so on 1 December 2017 and that an action plan would be agreed for any outstanding actions beyond 1 February to provide assurance. MC added that she and TP had emphasised NHS Vale of York CCG wanted a more immediate transition but this had not been supported by the other three CCGs.

TP explained that the governance arrangements through the Transition Programme Board, which included Internal Audit, provided more assurance than previously. SP, however, expressed continuing concern in light of the earlier discussion at agenda item 7 and reiterated that issues associated with the

transition delay had been regularly raised at both the Audit Committee and the Finance and Performance Committee. She also questioned whether concerns about the implications of the delay had been escalated to the respective CCG Governing Bodies as it had been in NHS Vale of York CCG.

SP advised that she would write to the Audit Committee Chairs of the other North Yorkshire CCGs about the concerns and associated implications of the transition delay. She also highlighted that the Partnership Commissioning Unit audit was for assurance, emphasised the need for lessons to be learnt and requested that the audit be expedited in any way possible.

In relation to the NHS Vale of York CCG's specific independent investigation for assurance on financial figures, TP advised that she was in discussion with NHS England as to whether this should be undertaken by Internal Audit or through commissioning a separate resource.

The Committee:

1. Approved the Partnership Commissioning Unit Transition Audit Plan noting amendments would be incorporated in line with approval by the other North Yorkshire CCGs.
2. Noted that SP would write to the three North Yorkshire CCG Audit Committee Chairs.
3. Noted the context of unknown pressures on the financial position from Partnership Commissioning Unit issues.

10. Internal Audit and Counter Fraud Effectiveness Review

Members considered the proposed discussion points for the annual review of effectiveness of Internal Audit and Counter Fraud in respect of: Understanding of the CCG, Scope of the Internal Audit and Counter Fraud Service, Skills and Experience, Communication and Performance. It was agreed that further consideration was required in the context of the earlier discussion and for a more strategic approach.

It was agreed that the Committee members and TP would meet to undertake the review.

The Committee:

Agreed that SP, DB, AK and TP would undertake the annual review of Internal Audit and Counter Fraud effectiveness at a separate meeting.

COUNTER FRAUD AND SECURITY

11. NHS Protect Quality Assessment of York Teaching Hospital NHS Foundation Trust's Counter Fraud Provision

SM referred to the report which was presented to provide assurance of York Teaching Hospital NHS Foundation Trust's compliance with standard 1.8 of the NHS Protect Counter Fraud Standards for Commissioners:

The organisation reviews the anti-fraud, bribery and corruption arrangements in place within the providers it contracts to deliver NHS services, to ensure they comply with the conditions set out in Service Condition 24 of the NHS Standard Contract. The organisation also ensures that the providers it contracts to deliver NHS services under the NHS Standard Contract implement any corrective actions recommended by the commissioner itself, or by NHS Protect if a quality assessment has been carried out.

The York Teaching Hospital NHS Foundation Trust action plan for implementation of the report's recommendations was also included.

TP sought and received clarification that York Teaching Hospital NHS Foundation Trust's policies included appropriate wording regarding potential claims by overseas visitors.

The Committee:

Received the NHS Protect Quality Assessment of York Teaching Hospital NHS Foundation Trust's Counter Fraud Provision and noted the action plan.

12. Security Management Annual Report and Security Management Self Review Tool

SN presented the report which comprised the Annual Report by the Local Security Management Specialist in line with the requirements of the current standards and an update on the work completed in 2016/17 in line with the NHS Protect Standards for Commissioners – Security Management 2016. He noted that NHS Protect had withdrawn from all involvement in security management in the NHS from 1 April 2017 and to date there was no replacement.

SN highlighted that the summary of risks against the standards was presented under the areas of strategic governance, inform and involve, prevent and deter, and hold to account; the overall score was 'Green'. SN noted that he was continuing to work on the 2016/17 standards in the absence of publication of an updated version and confirmed that they were included in the NHS Standard Contract.

SN explained the CCG's responsibility in relation to providers' security management processes. He proposed and members agreed that, as with counter fraud, this should only apply to NHS bodies where the CCG was the lead commissioner.

The Committee:

Approved the Security Management Annual Report and Security Management Self Review Tool

SM and SN left the meeting

FINANCE GOVERNANCE

13. Draft Accounts Preparation Plan and Timetable

TP referred to the report presented to provide assurance of an efficient year-end accounts process that would meet the NHS England deadlines. She highlighted two key dates: 24 April 2018 for submission of the 2017/18 Draft Accounts and 29 May 2018 for submission of the 2017/18 Audited Accounts. In view of the latter the Committee's meeting scheduled for 30 May required review.

TP noted that in January 2018 there would be a Month 9 submission of the accounts template to NHS England in line with the submission at Month 9 in 2016/17. This would be prepared on the same basis as the year-end Accounts for 2017/18.

TP agreed to seek clarification on the timescale for the Head of Internal Audit Opinion.

The Committee:

1. Received the draft accounts preparation plan and timetable.
2. Noted that TP would seek clarification on the timescale for the Head of Internal Audit Opinion.

Post meeting note: The May Committee meeting was subsequently brought forward to 23 May 2018.

14. Review of Losses and Special Payments

TP advised there were no losses or special payments to report.

The Committee:

Noted there had been no losses or special payments.

15. Update on Scheme of Delegation and Financial Policies

TP reported that the Detailed Scheme of Delegation had been amended to incorporate a number of changes to the CCG's organisational structure, noting that further changes would be required to accommodate the final stages of the Partnership Commissioning Unit transition during the final quarter of 2017/18. Updates would be made as often as necessary to ensure proper governance was in place.

Members agreed the proposal that the current Delegated Matter which covered the Partnership Commissioning Unit be changed to the Executive Director of Transformation during the transition period, after which all functions would be wholly incorporated in to the CCG structures, scheme of delegation and decision making. The Executive Director of Transformation would act within the existing CCG structure and governance during the transition period to ensure all decision making was in line with CCG objectives.

The Committee:

1. Approved the proposed changes to the Detailed Scheme of Delegation.
2. Noted the information regarding the transition of the Partnership Commissioning Unit information.

16. Review Risks and Controls Around Financial Management

TP reported that no specific reviews had been undertaken to date. She noted the potential for NHS England to provide additional financial support in the latter part of the year via the Assistant Head of Finance, NHS England North (Yorkshire and the Humber) and that discussion was taking place about the role of the NHS England North (Yorkshire and the Humber).

TP highlighted that positive feedback had been received on the CCG's financial performance reporting which was being recommended by NHS England to other CCGs in terms of detail and read-through to national reporting.

The Committee:

Noted the update.

17. Review Progress against Financial Recovery Plan

TP reported on discussion of the system medium term financial plan in terms of acute commissioning with regard to the regulators and the 2018/19 planning refresh.

TP referred to discussion at the Finance and Performance Committee regarding the £19.5m risk adjusted forecast. She noted that, following discussion with NHS England, the month 8 report would include the £2m to £2.5m risk to the CCG from the national prescribing issue of No Cheaper Stock Obtainable. Discussion was also taking place with NHS England regarding the year-end forecast.

In terms of financial recovery TP noted some progress including a number of areas of stabilisation. She cited the examples of the 4% reduction in GP referrals; York Teaching Hospital NHS Foundation Trust forecast outturn being similar to 2016/17; and controlled prescribing.

TP advised that commissioning intentions were being developed encompassing joint commissioning, primary care and acute care and the Medium Term Financial Strategy was being refreshed in line with the Financial Plan refresh which would reflect QIPP. In respect of the latter TP highlighted improved delivery and monitoring processes.

A single acute commissioning team for NHS Vale of York and NHS Scarborough and Ryedale CCGs was being established, led by Simon Cox, Chief Officer of NHS Scarborough and Ryedale CCG, and Dharminder Khosa, who had been appointed as Turnaround Delivery Director across the two CCGs, was undertaking confirm and challenge with both CCGs.

TP expressed concern about risks to the CCG relating to York Teaching NHS Foundation Trust noting that no new contract had been signed to date. She reported on progress in discussions about aligned incentives noting that York Teaching Hospital NHS Foundation Trust had given consideration to potential opportunities if payment by results was removed.

TP reported that the Executive Director of Transformation was undertaking a stepped programme of work to address the risks associated with continuing healthcare and mental health services.

TP noted that NHS England and NHS Improvement had established a national single Finance Committee and that NHS England locally had requested escalation of any behaviours or actions that did not support the system approach.

In response to SP seeking assurance about addressing the financial gap, TP reported that QIPP would account for some aspects and further consideration was taking place in this regard.

The Committee:

Noted the update.

PF joined the meeting

18. Control Mechanisms for Business Cases

TP presented the report which described control mechanisms for the approval of business cases in terms of assurance of the current level of control and governance. These encompassed Scheme of Delegation and governance, contracting with primary care providers, culture, and other assurance namely via Internal and External Audit.

SP referred to the terms of reference of the Primary Care Commissioning Committee regarding its role in 'collective decisions on the review, planning and procurement of primary care services'. She reported on concerns expressed at that Committee's recent meeting, in the context of newly designed enhanced services, that the Prescribing Indicative Budgets had not been presented. Following discussion about the prescribing budget and process for the Prescribing Indicative Budgets, TP agreed to seek clarification from NHS England and legal advice from AC.

The Committee:

1. Received the report on control mechanisms for business cases.
2. Requested that TP seek clarification regarding the process for Prescribing Indicative Budgets.

CORPORATE GOVERNANCE

19. Update and assurance – Review other reports as appropriate

PF advised that on this occasion there was nothing to update.

20. Review the Risk Management System – Progress Report

PF presented the report which comprised the refreshed Risk Management Strategy and an updated risk reporting format. The latter was in line with the framework set out in the updated Risk Management Strategy and defined how risks would be managed in line with risk appetite and tolerance through the Governing Body committees. The framework ensured appropriate assurance that risks were being managed effectively by the organisation. The risk tolerance appetite would be reviewed following the Governing Body Workshop on 7 December.

DB noted that he had been a member of the group reviewing the risk management system. He welcomed the approach and commended the work undertaken by this group.

The Committee:

1. Approved the refreshed Risk Management Strategy/Policy.
2. Approved the approach to risk management reporting in line with risk appetite.

21. Audit Committee Annual Report

TP presented the draft Annual Report, which was in the same format as the 2015/16 report. She expressed appreciation to the Deputy Chief Finance Officer and Assistant Head of Finance for their work on the report.

TP invited comments from members prior to publication of the report for the January meeting of the Governing Body.

The Committee:

Approved the Audit Committee Annual Report subject to any comments provided direct to TP.

22. Note business of other committees, review relationships

MC reported that a review of all terms of reference was being undertaken in line with the organisational structure which was currently being finalised in terms of aligning portfolios. Following review at the next meeting of the Executive Committee the new structure would be circulated.

The Committee:

Noted the update.

23. Review assurance from other committees and Partnership Commissioning Unit and commissioning support (third party assurance)

Members noted the earlier discussion relating to the Partnership Commissioning Unit and the matter arising relating to third party assurance.

The Committee:

Noted the earlier discussion.

24. Raising Concerns / Whistleblowing Update

MC reported that the Raising Concerns / Whistleblowing Policy had been updated in line with recent changes including the new arrangements for the Freedom to Speak Up Guardian. MC advised that she was the CCG's Guardian and the Head of Engagement was an alternative.

MC reported that robust processes had been established and that the Quality and Patient Experience Committee would receive an annual report. Any issues identified through this policy would, subject to consent, be reported at the appropriate forum.

The Committee:

Noted the update on the CCG's Raising Concerns and Whistleblowing arrangements.

25. Primary care commissioning assurance

MC reported that the first iteration of the Primary Care Quality Assurance report had been well received at the November meeting of the Primary Care Commissioning Committee. This addressed an action in the Limited Assurance report.

The Committee:

Noted the update.

26. NHS Vale of York CCG Constitution Update

MC reported that the CCG's Constitution had been drafted but was now pending the redesign of the Governing Body.

Whilst recognising that active discussion was taking place, SP expressed concern that the CCG did not currently have a valid Constitution in the context of the link to the Scheme of Delegation and decision making. She noted that this would remain as a Matter Arising for the Committee.

The Committee:

Noted the update.

AK left the meeting during item 27

27. Conflicts of Interest

Managing Conflicts of Interest – CCG Improvement and Assessment Framework and Update on Conflicts of Interest Audit

PF reported that the CCG had been one of ten CCGs selected to participate in an audit of the conflicts of interest and gifts and hospitality management. AC was undertaking work to address the issues identified in a debrief session; this included devising a training module about mitigating conflicts of interest.

In respect of managing conflicts of interest in decision making, TP explained that the CCG did this well formally but it had not been possible to provide evidence informally, for example with regard to GP awareness. She noted this was a tension in CCGs nationally.

The Committee:

1. Received the quarterly conflicts of interest assessment which had been submitted to NHS England North Region on 6 October 2017 in compliance with the timescale of submission by 13 October.
2. Noted that Deloitte's, on behalf of NHS England, had carried out an audit of the CCG's processes and systems in relation to the management of conflicts of interest.

28. Management of Freedom of Information Requests Update Report

PF referred to the report which provided assurance on the CCG's statutory obligation in relation to the processing of Freedom of Information requests.

The Committee:

Received the Management of Freedom of Information Requests Update Report.

INFORMATION GOVERNANCE

31. Information Governance Update Report

In presenting this report, which comprised an amendment to the terms of reference for the steering group managing information governance business and an update on information governance incidents, PF noted that the former Information Governance Steering Group had been expanded to encompass emergency planning and business continuity to comply with the mandate from NHS England that CCGs should have an operational group for these areas. Reporting would continue to be to the Audit Committee.

The Committee:

1. Approved the revised Terms of Reference for the Emergency Preparedness, Business Continuity and Information Governance Steering group.
2. Noted the Information Governance Incidents report.

EXTERNAL AUDIT

34. External Audit Audit Strategy Memorandum

TP referred to the Audit Strategy Memorandum which included an executive summary, audit scope and approach, significant risks and key judgements, timetable and communication, value for money conclusion and fees; four appendices related respectively to service organisations, independence, materiality and External Audit's added value. Members welcomed the change in the level of materiality as a result of review of accounts assurance over recent years.

TP noted that External Audit would be submitting a letter to the Secretary of State in line with requirements for organisations that were exceeding their resources.

The Committee:

Approved the External Audit Plan.

AK returned to the meeting

INFORMATION GOVERNANCE CONTINUED

29. Information Governance Update Report

In presenting this report PF noted the expectation that, as previously, Internal Audit would review the work plan evidence base in quarter 4. She highlighted that TP had taken on the role of Senior Information Risk Owner and noted that the issues with the mandatory training system software had been resolved.

TP clarified that her role also included security, cyber security and corporate information technology.

The Committee:

Received the Information Governance update report.

30. Note business of the Information Governance Steering Group

PF referred to the minutes at agenda item 39 and noted that regular meetings were taking place. She reported that the current Information Governance support from eMBED was changing due to restructuring but confirmed there would be a handover period.

The Committee:

Noted the update.

32. Information Governance Policies

PF advised that the amendments to Information Governance policies, namely Information Security, Records Management, Mobile Working and Information Governance Strategy, had been approved by the Executive Committee in line with the corporate policy.

The Committee:

Noted the amendments to Information Governance policies.

PF left the meeting

EXTERNAL AUDIT CONTINUED

33. External Audit Progress and Technical Update Report

In referring to this report, which included audit progress and national publications and other updates, TP highlighted that Mazars had for the third consecutive year been rated as 'Green' in the Public Sector Audit Appointments Annual Regulatory Compliance and Quality Report.

The Committee:

Received the External Audit Progress and Technical Update Report.

OTHER ACTIVITIES

35. Report on Suspension of Standing Orders and Waiver to Tender

TP reported that procurement advice had indicated that a waiver to tender was a valid route for award of a contract to NYNET (a North Yorkshire County Council owned company) for Health and Social Care Network provision. She advised that a detailed paper had been presented at the Executive Committee and that the other North Yorkshire CCGs were following a similar approach.

The need to update documentation regarding reference to the Chief Clinical Officer was highlighted.

The Committee:

1. Received the report on the waiver to tender for Health and Social Care Network provision.
2. Requested documentation was updated regarding reference to the Chief Clinical Officer.

MINUTES FROM OTHER MEETINGS

36. Finance and Performance Committee Minutes

In addition to the minutes presented, MC reported on discussion at the November meeting of the Finance and Performance Committee when she had raised concerns about the process for approval of clinical thresholds across the Sustainability and Transformation Plan organisations. She explained that quality impact assessments had not taken place prior to approval of the thresholds and noted that a report would be considered at the Executive Committee on 6 December.

The Committee:

1. Received the minutes of the Finance and Performance Committee meetings held on 27 July, 24 August, 28 September and 26 October 2017.
2. Noted the concerns about implementation of clinical thresholds.

37. Quality and Patient Experience Committee Minutes

The Committee:

Received the minutes of the Quality and Patient Experience Committee meetings held on 14 August and 12 October 2017.

38. Executive Committee Minutes

The Committee:

Received the minutes of the Executive Committee meetings held on 19 July, 16 August, 20 September and 18 October 2017.

39. Emergency Planning, Business Continuity and Information Governance Steering Group (formerly Information Governance Steering Group):

The Committee:

Received the minutes of the Emergency Planning, Business Continuity and Information Governance Steering Group meeting held on 4 October 2017.

40. Audit Yorkshire Minutes

The Committee:

Requested that AEP arrange for Audit Yorkshire minutes to be circulated for the next Audit Committee meeting.

41. Key Messages to the Governing Body

- The Committee expressed continuing concerns about the Partnership Commissioning Unit.
- The Committee commended the progress on risk reporting.
- The Committee noted that the Annual Report would be presented to the January meeting of the Governing Body, subject to any comments forwarded to TP.
- The Committee expressed concern with regard to the delay in the revision of the CCG Constitution and requested that this be expedited.

The Committee:

Agreed the above would be highlighted by the Committee Chair to the Governing Body.

42. Next meeting

7 March 2018: Pre-meets at 1pm and 1.15pm; full meeting at 1.30pm.

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Chair's Report: Executive Committee

Date of Meeting	18 October and 15 November 2017
Chair	Phil Mettam

Areas of note from the Committee Discussion

- The 2017/18 financial position was reviewed. A number of measures were discussed to support delivery of the control total. Achievement of this is still at risk.
- Opportunities for alignment of commissioning thresholds with other CCGs was considered; further work is required on this.
- The Better Care Funds were discussed as the CCG continues to play a collaborative part in these being approved at a national level.
- A number of investment options for resources mandated nationally for primary care were considered. These discussions were consistent with previous agreements at the Primary Care Commissioning Committee.
- The proposal to develop a strategic transformation programme across the Vale of York and Scarborough and Ryedale was discussed and agreed.

Areas of escalation

- The turnaround position will be outlined by the Chief Finance Officer in Governing Body.
- Other issues will be reported by the Accountable Officer and/or lead Executive at a point of agreement or escalation.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Minutes of the Executive Committee, meeting held on

18 October 2017 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation and Delivery
Dr Andrew Phillips (AP)	Medical Director
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Tracey Preece (TP)	Chief Finance Officer

In Attendance

Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Paul Howatson (PH)	Head of Joint Programmes (Item 8)

Apologies

Dr Shaun O'Connell (SO)	Medical Director
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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 20 September were approved

4. Finance, QIPP and Contracts

4.1 Month 6 Financial position & Running Cost Position

TP reported the month 6 financial position to be a year-to-date deficit of £5.9m which is £2.7m worse than plan (£3.2m). Within this, the underlying trading position was remaining relatively stable and was only worse by 100k.

The main areas of deterioration within this were mental health & CHC at circa 500k across the two areas. The Finance team were working with Denise on the CHC figures.

TP reported that there could be no amendment to the financial plan on the national NHSE ledger so we would show the position in forecast outturn instead. This would be reported to F&P then GB. Key point being we were now reporting the forecast gap to the original approved plan.

TP updated the committee on a positive outcome with the Trust on the 16/17 year end position. This had been unresolved however a year end position had now been agreed with challenges all in the CCG's favour.

–The CFOs/FD had asked 3 deputies to complete a piece of work on differences reported in month 6 and in the forecast and report due back in 2 weeks to the Exec Programme Board. This would also be used to inform the meeting with regulators.

4.2 Capped Expenditure Process

PM updated the Committee on the recent NHS England review of directions and process meeting that had been attended by PM, TP and CA.

At the meeting NHS England had advised they hoped to provide hands on support and advice working directly with the CCG, for the latter part of the year as per last year for Scarborough & York. Details of the individual would be advised in due course.

Advice from NHS England had been around the importance of consistent reporting, highlighting areas where stability could be demonstrated. These should be focussed on to allow the system to see progress and help manage turnaround messages. PM/TP/CA to meet and agree 5-8 bullet points for turnaround messages.

5 Performance & Delivery

5.1 Winter Planning

A discussion took place around the current costed Winter Plan submitted to regulators on behalf of the system through the A&E Delivery Board. This would be further discussed at A&E Delivery Board on the 19th October at which Andrew Phillips would be in attendance.

The Committee noted the following:

- The inclusion of the lost income for pause on elective care delivery over winter as a cost pressure for the system – it was agreed this would be challenged at the A&E Delivery Board
- The additional cost pressure for the CCG this winter plan created as there is no inclusion of winter planning costs in the current financial plan for 17/18 and the funding allocation for the STP for winter planning did not meet the full current winter plan cost pressures
- The iterative process for developing the winter plan and multiple changes and requests for submissions over the past weeks which proved

challenging for the system to jointly review and agree outside of the regular A&E Delivery Board meetings

- The fact that the system was already in winter and there as a need for rapid ratification of this winter plan and associated funding in order to mobilise the plan
- The recent performance improvement in ECS performance due to the YFT implementation of strong operational standards

It was agreed:

1. Andrew Phillips to provide CCG input and challenge to the winter plan cost pressures at A&E Delivery Board on 19th October
2. Phil to continue to feedback around discussions with Regional team and YFT about the approach for mobilisation for winter planning and the capacity for the senior team to support this year
3. Further discussion to be had at Governing Body around winter planning and cost pressures

5.2 Commissioning Thresholds

CA outlined the paper to the Committee which was to ratify the governance process for approving the first tranche (22) of the STP standardisation of commissioning statements ('thresholds') All thresholds had now been shared with YFT and it was anticipated there would be further discussion with clinicians and operational managers around mobilising these. The thresholds had also been presented at CMB for formal approval in November 2017 and aspiration for implementing all thresholds from 1st December 2017.

There are a further 5 thresholds which are being finalised through the STP collaborative process in November and further update on these will be given to the Executive and Clinical Executive.

The Cataracts commissioning statement was highlighted as a particular concern and the committee felt more discussion was needed with the Trust and at the planned care steering group. More assessment of the clinical and quality impact were required and the need to understand the number of patients currently awaiting second eye operations would help understand the scale of patients this threshold would potentially impact on.

It was agreed:

1. To ratify the STP process and approvals of the 21 thresholds acknowledging there was still work to be done locally in relation to the cataracts threshold
2. CA & AP to discuss the cataracts policy further particularly to provide a clear COR discussion in SO's absence
3. CA & MC to progress with any further local addendum supported by a quality impact assessment

4. CA to continue discussions with YFT through the planned care steering group and to liaise with Liza to ensure all contract variation documentation is aligned to the approvals process and incorporates any required local addendums
5. Andrew Bucklee will provide the link back to the STP on any local cataracts addendum and agreements and for the next tranche of 5 thresholds
6. Further feedback or approval for the cataracts policy at the next Executive Committee

5.3 Bids for £3 per head

DN reminded the committee of the background to the £3 per head bids which had been instigated through the Unplanned Care Programme where people had been asked to work together and develop a plan/bid pointed to frailty.

The project initiation document had therefore been worked up in the last 3 months.

Through discussion the committee felt that whilst the Primary Care Commissioning Committee and the Council of Representatives had been clear the £3 per head should generate QIPP this message may not have hit the locality groups.

The committee reviewed the North & Central locality papers and discussed how to move forward agreeing that any decision would need to justify a return financially and be enabling for the future. It was also felt that any agreement would need to correlate with the Winter Plan.

TP suggested working with colleagues as appropriate outside of the meeting on the finer details and bring back to the Executive Committee for approval. TP also suggested revisiting the paper she and Elaine had developed back in April for Executive around investment decisions at that time to ensure that we are prioritising appropriately.

5.4 Social Prescribing for South Locality

The committee considered the request to provide financial support for the South locality on social prescribing with the Department of Health and Public Health England. They agreed the model would not meet the criteria re turnaround and were therefore unable to support. They would however welcome a discussion with the project leader to look at alternatives.

6 Service, Quality & Safety

6.1 Safeguarding

The committee approved the request of an interim proposal to increase the establishment of .2wte designated nurse with immediate effect.

The committee also noted in advance that a paper would be brought back to the committee in due course to seek a further increase in establishment from April 2018.

6.2 Serious Incidents

The committee agreed the need for a serious incidents process and agreed all future serious incidents should go to the Quality & Patient Experience Committee prior to coming to the Executive Committee.

A meeting was planned to agree the process and recording of future incidents.

6.3 Pay Protection Policy

The committee approved the policy

7.1 Draft Agenda for Governing Body

The committee requested a number of small amendments to the agenda

8. Better Care Fund

PH updated the committee on the reasons why the North Yorkshire and York BCF plans were not approved.

One issue common to both was the NHS attributed zero delayed transfers of care which had been pulled through from a submission earlier in the year by the A&E Delivery Board.

The additional reason for the York plan not being approved was due to the minimum amount of spend on social care protection.

As a consequence of the plans not being approved the National Better Care Team had invited both the York and North Yorkshire representatives to escalation panel meetings on Wednesday 18th October and Thursday 19th October.

In order to avoid attending the escalation panel meetings, both the York and North Yorkshire systems had sent in additional evidence to support the BCF

plans, however the national team requested their participation in the meetings as previously indicated.

As this would have meant travel to London on two consecutive days, at significant expense to all organisations involved from Health & Well-being Board representatives across the NHS and local authorities, there was local agreement not to attend in person. This decision avoided further pressure on already stretched budgets by making appropriate use of teleconference facilities.

We await the outcomes of the escalation meetings.

9. Corporate

9.1 Post for managing the CCG's online resources

The committee approved the request to recruit an FTE permanent Band 4 post to manage the CCG's online resources.

10. Any other business

Ratification of GP IT public access WIFI decision

The decision to approve the award of the GP IT public access WIFI project to eMBED was taken outside of the meeting due to the timescales required. This decision was approved by the Accountable Officer and Chief Finance Officer on behalf of the committee and in line with the Scheme of Delegation, but required formal ratification and was therefore requested and approved by the committee.

Minutes of the Executive Committee, meeting held on
15 November 2017 at West Offices, York

Present

Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation and Delivery
Dr Andrew Phillips (AP)	Medical Director
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Tracey Preece (TP)	Chief Finance Officer

In Attendance

Dr Kev Smith (KS) for items 1- 4	Executive Director of Primary Care and Population Health
Simon Cox (SC) for items 1-4	Chief Officer, Scarborough & Ryedale CCG
Fiona Bell (FB) for item 5.1	Deputy Director of Transformation and Delivery
Becky Case (BC) for item 5.2	Head of Transformation & Delivery

Apologies

Dr Shaun O'Connell (SO)	Medical Director
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The agenda was discussed in the following order:

1. Apologies

As noted above.

2. Declaration of Interests

Andrew Phillips declared an interest in relation to item 5.6 and took no part in the decision, please see below for details. There were no further 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 18 October were approved

4. Transformation Programme

4.1 A Man of Straw

SC outlined the background to the Man of Straw paper which had been developed following a System Call with NHS England & NHS Improvement. The paper aimed to provide an overview strategic outline of a financial recovery programme for the York and Scarborough healthcare system. The paper was still in draft and would be finalised shortly.

The committee discussed the paper and agreed the success of the programme would be underpinned by the CCG's working together. Through discussion a query was raised on where the responsibility for delivering standards would sit and the committee agreed with the principal that the programme would take responsibility for this. The discussion ensued around where Medicines Management would fit and the Committee agreed it would be best placed out of the programme, whilst acknowledging it was an area to explore to collaborate across the Vale of York CCG and Scarborough and Ryedale CCG.

4.2 Delivering System Recovery and Transformation for the York and Scarborough Healthcare System

SC presented the 2nd paper which summarised the proposal for the approach and capacity required for the development of a system wide Recovery and Transformation Programme within the NHS, working with the Vale of York CCG, Scarborough and Ryedale CCG and the York/Scarborough element of the East Riding of Yorkshire CCG. The paper was not yet complete but had been brought to the meeting for discussion.

SC reported that work was needed on 3 levels of strategic work: Management of demand, productivity and sustainability, all of which should create cost reduction.

The committee discussed demand management versus supply management and agreed a further discussion was needed outside of the meeting.

SC also outlined the small leadership team required to support delivery of the proposal and advised that further work was required on the finer details around the positions and structure.

The committee agreed to work up a governance model to include Out of Hospital, joint commissioning and new arrangements to replace or amend the current Acute Services Contract Management Board.

PM closed by acknowledging the good work that had already been completed on the papers, they highlighted the growing and shared ambitions of the Vale of York CCG and Scarborough and Ryedale CCG.

5. Finance, QiPP and Contracts

5.1 £3 per Head Investment Decision

FB joined for this item

The committee reviewed the 3 proposals received from the localities. The proposals included one from the North locality relating to Integrated Care Teams and Multidisciplinary teams, and two proposals from the Central locality, including care home support and Telehealth.

No proposals had been received from the South locality at this point.

The committee felt it was important to show support in principle to the 3 proposals and approved the recommendations in the paper for financial support for the remainder of 2017/18. Funding from the 2017/18 PMS allocations were agreed in principle for the North Locality proposal, and for the care home pilot in central locality. The committee fully supported the work around telehealth submitted by York Medical Group but agreed that phase 1 could be supported through unused capacity from the existing telehealth contract with City of York Council. Funding for phase 2 would be worked up over the coming months. To ensure fairness across the localities the committee agreed where localities had not yet submitted a proposal the 4 months non recurrent support from weighted locality allocations would be made available for the first 4 months of 2019/20 for agreed projects. This would mean that all localities would get access to 16 months of funding.

The committee agreed to discuss the positive decision further at the next Council of Representatives meeting before writing to the 3 practices who had submitted bids.

KS left the meeting

5.2 Winter Planning – finance plan

BC joined for this item

Whilst presenting the paper to the committee, BC advised that revised information had just been received from York Teaching Hospital Foundation Trust. As further understanding was required on the information, the committee felt they were unable to approve the paper and agreed to focus on the out of hospital items. Further work with York Teaching Hospital Foundation Trust would take place outside of the meeting.

In respect of the out of hospital items, the Committee agreed the following:

Additional primary care sessions – the committee were in principle of supporting however felt further details were required. AP and BC to work through implementation.

Additional resource to support the morning review of GP patients by Urgent Care Practitioner- supported

Expansion to Community Response Team- the committee did not support as it was felt that the oversight role sat within the current CRT team and if needed would have to be a substantive post, not a winter scheme.

Additional PTS – supported

Home/Community IV- the committee felt more details were required from York Teaching Hospital Foundation Trust (as per changed information from YTHFT as above)

Respiratory rescue packs which will be primary care controlled- supported

Additional winter communications –supported if managed through running costs

Spot purchase of beds - The committee did not support the spot purchase of beds however did wish to consider up to 8 additional Continuing Health Care beds as a priority. BC and Michael Ash-McMahon to take forward with DN.

In closing the item, PM and TP stressed that the provision for winter must now be included in any future planning costs.

5.3 Month 7 Financial Position & Running Cost Position

TP reported that month 7 delivery year to date was £9.5m deficit against a planned deficit at this point in the year of £3.7m so behind plan by £5.8m. There had been a further deterioration of £1.2m from York Teaching Hospital Foundation Trust in month 6 which was being investigated further. Other areas of deterioration were prescribing - due to the national No Cheaper Stock Obtainable issue, CHC and mental health out of contract.

Forecast remains overall at £19.5m (risk adjusted) but that this is now riskier due to the deterioration in month 7 and includes £2m of non-recurrent measures to achieve this. NHS England are aware.

The additional pressure in the system is being formally reported to NHS England and reported to Finance & Performance Committee, mainly rehab beddays challenge but also winter and lack of confidence in £2m non-recurrent measures included as mitigations.

TP approach is to fully brief Jon Swift and Tim Savage, meeting planned Thursday 23rd November after Finance & Performance. Richard D and Emma S from STP to also be involved as STPs are being asked to help resolve material challenges and land control totals.

TP raised a concern about regulator joint working and agreed to raise with Jon Swift. TP recommended the approach with the Trust should be to go to both regulators

collectively and advise position – the impact and the numbers for a NHS-wide position in York, not organisational.

Escalation principle – SC & PM write to regulator and/or Pat Crowley

The committee asked TP to pursue by the end of the week details regarding month 7 and agreed in principle to raise concerns via escalation and take advice from the Council of Representatives on Thursday 16th November.

5.4 Capped Expenditure

The CCG remains part of the Capped Expenditure Process. PM advised that a call had taken place between the Chief Officers of VoY and S&R CCGs and Pat Crowley at York FT with both regulators (Lyn Simpson and Richard Barker) and had asked for assurance that all possible actions were being taken to deliver 17/18 and a medium term system plan that outlined recovery as a system in the medium to longer term. Simon Cox was pulling together a 'straw man' starter on this and will consult with Exec teams across the 3 organisations to submit to the regulators in advance of a further call.

5.5 Rehab Bed Days Challenge

TP advised the committee that this issue was still unresolved. The committee therefore agreed that the item should be brought back to the Executive Committee to consider a negotiated settlement or arbitration.

5.6 Out of Hours GP Contract Rollover

Prior to TP presenting the proposal to the committee, AP advised of a conflict of interest in relation to the current provider, Yorkshire Doctors Urgent Care (YDUC). AP was therefore invited to add clinical input into the discussions however was not involved in any decision making.

The committee discussed and agreed to extend the expiring YDUC contract for a further 2 years as per the current specification, with a variation to the costing specification as recommended.

5.7 Procurement of HSCN Network

The committee discussed the details in the paper noting that the paper had been produced in alignment with the other North Yorkshire CCG's and that the costs were within the notified HSCN provision allocation.

The committee agreed to waive the standing orders and progress a direct award to NYNET for the HSCN connections required.

In accordance with the scheme of delegation and detailed financial policies the decision to waiver to tender would be reported to the Audit Committee.

5.8 Community Equipment

All proposed agreements in the paper had been discussed and developed with the North Yorkshire CCG Chief Finance Officers, subject to individual CCG approval processes. North Yorkshire County Council (NYCC) approval would therefore still need to be confirmed

The committee considered the detailed decisions required as outlined in the paper and agreed the following, pending approval from NYCC:

- Agreement to leave 2016/17 actual cost split on basis of planned contract share
- Agreement to 2017/18 YTD or Year 1 actual cost split on basis of planned contract share
- Agreement to develop and agree actual cost split methodology
- Agreement to cover the funding gap via a formal local price review as required under the terms and conditions of the contract from Year 2 of the contract
- Agreement to review the equipment catalogue with a view to bringing this back in line with original tender

The committee did not agree to cover Medequip's £171k gap within Year 1 of the contract, however did agree from year 2 onwards.

5.9 MSK Contract 2017/18 Options Appraisal

As the MSK service was currently operating out of contract, a decision was required by the CCG prior to contract negotiations being completed in order to sign the contract for 2017/18.

The committee discussed the recommendation to cap the contract in 2017/18 and any risk associated with new price changes. This would improve the CCG's outturn forecast and cover the Trust's actual cost of service provision and continued the recent direction of travel around aligned incentive type approach to the contract.

It was felt this would also help with engagement of shared decision making and the 6 week pause.

A detailed discussion followed with regards to the options presented and the committee agreed to the new prices and the proposed cap for 2017/18.

6. Performance & Delivery

Due to time constraints the committee agreed that the performance & delivery items on the agenda should be considered by the Finance and Performance committee.

7. Service, Quality and Safety

7.1 Chronic Fatigue Syndrome / Myalgic Encephalitis (ME) Service

The committee discussed the options regarding the expiring contract for Chronic Fatigue Services.

The paper had already been presented to the Scarborough & Ryedale and Hambleton Richmondshire & Whitby CCG's in August 2017 who had approved option 5.

The committee also agreed option 5, to retender using the same specification, at current contract values within an 18 week pathway with each CCG paying for its own activity.

8. Strategy

8.1 Integrated Urgent Care

The committee received a number of papers on the Integrated Urgent Care asks. AP confirmed the actions were being progressed through relevant responsibilities.

9. Local Issues

9.1 BCF Approval process

The Better Care Funds plan for North Yorkshire County Council and City of York Council (CYC) had been agreed

Post meeting note – A letter had been received from NHS England on 24.11.17 advising that the Integration Partnership Board had not accepted the case for a revision to the social care baseline and consequently the plan was not approved. Meetings were therefore taking place with the CCG and CYC to agree the next steps

10. Corporate

10.1 Flexible Working

PM asked the committee to give thought outside of the meeting around flexible working to ensure fairness and to apply principles amongst the organisation. MC and TP agreed to take forward to the next Heads of meeting.

10.2 Fit for Purpose Online Information

The committee approved the request for funding to procure a new website for the CCG

10.3 Whistleblowing Policy

The Committee approved the policy noting the proposed changes made.

10.4 Induction Policy

The Committee approved the policy noting the proposed changes made.

10.5 Information Governance Policies

The Committee approved the policy noting the proposed changes made.

11. Engagement & Communications

11.1 Local CCG Staff Barometer Questions

The committee reviewed and approved the questions

12. AOB

12.1 Clinical Peer Review

The committee agreed for this to be discussed further at the next Clinical Executive meeting

12.2 Clifton Park Hospital letter

Further information and advice was being sought before an agreement could be made

There were a number of items deferred to the next meeting. Due to the expanding monthly agenda for the Executive Committee, the committee agreed the meeting would now be twice monthly until further notice. The next meeting would therefore be Wednesday 6th December.

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Chair's Report: Finance and Performance Committee

Date of Meeting	26 October and 23 November 2017
Chair	David Booker

Areas of note from the Committee Discussion

26 October – Chaired by Keith Ramsay

- The Committee emphasised the need to focus on meeting statutory financial responsibilities noting the significant work, including QIPP, to address the challenging financial position.
- The Committee welcomed the revised approach to risk management.
- The Committee noted the Partnership Commissioning Unit QIPP focus.
- The Committee highlighted that the CCG should “not lose sight of the bigger picture” through a culture change of positivity about what was being achieved.

23 November

- The Committee noted the continued financial pressure facing the CCG particularly, from York Teaching Hospital NHS Foundation Trust which was set to exceed forecasts. The resources of the CCG had wider application than York Teaching Hospital NHS Foundation Trust alone. The Executive was authorized to continue to lever a clear outcome for the current financial year, with an agreed target figure as soon as possible.
- The Committee noted that SP and KR would meet with the Head of Internal Audit to discuss concerns over recent internal audits of the Partnership Commissioning Unit in light of further serious emerging concerns.

Areas of escalation

As described above

Urgent Decisions Required/ Changes to the Forward Plan

The Finance and Performance Committee will continue to monitor financial recovery on a monthly basis.

**Minutes of the Finance and Performance Committee Meeting held on
26 October 2017 at West Offices, York**

Present

Keith Ramsay (KR) – Chair	CCG Chairman
Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Phil Mettam (PM)	Accountable Officer
Tracey Preece (TP)	Chief Finance Officer

In attendance

Becky Case (BC) – for item15	Head of Transformation and Delivery
Denise Nightingale (DN)	Executive Director of Transformation and Delivery
Dr Kevin Smith (KS) - part	Director of Primary Care and Population Health
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Michele Saidman (MS)	Executive Assistant
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)

Apologies

David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Abigail Combes (AC)	Head of Legal Services and Governance
Dr Shaun O’Connell (SOC)	Joint Medical Director
Dr Andrew Phillips (AP)	Joint Medical Director

KR welcomed KS to his first meeting of the Committee. KR also noted that the Committee’s Terms of Reference required further review in respect of membership and attendance.

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.

KR noted that the Committee would understand if JS felt compromised during any of the discussion and decided to leave the meeting.

3. Minutes of the meeting held on 28 September 2017

The minutes of the previous meeting were agreed subject to amendment under *Finance and Performance Risk Update Report* at 5.1: paragraph 4 to be moved to the first paragraph of item 5.2 *Update on Risk Review from Risk Working Group* and to read:

‘SP, as chair of the Audit Committee, commented on the Risk Review Report and detailed her concerns at the fact that it referred to deleting risks. She highlighted that this was inappropriate and emphasised that calibration of the risk required review to determine whether there was a requirement for a risk to be escalated for action. SP was also concerned that reviewing the risk register in isolation did not meet all the requirements of CCG assurance and links with the Board Assurance Framework.’

The Committee:

Approved the minutes of the meeting held on 28 September 2017 subject to the above amendment.

4. Matters Arising

F&P30 Risk Update Report - recovery plans for 18 week referral to treatment and cancer 62 day target: In response to CA advising that information required for the presentation on referral to treatment was not yet available, it was agreed that this be deferred to the next meeting. She also noted that York Teaching Hospital NHS Foundation Trust had established a new structure with five thematic performance improvement boards and that referral to treatment recovery would be managed by the Trust differently moving forward.

F&P32 Integrated Performance Report Month 3: DN noted that Improving Access to Psychological Therapies and dementia coding would be covered under agenda item 14; 62 day cancer target as above.

F&P35 Dementia Coding – Performance and Action Plan: DN advised that she would provide an update at agenda item 14.

F&P37 Financial Plan 2017/18 and Contract Trading Report. Proposal to be developed for presentation to the Governing Body recommending a reset of the financial plan to that of 31 March 2017, identifying further specialist support and proposing alternative commissioning approaches: TP noted that this was reported in the Financial Performance Report at agenda item 6.

A number of other items were therefore noted as completed, ongoing or on the agenda.

The Committee:

Noted the update.

5. Risk

Update Report – Restructuring the Risk Registers and Board Assurance Framework and Risk Management

CA presented the report on behalf of AC which, in addition to the regular Risk Register had been updated and refreshed, and included a proposed format for managing, monitoring and reporting risk in line with the Board Assurance Framework. The CCG's Risk Management Policy and Strategy was currently being updated and was also included with tracked changes for review. CA noted the recommendation from the report for the need for risk training across the organisation, as referred to at the previous meeting.

CA highlighted in the current risk register that the five corporate events reported had remained unchanged for a number of months and that 16 strategic 'red' risks were reported. She noted that the current review of risk reporting was considering how these risks could be more proactively managed and delegated to each of the appropriate CCG's committees on behalf of the Governing Body.

CA reported that the previous risk relating to the CCG's Operational Plan had been removed as the plan had now been approved by NHS England. She noted that the current five corporate events did not include Child and Adolescent Mental Health Services, which was a significant risk. CA also highlighted that there was no risk currently included around the CCG Special Measures framework for continuing to be under legal Directions further to the 2016/17 NHS England Annual Review as this framework had not yet been clarified by NHS England.

KR commended the number of risks that had moved from 'red' to 'amber' but additionally noted the risks associated with the Partnership Commissioning Unit transition. In this regard MC reported that phase 3 of the staff consultation with the Finance, Contracting and BI Teams had ended on 11 October. As the other North Yorkshire CCGs were continuing the current joint arrangement, NHS Vale of York CCG would utilise its existing Partnership Commissioning Unit budgets, including vacancies, to fund the TUPE of staff plus recruit to vacancies. A Project Manager and Transition Programme Board had been established with the aim of a 1 December 2017 TUPE transfer completion, however there was potential for the full transition to be delayed due to the interdependencies of transfer of systems, processes and knowledge, and also the need for recruitment.

Members discussed in detail ongoing concerns about the transition. TP reported that Internal Audit was undertaking a review on behalf of the four North Yorkshire CCGs noting that, although there had been significant improvements in terms of structure, timetable and governance, a detailed action plan was expected and would also inform the audit. She also noted that the Transition Programme Board, established as a task and finish group, recognised significant assurance was likely to require a year of the new operational arrangements but would inform decisions to address identified areas of risk.

CA noted that the risk report would continue to be refreshed with the aim of each committee receiving an updated iteration of their risks by December 2017. This would require all risks to be refreshed by risk owners in November.

Board Assurance Framework

CA explained that the proposed Board Assurance Framework aimed to clarify risks that may compromise delivery of the CCG's strategic objectives, both in terms of the NHS Integrated Assurance Framework and the priorities included in the Operational Plan 2017/18 to 2018/19. She highlighted that consideration of 'risk appetite' was required by the Governing Body and its committees and noted that the Risk Management Policy and Strategy was presented for members' comments prior to approval being sought at the November meeting of the Audit Committee.

SP commended the progress since the last Committee meeting but referred to the comments made by the working group refreshing risk reporting about ensuring patient focus and expressed concern that the language was 'corporate'. CA responded that risk owners would be requested to address this clinical and patient focus as part of the refresh of their risk areas.

Discussion ensued on the proposed Risk Appetite Assurance Statements and the identified need for risk training. KR proposed that a session on 'risk appetite' be arranged for the December Governing Body date. Discussion also included recognition that risk reporting, including clinical and financial impact, required review and appropriate assignment to committees would be needed during November. CA noted dedicated time was scheduled for the Executive Team to review and assess risk registers in terms of clinical and patient quality. She also requested feedback from members to inform the refreshed risk report to be presented at the Audit Committee on 29 November 2017 and the Governing Body in January 2018.

Continuing Healthcare

In presenting this item DN began by explaining the checklist process for eligibility to access Continuing Healthcare, a joint CCG and Local Authority decision making process for long term conditions. The report provided an update on the management, performance and delivery of QIPP associated with Continuing Healthcare in respect of Funded Nursing Care, Joint Funded Care, Fully Funded Continuing Healthcare, Continuing Healthcare appeals, Personal Health Budgets, Children's Continuing Healthcare and Partnership Commissioning Unit financial management. Ongoing and new risks and opportunities were also identified. DN also noted that the potential Funded Nursing Care QIPP was being supported by North of England Commissioning Support. In this regard JS explained that the current 30 days support had been agreed specifically for QIPP with an expected rate of return. He would review the CCG's requirements with DN in light of the discussion.

DN detailed concerns about the processes by which financial resource was currently committed for Funded Nursing Care and accuracy of eligibility information, including in relation to out of date reviews. She additionally noted potential further impact on the performance target of 28 days from checklist to assessment following review of the current cases and also the potential requirement for funding for high cost learning disabilities packages. DN advised that the financial risk to the CCG from Continuing Healthcare was unquantifiable at the present time.

Members sought clarification on the associated issues, the potential financial impact on the CCG and implications for families. PM highlighted that discussion with JS was required to inform decision making in the context of the CCG's statutory duties.

DN advised that the CCG would need to support a number of discharge to assess beds and review use of community beds to fulfil the four week assessment timescale for Continuing Healthcare, noted concern about learning disabilities assessments, and reported that 52 historical Continuing Healthcare appeals were attributed to the CCG. With regard to the latter TP had allowed some funding but confirmation that funding was sufficient would only be reached through the review process.

Further discussion included emphasis of the need to address the current financial management issues as quickly as possible and bring them within the CCG's structure, learn lessons from the historic issues, and address governance and leadership issues.

SP highlighted that issues relating to Continuing Healthcare were a national concern and also referred to discussion at the Audit Committee emanating from a number of Limited Assurance reports relating to the Partnership Commissioning Unit. She emphasised the need for a robust action plan and clarification of numbers.

In response to JS referring to the need for accuracy of numbers in terms of financial ledger reporting TP advised that there had been a period of improvement of Partnership Commissioning Unit financial reporting and alignment of business systems. However, as a result of the transition, reduced capacity had led to a deterioration and concern about confidence in the numbers across all the CCGs. A number of actions were already being taken to gain confidence in the finances reported and ensure resilience in the team.

DN additionally explained further risk in respect of an annual uplift for care homes and potential cost associated with the legal duty relating to payment for sleep-in nights.

Transforming Care / Section 117 Vulnerable People Risks

DN presented the report which described the requirements and issues in respect of Section 117 assessments and reviews and arrangements for care and treatment reviews for Transforming Care. These were additional Partnership Commissioning Unit risks with potential financial risk to the CCG's plans for 2017/18 and 2018/19.

In relation to Section 117 DN explained that she had requested clarification of caseloads to inform discussion with City of York Council about decision making for shared funding and joint assessment. She advised that City of York Council was arranging training in December but highlighted that the Partnership Commissioning Unit Vulnerable People's Team did not have the capacity to undertake reassessment of the c300 cases attributed to the CCG, also noting that these were potentially high cost cases.

DN also reported that the Partnership Commissioning Unit Vulnerable People's Team did not have the capacity to undertake the Care and Treatment Reviews for Transforming Care in accordance with the national aim and guidance of moving patients from locked rehabilitation or assessment and treatment centres. She noted that

the CCG was aware of three cases for discharge for the first quarter of 2018/19 and that no accrual had been made in the accounts for this cohort, also highlighting that regular care and treatment reviews were required. MC added that Transforming Care for learning disabilities remained a shared resource; the CCG provided the clinical element to the Transforming Care Board. She noted the need for significant work in respect of Responsible Commissioner for individuals.

DN also reported that Tees, Esk and Wear Valleys NHS Foundation Trust were reviewing long stay hospital placements and moving individuals to nursing homes where appropriate with the associated costs often being the CCG's responsibility.

TP explained that funding for Transforming Care provision should transfer from specialist services with the original expectation of being cost neutral but business cases for forensic services in the community were higher than the funding available. No CCG locally had made provision and the cost of these packages was now emerging as a material risk nationally.

In respect of the concerns relating to the Continuing Healthcare and Transforming Care / Section 117 Vulnerable People Risks reports KR requested an urgent action plan and recommendation to the Governing Body about addressing the issues and SP agreed to discuss with TP the remit for a financial audit by Internal Audit prioritising review of ledger accuracy.

TP referred to the current joint working with NHS Scarborough and Ryedale CCG and highlighted that the transition of members of the Finance Team was a priority, noting that NHS Vale of York CCG's new structure incorporated these staff. She advised that recruitment to vacancies was taking place and that interim agency staff were being employed to progress the work.

KR and PM agreed to discuss concerns arising from the Partnership Commissioning Unit transition with their respective counterparts in the three North Yorkshire CCGs. DN, in addition to discussing with JS additional support for Funded Nursing Care reviews, proposed a pragmatic approach to assess financial risk and build a profile based on the checklist process for 10 cases per year from 2014.

PM proposed that a briefing paper summarising the position be provided for discussion with the Accountable Officers and Audit Chairs of the other North Yorkshire CCGs and to escalate the concerns to NHS England.

DN and TP agreed to provide an action plan for consideration at the November Committee meeting.

The Committee:

Update Report – Restructuring the Risk Registers and Board Assurance Framework and Risk Management

1. Received the Risk Update Report.
2. Welcomed the proposed restructuring of risks line with the Board Assurance Framework.

3. Noted that the Risk Management Strategy/Policy would be presented to the November meeting of the Audit Committee and the January meeting of the Governing Body.
4. Requested that risk training be arranged for the Governing Body on 7 December.
5. Requested that all current risks be reviewed by risk owners to incorporate the clinical impact and consequence for patients of each risk in order to present a refreshed risk register to the Finance and Performance Committee in November.
6. Requested that the current risk register be split into component risk registers to be maintained by each of the delegated committees of the Governing Body.

Continuing Healthcare and Transforming Care / Section 117 Vulnerable People risks:

7. Noted detailed concerns.
8. Requested that DN and TP provide an action plan for the November Committee meeting.
9. Noted that SP would agree the remit for a financial audit with TP.
10. Agreed the approach described by DN to assess financial risk.
11. Noted that PM would arrange for a briefing paper summarising the position.

PM left the meeting

6. Financial Performance Report Month 6 and QIPP Progress and 7. Capped Expenditure Update

TP highlighted the addition of an Executive Summary to the financial performance report. She referred to discussion at the October private Governing Body meeting when members had expressed the preference to deteriorate the financial plan by at least £2.8m in respect of the NHS Scarborough and Ryedale CCG capped expenditure process adjustment. However NHS England feedback was that a plan movement would not be permitted therefore reporting to NHS England was against the £6.3m deficit plan.

TP explained in detail the forecast with regard to the planned deficit, forecast outturn, reported deficit and 'gap' from the reporting at the September meeting of the Committee to the present month 6 actual position. She advised that the month 7 position would be £19.4m risk adjusted forecast deficit, comprising £16.0m reported deficit and £3.4m risk to ensure alignment to the Governing Body approved financial plan from 31 March 2017.

PM rejoined the meeting

In response to SP seeking clarification about the CCG's accountability for the reported position and work to achieve this, TP advised that the forecast position was as previously reported and had been discussed with JS. The Governing Body had agreed that all possible action should be taken to deliver the £16.0m deficit plan. The £3.4m 'gap' was recognition of a potential for the deficit to increase. From month 7 reporting would be of a forecast £16.0m deficit and a commitment to work to deliver this. TP also noted that £2.8m would be moved from forecast risk to forecast outturn in month 7. She added that the CCG was one of a number in the North whose forecast deficit had increased from their planned position.

CA explained that, in terms of programme delivery, there was clarity of the scale of current QIPP requirements and noted that DN's reports added to the QIPP challenge. TP also explained the position of York Teaching Hospital NHS Foundation Trust in terms of overall forecast, including confirmation that their financial plan now incorporated the impact of both NHS Scarborough and Ryedale and NHS Vale of York CCGs' QIPP delivery plans and the system working which was undertaking joint financial forecasting, noting a level of stabilisation across the system. PM reported on discussion with CA and TP regarding the mid year assessment both as a system and from the CCG's perspective. Proposals were being developed to address the CCG's QIPP gap.

TP noted that the month 6 year to date position was £2.7m behind plan, a deterioration from month 5 of £1.5m of which £1.4m related to 6/12ths of the £2.8m NHS Scarborough and Ryedale CCG capped expenditure process adjustment; the overall trading position was stable. She explained that £3.4m gap to delivery of the £16.0m deficit plan relied on challenges with York Teaching Hospital NHS Foundation Trust relating to rehabilitation bed days and that costs relating to winter were not included. TP also referred to the increased risk relating to continuing healthcare, Transforming Care and Section 117 vulnerable people risks as discussed at item 5 above.

With regard to QIPP TP advised that continuing assurance was being sought through confirm and challenge.

TP highlighted that the CCG had narrowly missed one of its internal Key Financial Measures, to have month end cash holding within 1.25% of the monthly drawdown due to an error in the cash book information provided to the CCG. She noted that this was not a statutory measure but that discussion was taking place with NHS England. Additionally, the deterioration of the forecast outturn meant that the CCG would breach its Maximum Cash Drawdown in March 2018 unless this was adjusted nationally.

Discussion ensued regarding key actions to mitigate delivery of the £19.4m forecast deficit. TP explained efforts taking place to resolve the £3.5m challenge in respect of rehabilitation bed days at York Teaching Hospital NHS Foundation Trust, noting the historical context of formal arbitration should this be the outcome.

Discussion continued after item 15 which was moved up the agenda.

BC joined the meeting

15. Winter Plan: Review and Potential Costs

KS left the meeting during this item

BC presented the report which included the draft York and Scarborough A and E Delivery Board Escalation Framework 2017/18 and an outline of possible schemes and associated costs. She emphasised that this was a system plan, reviewed and agreed in principle by the A and E Delivery Board on 19 October but with acknowledgement that approval and sign off of their potential contribution was required by each organisation and with potential for successful schemes to remain in place after the winter period. The estimated impact on the schemes for NHS Vale of York CCG was

currently £193k although discussions were ongoing about opportunities to support additional beds in the community. BC noted that confirmation had now been received from the Urgent and Emergency Care Network of allocation for the Sustainability and Transformation Plan footprint of £62k for respiratory and diversionary pathways and £70k to manage discharge to assess beds with NHS Scarborough and Ryedale CCG.

BC highlighted the proposal for additional primary care sessions for a six week period, including Christmas and New Year. She noted this was based on similar provision during the winter of 2015/16 and added that there was little evidence to support its direct impact on A and E attendances or performance. Discussion included the context of the current extended primary care access developments and the need for public engagement.

Further discussion ensued in respect of the fact that a number of the proposals were not sufficiently developed to assess financial impact, dependency on partners for delivery, staff capacity and this funding was not included in the current financial plans. CA explained that, as well as the financial and system impact, the plan was key to the joint regulator body aspiration to deliver the Emergency Care Standard indicator nationally; and the Committee's view was being sought about its effectiveness and affordability. In response to SP also noting that approval of the plan was implicit approval of the associated funding, TP advised that a meeting of Urgent and Emergency Care Leads and organisational Finance Leads was taking place on 8 November, at the request of the A and E Delivery Board, to assess the costs and timing of these.

JS explained that the Winter Plan was part of organisational preparedness and in no way related to bridging financial gaps or meeting control totals.

PM emphasised the need for lessons to be learnt regarding an annual winter planning contingency and highlighted the need for clarity of governance for the total £2.2m of schemes. He explained that the role of the Committee was to form a view about the lack of a winter planning contingency and whether, in the context of the financial deficit and recovery plan, members were prepared to mandate release of funding for this purpose. PM also highlighted that as part of the system it was incumbent upon the CCG to contribute but expressed concern as to how this could be achieved.

It was agreed that the Executive Team review the costs in terms of responsibility to deliver over the winter period and report back to the Committee any decisions that would cause a deterioration and impact on the CCG's financial recovery.

The Committee:

Requested that the Executive Team review the costs of the winter plan in terms of responsibility to deliver over the winter period and report back to the Committee any decisions that would cause a deterioration and impact on the CCG's financial recovery.

BC left the meeting

6. Financial Performance Report Month 6 and QIPP Progress and 7. Capped Expenditure Update – Continued

Discussion resumed in respect of key actions to deliver the £19.4m deficit plan. PM highlighted that action relating to Unplanned Care required support from partner organisations but in respect of Planned Care QIPP there were opportunities relating to:

- Prescribing, including restrictions on such as headache and indigestion remedies: work had begun in this regard. Support would be required from the Council of Representatives.
- Dressings for which urgent scoping was required.
- Planned theatre closure in March 2018.
- Requesting a pause by Tees, Esk and Wear Valleys NHS Foundation Trust in the transfer of costs to the CCG from individuals being moved to nursing homes where appropriate. This would be subject to their willingness to absorb further costs.
- Financially incentivising change to GP referrals; these were already down 4% year on year.

PM emphasised the statutory responsibility to identify a range of proposals to address the gap and reported on discussion with GP members of the Accountable Care System Partnership Board and the Council of Representatives advising that they had indicated support for non recurrent measures in response to the system running out of money. The proposals above would be worked up for discussion at the Governing Body meeting on 2 November and with the regulators. The outcome would be communicated to the Committee.

PM also described discussions taking place with NHS Scarborough and Ryedale CCG, York Teaching Hospital NHS Foundation Trust, NHS England and NHS Improvement with a view to agreeing a system cost reduction programme but emphasised the CCG's statutory duty to focus on the £14.4m QIPP target. He noted that the system assessment was an improvement on the historic position highlighting that the position with urgent and emergency attendances was due to acuity leading to conversion rate. Impact was being seen from RightCare, surgery thresholds had been brought forward where possible, and, although a QIPP gap remained, year to date delivery was more than the total 2016/17 QIPP. Clinical engagement was required to make further progress. PM also noted the intention for the CCG to return to a clinical leadership model through appointment of a clinical chair.

TP added that the October Governing Body meeting had requested proposals from SOC be worked up in respect of planned care options, implementation of a warfarin first policy in the community and for Practice held indicative budgets. She also noted that further proposals from GPs would be incorporated and commented that impact from unplanned care opportunities would have the most impact on QIPP but took time to affect patient flow.

Members sought and received clarification on a number of aspects of the financial challenge noting TP's confidence in £6.4m QIPP delivery and that £3.7m was subject to monthly confirm and challenge assessment. Additionally, it was recognised that measures introduced in year would indicate fundamental change for 2018/19 onwards and there was an urgent need for culture change in terms of partnership working.

JS highlighted that, whilst it was imperative to focus on the financial challenge, a culture change within the CCG was required in terms of recognising areas of improvement.

The Committee:

1. Received the month 6 financial performance report noting the ongoing challenges.
2. Noted that a range of proposals to address the gap would be worked up for discussion at the Governing Body meeting on 2 November and with the regulators.

9. Contract Trading Report Month 5

Due to time constraints TP requested members seek any clarification outside the meeting but highlighted two areas relating to York Teaching Hospital NHS Foundation Trust that had been resolved in the CCG's favour: the 2016/17 final outturn position had been fully resolved through the resolution of the outstanding contract challenges and amounted to £0.3m; there was a £200k reduction in ambulatory care following agreement on a lower price.

The Committee:

Received the Contract Trading Report.

10. Integrated Performance Report Month 6 including Primary Care Programme

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 also noted that a number of the suggested headlines for discussion had already been covered in previous items.

CA noted the improved and, on certain days, over achievement of Emergency Care Standard performance in the Emergency Department due to internal operational resilience and embedding of core processes but that clarification was still required in relation to the winter plan.

In respect of cancer 62 day performance, which would be discussed in detail at the next meeting of the Committee, CA explained that this was complex due to cancer performance improvement plans being at both local and regional level and the fact that the Cancer Plan was driven by the Cancer Alliance.

CA referred to the Primary Care Programme Update noting that discussion would be incorporated at the November meeting of the Committee.

CA reported that York Teaching Hospital NHS Foundation Trust had refreshed its Return to Operational Standards which would be presented for assurance at the next Committee meeting.

In respect of diagnostics CA noted that further information would be provided and advised that the Cancer Alliance was working with York Health Economic Consortium to undertake a review of diagnostic capacity regionally. She also reported that York Teaching Hospital NHS Foundation Trust was considering diagnostics in the context of their cost improvement plan with the potential for support from NHS Improvement.

The Committee:

Received the month 6 Integrated Performance Report.

11. Referral to Treatment Recovery

This item was deferred to the next meeting.

12. Performance Review: Cancer 62 Day Performance Delivery

This item was deferred to the next meeting.

13. Child and Adolescent Mental Health Services

DN presented the report which provided an update on the current performance of Child and Adolescent Mental Health Services and actions being taken to address issues. Interim feedback from the Care Quality Commission Thematic Review of the North Yorkshire Child and Adolescent Mental Health Services was also included.

DN highlighted areas of improvement including the implementation of the local Single Point of Access and improved reporting information. She noted that manual data indicated triage for early assessment was good and that the average time from triage to treatment was eight weeks in Selby and four weeks in York. However, there were aspects of the service where the CCG was an outlier, for example children were waiting up to 17 weeks for emotional support and children with autism were waiting up to 58 weeks.

DN noted improvements in transparency and openness which enabled an understanding of risk and that work was ongoing with Tees, Esk and Wear Valleys NHS Foundation Trust in respect of the national reporting tool.

The Committee:

Received the report on Child and Adolescent Mental Health Services.

14. Improving Access to Psychological Therapies

DN referred the Intensive Support Team's visits to Tees, Esk and Wear Valleys NHS Foundation Trust in respect of Improving Access to Psychological Therapies. She highlighted that Tees, Esk and Wear Valleys NHS Foundation Trust had increased practitioner capacity and were attempting to clear the backlog with the aim of achieving the 15% performance target by the end of the financial year.

DN also provided an update on dementia coding performance as referred to at item 4 above noting that multi agency actions were being implemented following the Intensive Support Team visit. Strategic work was required with partner organisations to provide evidence of the coding. Additionally, a number of members of the CCG were working with Practices who were not currently counting dementia diagnosis to improve performance.

The Committee:

1. Received the report on Improving Access to Psychological Therapies.
2. Noted the ongoing work to improve performance against the dementia diagnosis target.

16. Final Assessment for Quality Premium 2016/17

CA referred to the report which confirmed that the CCG had not met the criteria in 2016/17 to go through the financial gateway for the 2017/18 Quality Premium scheme.

The Committee:

Noted that the CCG had not met the financial gateway to progress to the Quality Premium scheme in 2017/18.

8. Better Care Fund

PM reported that neither the City of York Council nor the North Yorkshire County Council Better Care Fund plans were yet approved due to delayed transfers of care trajectories and targets. He advised that Paul Howatson (PH), Head of Joint Programmes had drafted a report for the Governing Body meeting on 2 November and expressed appreciation commending PH's work in respect of the Better Care Fund

The Committee:

1. Noted the update.
2. Commended PH's work in respect of the Better Care Fund.

17. Key Messages to the Governing Body

- The Committee emphasised the need to focus on meeting statutory financial responsibilities noting the significant work, including QIPP, to address the challenging financial position.
- The Committee welcomed the revised approach to risk management.
- The Committee noted the Partnership Commissioning Unit QIPP focus.
- The Committee highlighted that the CCG should "not lose sight of the bigger picture" through a culture change of positivity about what was being achieved.

The Committee:

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

18. Next Meeting and Forward Plan

The next meeting would be 9am to 1pm 23 November 2017.

**Minutes of the Finance and Performance Committee Meeting held on
23 November 2017 at West Offices, York**

Present

David Booker (DB) (Chair)	Lay Member and Finance and Performance Committee Chair
Caroline Alexander (CA) – for items 11 and 12	Assistant Director of Delivery and Performance
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation
Dr Andrew Phillips (AP)	Joint Medical Director
Tracey Preece (TP) - part	Chief Finance Officer
Dr Kevin Smith (KS) - part	Director of Primary Care and Population Health

In attendance

Abigail Combes (AC) – for item 5	Head of Legal Services and Governance
John Hancock (JH) – for items 11 and 12	Service Delivery Lead, North Yorkshire and Humber Clinical Networks Team
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Keith Ramsay (KR)	CCG Chairman
Michele Saidman (MS)	Executive Assistant

Apologies

Dr Shaun O’Connell (SOC)	Joint Medical Director
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)

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. However, as an Independent Member of NHS Harrogate and Rural District CCG Audit Committee SP declared an interest during discussion of podiatry services at item 9.

3. Minutes of the meeting held on 26 October 2017

The minutes of the previous meeting were agreed.

The Committee:

Approved the minutes of the meeting held on 26 October 2017.

AC joined the meeting during item 4

4. Matters Arising

F&P39 Risk - Continuing Healthcare and Transforming Care / Section 117 Vulnerable People Risks: TP reported that the remit for the financial audit was currently being agreed with Internal Audit for a mid December start date. She explained that from 1 December continuing healthcare and the other remaining members of the Partnership Commissioning Unit would transfer to NHS Scarborough and Ryedale CCG and would provide the month 8 continuing healthcare report. The audit would seek assurance on the accuracy of the data and systems. TP noted that the CCG Finance Team was already working with the NHS Scarborough and Ryedale CCG team and that discussion had also taken place with the North Yorkshire CCGs' Chief Finance Officers who had identified similar issues. Further discussion would take place regarding the associated risk at agenda item 7.

A number of other items were noted as ongoing or on the agenda.

The Committee:

Noted the update.

“Good News”

MC reported that approximately 40 people had attended the gluten free foods consultation event the previous evening. She noted that a variety of views had been expressed by both coeliac and non coeliac sufferers in open discussion but overwhelmingly, both at the event and via the website consultation, the public did not support restricting prescribing of gluten free foods as described currently in the consultation.

MC explained that 450 patients currently received prescriptions for gluten free foods and 160 were on a pilot card scheme. She noted that the proposal currently subject to consultation did release financial savings.

KR agreed that consideration would be given to including a patient story from a patient with coeliac disease at the January 2018 meeting of the Governing Body.

DN joined the meeting during item 5

5. Risk Update Report

In presenting this report AC advised that the refreshed Risk Policy included guidance from the Treasury. She explained that, in preparation for the Governing Body risk tolerance training on 7 December, a workshop would be held with the CCG steering group excluding the Governing Body members and potentially colleagues from City of York Council to establish a tolerance baseline using Red, Amber, Green (RAG) rating. The training would be rolled out to all CCG staff after 7 December to ensure appropriate escalation through the committee structure and to the Governing Body where required.

AC noted the addition of a column on the Corporate Risk Register 'Impact on Service Care/Delivery'.

PM commented on the breadth of the CCG's statutory responsibilities. He highlighted the requirement for providers and partner organisations to understand the impact on the CCG and the need for risk to be shared.

Discussion ensued with regard to the assurance process, particularly in relation to the long standing 'red' and the 'amber' risks. AC advised that the risk tolerance training would include articulation and interpretation of likelihood and impact to inform the reporting policy. SP noted the role of the Audit Committee as ensuring processes were appropriate, not managing risk.

AC noted that, following the Governing Body risk tolerance training, the Risk Policy and Strategy would be updated for approval by the Executive Committee and sign off by the Audit Committee Chair. Staff training would then commence.

The Committee:

1. Approved the Risk Reporting format and supported the continuing work.
2. Expressed appreciation to AC and the steering group.

AC left the meeting

6. Finance and Performance Committee Terms of Reference

TP noted that the Committee's terms of reference were presented for consideration due to the revised membership which ensured focus on executive accountability but with scope to invite additional attendees. In addition to the proposed amendments it was agreed that KS be added to the membership and that the final paragraph under membership be amended to read 'Anyone else at the invitation of the Accountable Officer, any Executive Directors and the Committee Chair.'

Members requested that clarification be sought as to whether KR could become a member of the Committee as DB was currently the only lay member.

The Committee:

1. Approved the proposed and additional amendments to the terms of reference.
2. Requested that clarification be sought as to whether KR could become a member.

7. Financial Performance Report Month 7 and QIPP Progress

In presenting the financial performance report TP explained that the forecast had moved to £16.0m deficit and that there was a £3.4m gap to deliver this, therefore the total deficit at month 7 was £19.4m. TP noted increased risk to delivering the £19.4m with a further £2.0m non recurrent measures required to maintain this forecast. She confirmed that NHS England was fully informed of the risk.

TP explained the main reasons for the deterioration were c£1m relating to the the York Teaching Hospital NHS Foundation Trust contract, £0.5m year to date prescribing costs, c£600k relating to continuing healthcare and c£300k in mental health out of contract placements. A number of mitigations had also been removed, including the responsible commissioner for a high cost patient as previously discussed, and the fact that the Transforming Care Programme funding would not flow in year. TP noted that the latter was a national issue and that 51 beds were planned to close across Yorkshire and the Humber. MC added that the CCG currently had 12 people in hospital awaiting packages in the community against the trajectory by the end of the financial year for no more than nine people waiting.

In respect of prescribing TP highlighted the good performance until month 6. However, a national issue had now emerged relating to No Cheaper Stock Obtainable (NCSO) drugs and GPs were therefore being required to prescribe more expensive alternatives. NHS England was working nationally to resolve this but the potential impact on the CCG prescribing budget in year was a further £2.1m pressure. This was discussed in the context of Practice Prescribing Indicative Budgets and had also been discussed in detail at the Primary Care Commissioning Committee the previous day.

TP explained that, although the actual activity at York Teaching Hospital NHS Foundation Trust was broadly returning to plan, the current pressures related to outpatient and planned activity which she had discussed with their Finance Director. The focus of clinic attendance was shorter waiting times for first appointments and longer for follow-ups, on the basis that this would be achieved in NHS capacity rather than premium costs, and for patients to be discharged without the need for a follow-up appointment. TP advised that the CCG would be monitoring the impact of these actions as there was significant concern that this could result in overall cost pressure. She also noted that, while GP referrals had reduced by 4%, consultant to consultant referrals had increased due to the requirement for internal referrals to take pressure off primary care. Guidance was being followed in this regard and there were no concerns, however TP expressed concern in the event of the overall result being a negative impact. She also noted that these measures were being organisationally, rather than clinically, led.

TP reported an undertrade with Ramsay and Nuffield Hospitals and that the BMI and smoking restrictions were having a significant impact. York Teaching Hospital NHS Foundation Trust was using this capacity for 18 week referral to treatment targets. TP noted that CA was working on referral to treatment modelling to identify how the QIPP could be delivered. Reduction in elective activity in the final quarter of the financial year would require discussion at the Executive Programme Board.

DB queried why the Heads of Terms escalation had not been invoked as previously authorised by the Committee. TP and PM explained that this had not happened for a number of reasons, including the current financial challenge faced by York Teaching Hospital NHS Foundation Trust and ongoing discussions to agree a 2017/18 year-end figure by the end of December followed by work to agree alternative contract mechanisms. TP also reported that different 2017/18 outturn scenarios were being developed for discussion with the respective regulators but highlighted the key concern of York Teaching Hospital NHS Foundation Trust was their current challenging cash position.

TP reported that York Teaching Hospital NHS Foundation Trust had introduced a number of cost reductions including further restrictions relating to bank and agency staff, a new travel policy and ceasing clinical excellence awards which cost c£300k. She noted however that the CCG had not to date seen their recovery plan.

Members discussed the requirement from the York Teaching Hospital NHS Foundation Trust contract in order that the CCG would achieve the £19.4m deficit position. TP also referred to the fact that within the Yorkshire and Humber footprint the York and Scarborough position was not deteriorating at the same rate as other areas and was relatively stable despite the risk.

In response to DB seeking further clarification about the fact that the Heads of Terms escalation had not been invoked, TP explained the involvement of the regulators whose view was that there was a joint commitment to work together within the financial envelope and focus on costs in the system being as low as possible. PM and KR emphasised that the CCG's statutory responsibilities related to more than York Teaching Hospital NHS Foundation Trust and the challenges were across the whole system, also highlighting support of the Council of Representatives was a key requirement.

AP referred to regional benchmarking of activity across acute trusts and noted a comparatively high level of outpatient activity at York Teaching Hospital NHS Foundation Trust. He highlighted the need to provide assurance to GPs about demand management.

MC raised concerns about the process for approval of clinical thresholds across the Sustainability and Transformation Plan organisations. This had been outwith CCG governance processes and the associated efficiencies had not always been identified. MC also noted that quality impact assessments had not taken place other than for cataracts which she had done. MC advised that these concerns had been discussed at the Executive Committee and agreed to report back at the next Finance and Performance Committee.

TP referred to the request at the previous meeting for an action plan to address the pressures relating to continuing healthcare and mental health performance and reported that detailed analysis of patients was taking place. DN explained that action was ongoing from a clinical perspective however it was not currently possible to produce an action plan for all Partnership Commissioning Unit risk due to concerns about accuracy of business intelligence information and financial reporting. These concerns were shared by all the North Yorkshire CCG Chief Finance Officers and DN's and TP's concerns in this regard were aligned.

Further discussion ensued on historical issues relating to the Partnership Commissioning Unit. DN additionally reported that she had updated the audit recommendations as far as possible but emphasised she had concerns through the entire continuing healthcare process.

DN referred to the significant spend on mental health out of contract placements and neurological and brain injury placements noting that there were no contracts in place for the latter. This was now being reviewed by the Contracting Team.

DN also explained in respect of out of contract mental health placements the context of the Tees, Esk and Wear Valleys NHS Foundation Trust contract and their review of these high cost patients. She advised that, while there was no concern about the appropriateness, on discharge the patients would become the CCG's responsibility under such as Section 117 or continuing healthcare. The CCG was also not currently aware of all the potential discharges and confirmation was required regarding current Section 117 payments.

In summary DN reported that a clinical plan had been established but that there was no overall assurance in terms of money, business intelligence and assessments. She also expressed concern that patients who had died may still be on the system.

TP referred to the transition process for the Partnership Commissioning Unit noting establishment of a Transition Board comprising the Chief Finance Officers and Chief Nurses of the four North Yorkshire CCGs and a Transition Project Manager. Three members of staff were joining the CCG under TUPE arrangements on 1 December and an advert was out to increase finance capacity.

TP reported that, in view of the concern expressed by the four North Yorkshire CCGs about reporting continuing healthcare, discussion was taking place with NHS England both in respect of a year-end position for 2017/18 and spend for 2018/19. DN additionally highlighted the potential for further complex mental health cases which would require inclusion.

Detailed discussion ensued regarding previous concerns about Internal Audit reports on the Partnership Commissioning Unit. Members emphasised the need to take some form of action in view of the issues raised and the lack of assurance but within the context of good governance and statutory responsibilities. It was agreed that an investigation, rather than an audit, was required and that TP would discuss with JS the potential for this to be undertaken through utilisation of potential additional days provided by North of England Commissioning Support or by NHS internal finance resource.

KR and SP agreed to meet informally with the Head of Internal Audit to discuss concerns over recent internal audits of the Partnership Commissioning Unit in light of the further serious emerging concerns. SP also agreed to draft a letter to the North Yorkshire Audit Committee Chairs to seek their views; she would share the draft with TP before sending.

TP additionally noted that External Audit had drafted a letter to the Secretary of State due to the CCG's breach of allocation. This would be sent by the end of December and would also be received by the Audit Committee.

The Committee:

1. Received the financial performance report.
2. Requested that MC report back on concerns relating to implementation of clinical thresholds across the Sustainability and Transformation Plan.

3. Noted that SP and KR would meet with the Head of Internal Audit to discuss concerns about Partnership Commissioning Unit audits. Post meeting note: meeting held on 8 December.
4. Noted that SP would write to the North Yorkshire Audit Committee Chairs seeking their views on concerns about the Partnership Commissioning Unit transition.

KS left the meeting

8. Update on Better Care Fund

AP referred to the report which provided an update on the Better Care Fund plans for City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council noting that the latter was the only plan approved nationally by the Better Care Fund Support Team. The outcome was awaited following the submission of further evidence to the Escalation Panel for the City of York Council and North Yorkshire County Council plans.

Although the CCG and City of York Council were in agreement, the Section 75 monies could not be transferred to City of York Council due to the required reduction in delayed transfers of care 4.8% forecast against the required 3.5 %. Areas that did not anticipate achieving the 3.5% were being required to take further action.

The Committee:

Noted the update on the Better Care Fund.

9. Contract Trading Report Month 6

TP highlighted the revised format of the Contract Trading Report noting that, although this was a month behind the Financial Performance Report, there was a reconciliation process for the information. She also referred to the earlier discussion about the York Teaching Hospital NHS Foundation Trust contract.

TP described the ongoing discussions with York Teaching Hospital NHS Foundation Trust to establish an aligned incentive contract from April 2018. She noted that both organisations were committed to the new form of joint working, the regulators were being kept informed and advice and support was being sought from NHS East Riding of Yorkshire CCG where this approach was already established.

TP advised that agreement of outline milestones for the 2017/18 position was expected by December with further detail of timescales to be agreed by March 2018. She confirmed that aligned incentives contracting aimed to reduce overall costs in the system and that an incentive mechanism for primary care would also be developed.

TP explained that the York Teaching Hospital NHS Foundation Trust Management Team was working with their Clinical Directors to identify improvements that could be enacted if payment by results was not the contracting method. PM noted that when the CCG had a clinical chair he/she would be actively involved in delivering the aligned incentive contract and that Lisa Marriott - Senior Account Manager, New Care Models Programme / Five Year Forward View, NHS England - was working with the CCG on developing draft Commissioning Intentions.

TP referred to the analysis of the York Teaching Hospital NHS Foundation Trust trading position. This compared the 2017/18 planned and assumed expenditure forecasts against the 2016/17 actual expenditure profiles and described the expenditure profile and comparison of plan and actual expenditure, both excluding and including challenges, for expenditure overall and individually for planned and unplanned care. She noted that the overall expenditure profile was in line with plan for year end.

With regard to the CCG's challenges to York Teaching Hospital NHS Foundation Trust TP reported that an informal view from a national expert was being sought.

In respect of the review of rehabilitation bed days, TP reported that there was clinical representation in to the audit from NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs, with the latter providing clinical challenge.

Members sought 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. SP declared an interest in respect of the latter in view of her being an Independent member of NHS Harrogate and Rural District CCG Audit Committee. TP agreed to circulate further information to the Committee. She additionally explained that part of the negative variance with Mid Yorkshire Hospitals NHS Trust was in the main due to the fact that they provided a weight management service to which the CCG GPs made referrals.

The Committee:

1. Received the Contract Trading Report.
2. Requested that TP circulate the information referred to above.

TP left the meeting

10. Winter Planning 2017/18

AP referred to previous discussion by the Committee of proposed winter plan system schemes and presented the report which provided an update on the outcomes of their consideration by the Executive Committee. AP noted that the schemes were system wide and that work was taking place with North Yorkshire County Council to find agreement on their commitment to schemes that they were required to support.

In response to SP seeking assurance about the additional £315k commitment by the CCG and the potential impact on 2018/19, AP explained that schemes such as the additional GP sessions would run for six weeks and the timetable for other schemes would vary. The cost pressure was recognised but assurance was provided that winter planning would be incorporated in future years' budget planning.

KR referred to feedback from the recent Care Quality Commission York Local System Review when the main concerns had been identified as seven day working and delayed transfers of care. AP reported that York Teaching Hospital NHS Foundation Trust recognised the need to progress this but rotas and staffing levels continued to be a challenge. Efforts were being made to improve planning despite the issues.

AP additionally referred to the appendix *Winter Briefing 1* issued by NHS England and NHS Improvement which detailed the operational management of winter in terms of expectations and communications.

The Committee:

Received the winter planning update.

CA and JH 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.

CA highlighted continued improvement in performance against the A and E four hour target, at 93.22% on 14 November, as a result of a number of initiatives implemented by York Teaching Hospital NHS Foundation Trust. She referred to the five performance boards established at York Teaching Hospital NHS Foundation Trust to deliver the improvement programmes outlined in the Trust Return to Operational Standards, and noted that A and E performance was overseen by the Acute Board. CA also advised that additional best practice guidance had been issued to address ambulance handover delays. In this regard AP added that a gap analysis was currently being completed.

In respect of the diagnostics six week target CA noted improved performance on the York Hospital site in September, 1.60% against the target of less than 1%, but audiology continued to affect performance in Scarborough. She advised that York Teaching Hospital NHS Foundation Trust had accessed support from the NHS Improvement Productivity Team and it was proposed by the Carter team to establish radiology at York Teaching Hospital NHS Foundation Trust as a national improvement site for their support. CA also reported that diagnostics was at a critical level across the Sustainability and Transformation Plan, particularly in radiology, and the cancer alliance was already mobilising the demand and capacity workstream within their diagnostic programme. This would present an initial option appraisal in January 2018.

CA referred to cancer two week wait performance reporting dermatology as a key specialty that was challenged. She described the York Teaching Hospital NHS Foundation Trust dermatology recovery plan highlighting that capacity was a major concern for its implementation and noting that further detailed work was continuing.

Performance of dementia diagnosis in primary care had improved for another successive month at 60.2% in October from 59.6% in September against the 66.7% target. DN added the expectation that this improvement, resulting from project support to Practices from the CCG's Commissioning Team, would continue. She also commended the clinical engagement of Practice staff with the CCG noting she had suggested that Practice Managers be involved. DB agreed to write to express appreciation for the progress achieved in dementia diagnosis. *Post meeting note: Letter to CCG Commissioning Team sent 1 December.*

CA noted that York Teaching Hospital NHS Foundation Trust's 18 week referral to treatment recovery plan presentation to the Committee had been deferred to the December meeting. She referred to the internal resilience work being undertaken, including with both the CCG and the NHS Improvement Productivity Team, and noted that capacity was an issue across all services, except trauma and orthopaedics, but was particularly challenging in rheumatology, dermatology, ophthalmology and urology.

With regard to cancer 62 day wait performance, CA advised that improvement was heavily dependent on the Cancer Transformation Funding in the short term to address diagnostics pressures locally. She noted the 62 day performance paper to be presented after the performance report.

CA reported that, although it had not been possible to validate the continuing healthcare 28 day assessment backlog, there appeared to have been some improvement. An action plan, including associated risks, had been submitted to NHS England for a trajectory to the end of the financial year. Additionally, discussions were taking place with NHS England's Chief Nurse regarding confidence in patient numbers.

In respect of mental health services DN reported that a redesigned contract management board was being implemented with more in depth discussion of performance and quality prior to its meetings.

DN reported the expectation that Improving Access to Psychological Therapies performance would reach 15% by the end of the financial year, noting that the 16.8% target was not achievable on the CCG's current commissioning of this service. She also explained that the Executive Committee would be considering information on waiting times in mental health services to inform discussion with regulators and partners.

DN added that early work taking place with City of York Council regarding Personal Health Budgets was a positive but noted that clarity of numbers was not yet known; infrastructure and increased delivery were challenging. Some areas of governance around Personal Health Budgets required significant work.

CA detailed the ongoing work on system transformation highlighting the CCG's appointment of a Turnaround Director whose role included reviewing QIPP programmes, undertaking confirm and challenge around current QIPP programmes, and providing learning on aligned incentive contracts from elsewhere in the Sustainability and Transformation Plan. Triangulation of programmes, performance and QIPP for 2017/18 was taking place to inform the forecast end of year position for 2017/18 and the 2018/19 baseline position.

DB commended the clarity of presentation of the Integrated Performance Report.

The Committee:

Received the month 7 Integrated Performance Report.

12. Performance Review: Cancer 62 Day Performance Delivery

JH explained that, as well as being Service Delivery Lead for North Yorkshire and Humber Clinical Networks Team, he represented the CCG at the Cancer Alliance. He presented the report which provided a stocktake of work around the 62 day cancer performance, the current trajectory for recovery and all actions driving this recovery.

JH explained that Cancer Alliances across Sustainability and Transformation Plan footprints had replaced the former Cancer Clinical Networks with the long term aim of eventually becoming the lead body for delivery of cancer services but more immediately developing a cancer transformation plan for 62 day performance. Nationally, the North of England had better performance than most of the country but within that the Humber, Coast and Vale had the worst performance for 62 day waits.

The Humber, Coast and Vale Cancer Alliance had identified priorities for focusing work with providers as:

- Pathways for Lung, Prostate, Head and Neck, and Upper Gastro Intestinal
- Short, Medium and Long Term access to diagnostics tests and reporting (across all diagnostic mediums)
- Timed pathways/Inter Provider Transfer Agreements
- Plans to implement 28 day diagnostic performance target

JH noted that York Teaching Hospital NHS Foundation Trust was actively engaged in the work and had also received additional funds for short term measures, namely c£100k for additional MRI capacity at Malton Hospital. He also highlighted challenges due to the requirement to manage referrals to three providers and advised that, although there were specific local issues, workforce issues were national and would take time to address.

In response to members seeking clarification about expectations of local performance JH explained that, as demand could not be anticipated, it was difficult to give accurate trajectories. He also noted impact from such as a consultant either leaving or being on sick leave. JH advised that work was taking place with the regulators in terms of data and that York Teaching Hospital NHS Foundation Trust was undertaking a risk assessment of not meeting trajectories. He also detailed the robust communications for performance monitoring and assurance purposes.

JH explained that a number of breaches were legitimate, such as a patient wishing to take time to consider their treatment, and referred to the Clinical Harm Review if a patient waited more than 104 days for their first treatment. In response to MC seeking clarification as to whether this constituted harm and was declared as a Serious Incident by the provider, CA advised that this would be picked up via sub contract management board.

Discussion ensued in the context of service delivery by the Cancer Alliance and the need for the CCG to be assured about impact on patients. DN also noted the CCG's responsibility for considering consultation in the event of patients being moved out of area and the need for consideration of arrangements for their return to the local system. KR additionally expressed concern in this regard in light of specialist services being developed at Leeds Teaching Hospitals NHS Trust and South Tees Hospitals NHS Foundation Trust.

The Committee:

1. Received the review of current performance in relation to the 62 day cancer recovery plan and associated concerns.
2. Agreed to receive a further report at a future meeting.

13. Key Messages to the Governing Body

- The Committee noted the continued financial pressure facing the CCG particularly, from York Teaching Hospital NHS Foundation Trust which was set to exceed forecasts. The resources of the CCG had wider application than York Teaching Hospital NHS Foundation Trust alone. The Executive was authorized to continue to lever a clear outcome for the current financial year, with an agreed target figure as soon as possible.
- The Committee noted that SP and KR would meet with the Head of Internal Audit to discuss concerns over recent internal audits of the Partnership Commissioning Unit in light of further serious emerging concerns.

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 21 December 2017.

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	22 November 2017
Chair	Keith Ramsay

Areas of note from the Committee Discussion

- The Committee noted the financial implications for the CCG from the prescribing budget in respect of No Cheaper Stock Obtainable drugs.
- The Committee agreed that a number of estate proposals be progressed, including a shared development in Easingwold and Tollerton Surgery development.
- The Committee noted that General Practice within the CCG was overall rated 'Good' by the Care Quality Commission.
- The Committee understood the complexity for the CCG in procuring additional services and ensuring the right balance between procurement and support for Practices.

Areas of escalation

- Impact on the financial plan from No Cheaper Stock Obtainable in relation to the prescribing budget

Urgent Decisions Required/ Changes to the Forward Plan

N/A

**Minutes of the Primary Care Commissioning Committee held on
22 November 2017 at West Offices, York**

Present

Keith Ramsay (KR) - Chair	CCG Lay Chair
Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Dr Kev Smith (KS)	Executive Director of Director of Primary Care and Population Health

In Attendance (Non Voting)

Laura Angus (LA) – for item 10	Lead Pharmacist
Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Rachel Cooke – for item 10	Head of Finance
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Andrew Phillips (AP)	Joint Medical Director
Stephanie Porter (SPo) – for item 14	Deputy Director – Estates and Capital Programmes
Michèle Saidman (MS)	Executive Assistant
Sharon Stolz (SS) – part	Director of Public Health, City of York Council.

Apologies

Kathleen Briers (KB)	Healthwatch York Representative
Dr Aaron Brown (AB)	Local Medical Committee Liaison Officer, Selby and York
Dr Shaun O'Connell (SOC)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer

Unless stated otherwise the above are from NHS Vale of York CCG

There were two members 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. He particularly welcomed KS to his first meeting of the Committee.

2. Apologies

As noted above.

3. Declarations of Interest in Relation to the Business of the Meeting

LB declared an interest in item 14. All other declarations in relation to the business of the meeting were as per the Register of Interests.

4. Minutes of the meeting held on 19 September 2017

The minutes of the meeting held on 19 September were agreed.

KS noted that since the last meeting clarification had been received from NHS England in relation to the £3.34 per head funding for 2018/19 for extended hours access which was now as per the report at agenda item 11.

The Committee

Approved the minutes of the meeting held on 19 September 2017.

SP joined the meeting

5. Matters Arising

PCCC26 Primary Care Commissioning Financial Report – Proposal for pilot initiatives for testing GP led services in localities during the winter months: Discussion was ongoing with the Council of Representatives linked with the £3 per head and PMS Premium monies.

PCCC27 General Practice Visits and Engagement – Briefing Summary: PM reported on discussion with the Council of Representatives about redesigning the Governing Body to a clinical model with a clinical chair. A number of options were being developed for consideration by the Governing Body on 7 December prior to discussion at the December meeting of the Council of Representatives. PM explained that expressions of interest were being sought for the role of clinical chair by 1 December.

A number of other matters arising were noted as agenda items.

The Committee:

Noted the updates.

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6. Primary Care Commissioning Committee Terms of Reference

PM noted that the Committee's terms of reference were in line with national requirements but would require further review following the appointment of a clinical chair and the overall redesign of the Governing Body from April 2018.

Members agreed that KS be added to the membership of the Committee and that section 13 under *Role of the Committee* should be amended to read: *'The functions of the Committee are undertaken in the context of commissioning to increase quality, efficiency, productivity, and value for money ...'*

The Committee:

Approved the Primary Care Commissioning Committee Terms of Reference subject to the above amendments.

7. Primary Care Commissioning Financial Report

MA-M presented the report which provided information on financial performance of primary care commissioning as at month 7. He noted that, although there was an overspend of £240k on the forecast outturn against plan for the reasons detailed, the actual forecast was within the £42.037m allocation. This £240k overspend included an underspend of £223k for the PMS premium as this is forecast to be fully spent within the CCG's core allocation as per NHS England advice, although to date a limited number of invoices had been submitted for this. With regard to the latter KS reported on discussion at the Council of Representatives emphasising that moving this money out into primary care was a priority. He noted that work was taking place to achieve this taking account of the fact that some Practices wished to receive their share direct whilst others supported pooling within their locality; any underspend would be carried forward to 2018/19.

Members sought and received clarification on a number of aspects of the report, including confirmation from MA-M that the net forecast was correct and that there was a six year timeframe for eligibility to submit maternity claims. The latter was noted as an issue in terms of forecasting expenditure.

In response to clarification sought regarding Quality and Outcomes Framework points, MA-M explained that the 2017/18 forecast was based on points earned in 2016/17 as the full year information would not be available until June 2018. LB noted that Practices focused on Quality and Outcomes Framework targets from January to March.

SP referred to the Internal Audit report following the demise of the Vale of York Clinical Network and sought assurance that lessons had been learnt regarding processes for the PMS Premium monies. MA-M responded that the eligibility and processes were clear and specific for the three areas of expenditure, namely:

- i) Costs to support GP attendance at Locality meetings, Unplanned Care Steering Group meetings and Accountable Care System Partnership Board.

- ii) Funding to support a GP lead in each of the localities who will work across their locality to develop the programme of work and secure engagement with each locality's constituent Practices to develop their sustainability and manage demand.
- iii) Any remaining funding should be offered through localities to support constituent Practices in the management of demand. A 'plan on a page' was required for this element.

MA-M also advised that any invoice would need to be backed up by appropriate supporting evidence as part of any payment.

KS advised that he was writing to Practices reiterating the processes for accessing the components and also taking account of the discussion at the Council of Representatives. Practices would be asked to 'opt in' if they supported the locality approach and wished to pool their share of the monies. SM emphasised that an audit trail was required.

Post meeting note: Letter from KS sent to Practices on 22 November confirming the funding arrangement for PMS and £3 per head monies for the remainder of 2017/18.

The Committee:

1. Received the report on the financial position of the Primary Care Commissioning budgets as at month 7.
2. Noted the update on the PMS Premium monies.

SS joined the meeting

8. General Practice Visits and Engagement Update

AP referred to the report and discussion at the previous meeting of the Committee noting that further consideration on engagement with Practices was required now that KS was in post. He emphasised that support from the Practices was crucial to the CCG's work.

KS explained the need for Practices to receive support in their provider role and in the context of working together to ensure viable and sustainable General Practice. LB added that an understanding was needed between individual Practices, for example in respect of variation, to enable progress to be made.

In response to KR requesting a plan for the next meeting PM explained that the Head of Legal Services and Governance was reviewing the CCG's overall governance arrangements to ensure there was a "firewall" for appropriate protection, including in terms of supporting General Practice as both commissioners and providers. Provision of a plan for engagement would be aligned with this process.

SS highlighted the availability of other resources, including Public Health and the voluntary sector, noting that a system approach would contribute towards ensuring sustainability of General Practice.

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The Committee:

Noted the update and ongoing work.

LA and RC joined the meeting

10. Prescribing Indicative Budgets

LA referred to the report which provided an update on Prescribing Indicative Budgets in response to the Committee's request. She additionally explained that a national risk had emerged which posed a £2.6m potential pressure to the CCG. This was due to No Cheaper Stock Obtainable which meant that generic drugs were not available therefore more expensive alternatives had to be prescribed. The shortages related to specific commonly prescribed drugs and it was not possible to mitigate against this. NHS England was working nationally to resolve the position and the CCG was working with the GP Federations as, unless there was a national resolution, there would be no gain share.

KS emphasised that, despite the current position, Prescribing Indicative Budgets were the most appropriate means of managing controllable prescribing expenditure and welcomed the culture change in this development. He reported that open discussion was taking place with Practices about the impact on the gain share opportunity and also noted that Practices expressing an interest in joining the Prescribing Indicative Budgets scheme were being advised that this was not the right time. KS additionally explained, in terms of the process, that the CCG was not recouping the money paid in respect of mobilisation / advanced sum payment made to Practices for Prescribing Indicative Budgets.

LA reported a further issue: the Government had issued a requirement for savings from Category M drugs to be held back until the end of the financial year therefore this potential means of offsetting the No Cheaper Stock Obtainable loss of savings had been removed.

Members noted that, despite the issues described, patients were receiving medication but the impact was on available money in the system. SS agreed to liaise with Healthwatch to raise awareness of the situation and to facilitate lobbying local MPs.

In response to clarification sought about contract arrangements relating to Prescribing Indicative Budgets LA explained that there was a Memorandum of Understanding between the CCG and the Practices which included a commitment to the mobilisation money, the details of how the Indicative Budgets operated and the payment arrangements including what any gain share could be spent on. A contract variation was required for the fact that the Category M gain share would not be

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available. MA-M added that as a result of lessons learnt legal advice had informed the Memorandum of Understanding, including regarding withdrawal by either side. He also noted that the CCG had agreed to continue to pay the mobilisation money in recognition of Practices' commitment and costs incurred to date and highlighted that the No Cheaper Stock Obtainable should be temporary. LA added that the CCG still held the budgets therefore Practices could withdraw at any time.

SP noted the following concerns to which KS and LA responded. Regarding the No Cheaper Stock Obtainable there was tension between payment of the mobilisation costs but recognition a commitment had been made. However, Category M savings were fortuitous, not the result of any work by Practices, therefore it was debatable whether there should be any payment. KS also advised that the Memorandum of Understanding was explicit that the mobilisation costs could only come out of savings.

With regard to the governance arrangements for approval of Prescribing Incentive Budgets SP referred to the Committee's Terms of Reference and queried the fact that the scheme had never been brought to the Committee for consideration. KS agreed that the Committee should have seen the Prescribing Incentive Budget scheme but expressed confidence having reviewed it.

In response to SP referring to the alternative approach of a points based scheme rather than indicative budgets, LA explained that not all Practices had wanted to implement Prescribing Incentive Budgets. She offered assurance that areas of mobilisation could be measured and noted the aim was for a culture change to ownership of budgets.

Further discussion included the fact that CCGs across the country were affected by the unforeseeable financial pressure from No Cheaper Stock Obtainable drugs, an issue that had never previously arisen to this degree; the potential for CCGs collectively to respond; and recognition of impact on patients which required communication to assure them that the issue was not the fault of GPs or pharmacists.

PM expressed appreciation for the work on Prescribing Indicative Budgets and apologised for the error of the scheme not being presented to the Committee prior to implementation. PM noted that he would raise the No Cheaper Stock Obtainable issue with NHS Clinical Commissioners.

KR requested an update to the March meeting of the Committee.

The Committee:

1. Received the Prescribing Indicative Budgets report.
2. Noted the financial risk relating to No Cheaper Stock Obtainable drugs.
3. Requested an update to the March meeting

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9. Draft Primary Care Assurance Report

MC explained the development of the draft Primary Care Assurance Report, including agreement with the Council of Representatives of a set of quality performance indicators and the context of seeking assurance of good primary care in the same way as assurance was sought in respect of other providers. It was proposed to provide an annual report to the Committee with subject-specific reports through the year as appropriate. MC noted that this was an assurance report, not a dashboard, and it provided an overview from available information.

With regard to the data SM explained that availability varied with some data being published nationally on an annual basis. He referred to the fact that the quality of General Practice in the Vale of York was good but highlighted opportunities for more detailed specific work with Practices noting the need for local data in this regard.

Members discussed the report from the perspective of opportunity to address variation, for example in respect of Atrial Fibrillation, noting the need to recognise that Practices varied in terms of characteristics and constraints for resources to provide information. SS also noted the need to address quality and health inequalities and sought clarification as to the most appropriate opportunities for the Public Health Team and YorWellbeing Service to engage with primary care and provide “wrap around” support for General Practice.

KS highlighted the need to engage with the public in terms of people knowing their own health and for the CCG to focus on bringing together data sources to enable both variation and commonalities to inform work. In response to DB enquiring where issues would be addressed, such as the Atrial Fibrillation and anti-coagulation information in the report, KS advised that this data was a reflection of recording not necessarily a reflection of practice. He also emphasised the need for more real time information and, in the context of ‘Good’ Care Quality Commission rating for General Practice in the Vale of York, noted that each Practice would also identify their areas of priority through receiving data.

PM noted that AB had recently started a Twitter commentary about quality in and pressure on General Practice. This had elicited responses from a number of organisations and provided an opportunity to learn from best practice regionally and nationally.

It was agreed that the Primary Care Assurance Report would be a standing agenda item.

The Committee:

1. Received the report as assurance that all Vale of York Practices were currently meeting the required national standards across Care Quality Commission and patient satisfaction domains.

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2. Agreed to oversee development of further reports, with more timely and locally sourced information, that provided a greater insight into some of the operational quality and safety issues affecting General Practice that support a programme of continuous improvement.
3. Agreed that a CCG working group be formed whose role would be to identify and provide support to Practices around any outliers or exceptions in the reporting data presented to the Committee and to update the Committee on any related actions. The working group would work closely with the Local Medical Committee to access additional locally sourced information/data from Practices that supported an open and transparent reporting culture and helped Practices to develop continuous improvement programmes of work.
4. Agreed that the Primary Care Assurance Report be a standing agenda item.

11. General Practice Forward View, Improving Access to General Practice Services

SM presented the report which provided an update on national guidance and local progress on the General Practice Forward View requirement to provide improved access to General Practice services during evenings, to 8pm, and at weekends. SM noted that, following discussion at the Council of Representatives to progress this on a locality basis, he had met with the three localities who were adopting different approaches, as described in the report.

SM highlighted the additional guidance and information from NHS England webex sessions which provided further clarity on the funding allocation and service provision requirements noting areas of flexibility but confirming that some form of provision was initially required on Saturdays and Sundays. SM also explained that GP oversight was required but not necessarily in every hub and that there was no individual Practice requirement to participate. The locality approach would provide support in respect of the latter.

SM advised that since the report had been written NHS England had stated that procurement was the favoured approach to securing the additional services. He highlighted that the CCG had hoped to proceed through the localities noting complexities if the services were not provided as a continuation of core GMS services, such as technical and practical issues for sharing patient records and continuity of care. LB also expressed concern regarding continuity of care supporting the approach of General Practice as providers of the additional hours.

KS described the complexity for the CCG to fulfil the legal requirements as a commissioner and at the same time support Practices to be able to bid in a procurement process. He assured members that this would be undertaken appropriately and in consultation with the Council of Representatives.

SP noted that Conflict of Interest guidance would ensure correct processes and also referred to the potential for the required clinical input to be from outside the CCG. KS advised that procurement preparation work was already taking place and PM noted the potential for "buddying" arrangements.

The Committee:

Received the update on General Practice Forward View, Improving Access to General Practice Services

12. Improving Access to General Practice Survey - Patient Engagement

In presenting this item HM highlighted that consultation had already taken place with both the Healthwatch Readability Panel and Practices. She noted that feedback included criticism that the consultation was on parameters set by NHS England relating specifically to evenings and weekends and concern that there may be a deterioration in services due to the increase being provided with no additional capacity. HM also explained the requirement to evaluate the impact of the increased access from the additional funding.

Discussion ensued on the generic term 'clinician' and the potential to be more specific, which would also inform workforce planning.

HM requested that members provide any further feedback direct to her as amendments could still be made to the survey prior to its "Go Live" date in early January.

The Committee:

1. Agreed the NHS GP Services Improving Access Survey.
2. Agreed the 'Go Live' date of the first week in January 2018.

13. Personal Medical Services Monies 2018/19

SM explained that 2018/19 was the final year of the four year programme for redistribution of the Personal Medical Services (PMS) Premium monies noting that Dr Paula Evans, Chair of the Council of Representatives, had requested consideration by the Committee to enable distribution to Practices as early as possible in the new financial year. He advised that c£80k of the c£312k available had in principle been committed to the Shared Care Amber Drugs Local Enhanced Service; the remainder was to be redistributed across Practices.

SM described the context and principles for the redistribution: Practices felt they should have the option to access the funding individually or pool the resource; the requirement for a clear audit trail for the allocation and spend; and there should be additionality to core General Medical Services (GMS).

KS referred to the earlier discussion at agenda item 7 and discussion at the Council of Representatives regarding both the £3 per head and PMS premium monies, noting the difference between the two resources. The Council of Representatives had agreed that the £3 per head monies would be carried forward to 2018/19 as it was too late in the financial year to demonstrate the required return on investment. KS also noted that, despite being under legal Directions and the fact that £3 per head was discretionary, the CCG was carrying forward the full amount.

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KS proposed that criteria for the 2018/19 £3 per head bids and the PMS Premium monies be developed in consultation with representatives from the localities and the LMC for consideration at the December Council of Representatives. He sought delegated authority from the Committee to progress principles for both these monies with reporting to the January meeting of the Governing Body and ratification at the January Primary Care Commissioning Committee. It was agreed that KR and KS have delegated authority.

The Committee:

1. Noted the update on both Personal Medical Services 2018/19 premium monies and £3 per head.
2. Agreed that KR and KS should have delegated authority to progress development of principles for the above primary care funding.

15. NHS England Primary Care Update

The Committee:

Noted the updates on the Quality and Outcomes Framework and the GP Forward View.

LB left the meeting table and sat with members of the public due to her declaration of interest in item 14. SPo joined the meeting.

14. Presentation of the Proposed Primary Care Estates Investment Bids Detailing the Revenue Impact for Approval by the CCG

In introducing this item MA-M expressed appreciation to SPo for her work with Practices. He noted that the approval of the bids included confirmation that the CCG understood how any revenue increase would be funded.

SPo presented the report which sought approval of a number of bids to the Estates and Technology Transformation Fund (ETTF) which required sign off by the CCG, and specifically by TP. Approval was also sought for a separate bid from Tollerton Surgery which was no longer included in ETTF bids following the prioritisation of proposed schemes.

SPo explained that ETTF was a capital injection that abated the rent giving the benefit of lower rent. She noted that all new build ETTF schemes were dependent on revised GMS Premises Directions which were currently being considered.

In considering the ETTF schemes members noted that if approval was given CCG communication with Practices would make it clear that reimbursement of fees incurred by Practices would only be undertaken if there was a successful ETTF bid.

Easingwold Integrated Care Centre - New Build

SPo noted that Easingwold Integrated Care Centre had been a Cohort 3 scheme in the original bids. She detailed the work undertaken with York Teaching Hospital NHS Foundation Trust and Hambleton District Council to understand the impact of

future housing developments on service delivery and reported that a site had been identified to co-locate existing renal services, Millfield Surgery and the services currently at Easingwold Health Centre in phase 1. Tollerton Surgery and Stillington Surgeries had declined to be involved in phase 1 of the development.

Members sought clarification on a number of aspects of the bid. In response to concerns that York Teaching Hospital NHS Foundation Trust was the lead organisation, particularly in view of their current financial challenge, SPo explained that the Trust was in effect the developer and that the site would still be available if this option was not progressed. With regard to delivery of primary care SPo confirmed that this remained the function of the GP Partners but leasing premises provided an opportunity in terms of workforce. MA-M confirmed that the Finance Team was assured about the financial consequences of approval and SPo confirmed that schemes commenced within the timescale of the ETTF, which would end in 2019/20, would progress.

Additionally, whilst recognising that Millfield Surgery was in the top five premises undersized for the current patient list size, further discussion included the context of giving approval in isolation from a primary care strategy. SM advised that a strategic review was taking place to prioritise schemes.

The Committee:

Approved progressing the Easingwold Integrated Care Centre to the next decision stage: submission of a fully worked up Project Initiation Document to NHS England and progress to the development of the Outline Business Case.

Sherburn Group Practice and South Milford Surgery - New Build

SPo explained that the site proposed for the Sherburn Group Practice and South Milford Surgery was equidistant between the two existing properties and the Practices were working with a third party provider, Apollo, to deliver the scheme. Progress was also dependent on receipt of a number of capital grants as detailed in the report.

Members sought clarification about due diligence in respect of Apollo and also in terms of CCG liability in the event of the funding failing. SPo advised that, as this was a GP not a CCG scheme, the CCG would not carry any liability in these circumstances. She also highlighted that any material change would require the proposal to be resubmitted to the Executive Committee for review and an additional approval stage before Outline Business Case.

The Committee:

1. Approved progressing the Sherburn Group Practice and South Milford Surgery new build to the next decision stage: submission of a fully worked up Project Initiation Document to NHS England and concluding the discussions to understand the likely capital grant contribution to the scheme.
2. Noted that if the scheme had to be reworked and this did not arrive at a revenue neutral position to the CCG then the proposal would need to be resubmitted to the Executive Committee for review and an additional approval stage before Outline Business Case.

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Burnholme Scheme - New Build

In discussion of this scheme MA-M referred to his declaration on the Register of Interests that his partner worked at a Practice involved in the Burnholme development.

SPo described the proposed new build for the Burnholme Scheme which would enable co-location of health, social care and voluntary sector services. The property would remain in the ownership of the GP Practice and GPs would lead development of the scheme. MC expressed support for this scheme in the context of housing development and addressing health inequalities in the area.

Discussion included the context of the CCG's out of hospital strategy, potential to seek funding contribution from the Local Authority and explanation as to the mechanism for attracting capital to extend their business if the GP Practice owned the premises. In respect of the latter HM explained that there were two options: NHS England's business as usual capital funding, which was a capital grant for improvement to premises and for which there would be an agreed period rent abatement, or alternatively borrowing money as a business. HM also explained that if a property was extended without prior agreement from the CCG, then the CCG was not obliged to abate the rent and that the CCG would only reimburse for GMS. The potential for void space arrangements also required consideration.

Members agreed the recommendation subject to the addition of a caveat providing clarity in relation to the GMS element of the additional space. MA-M agreed to progress this and report back to the Committee.

The Committee:

Approved progressing the Burnholme Scheme to the next decision stage: submission of a fully worked up Project Initiation Document to NHS England and concluding the discussions to understand the likely capital grant contribution to the scheme subject to clarification relating to the GMS element of the additional space.

Carlton Branch Surgery – Expansion of Existing Property

SPo reported that the proposed Carlton Branch Surgery extension was to manage patient list size growth and would be on the basis of an improvement grant. The Practice owned the site, there were no boundary issues and the scheme was well advanced technically.

The Committee:

Approved progressing the Carlton Branch Surgery development to the next decision stage: submission of a fully worked up Project Initiation Document to NHS England and progress to the development of the Business Case.

Tollerton Surgery - Non ETTF Estates Bid

SPo reiterated that Tollerton Surgery had not wished to be part of phase 1 of the Easingwold Integrated Care Centre scheme but wished to continue to pursue the more developed option to replace their existing premises via Daniel Garth Homes,

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noting however that they did support clinical transformation. The Practice had requested specific consideration of their proposal, which was for full revenue reimbursement, as the scheme was developed and could deliver an interim or long term solution for the Practice much quicker than the larger scheme in Easingwold; the scheme was likely to be delivered in 12-16 months; the proposal addressed the significant space constraints for the Practice as identified in the CCG estates strategy and it represented value of money.

Members sought and received clarification on financial aspects of the proposal. It was noted that funding of the £62k capital request, which included stamp duty, would be required from the CCG's primary care commissioning budgets. However, the potential for access to the business as usual grant should be pursued.

Detailed discussion ensued with recognition of the Practice's significant space issue but concern that the proposed new development may not align with the strategic transformation for the locality, which was not yet clearly identified. Members also discussed potential risk to the CCG of being left with the premises in the event of the Practice deciding to join the Easingwold development before the end of the proposed 15 year lease. SPo explained that the risks at the present time were: the current cost, the impact of not securing capital grant and responsibility for the lease. She also confirmed that the Practice owned the building from which they were currently delivering services; any sale would be on the basis of risk and reward.

Members agreed that the bid should be supported in principle in the best interests of patients but highlighted that this in no way set a precedent and emphasised the need for further detail regarding full costs, including in respect of reimbursement of stamp duty, and the expectation that the Practice would engage with the system transformation.

SPo noted that all schemes would be presented to the Committee again when costs had been confirmed.

The Committee:

Supported the Tollerton Surgery bid in principle subject to confirmation of full cost implications, clarification about reimbursement of stamp duty, and commitment to engage with the wider primary care strategy in the locality.

16. Key Messages to the Governing Body

- The Committee noted the financial implications for the CCG from the prescribing budget in respect of No Cheaper Stock Obtainable drugs.
- The Committee agreed that a number of estate proposals be progressed, including a shared development in Easingwold and Tollerton Surgery development.

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- The Committee noted that General Practice within the CCG was overall rated 'Good' by the Care Quality Commission.
- The Committee understood the complexity for the CCG in procuring additional services and ensuring the right balance between procurement and support for Practices.

The Committee:


Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

17. Next meeting

9.30am on 24 January 2018 at West Offices.

18. 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.

Item Number: 22	
Name of Presenter: Dr Shaun O'Connell	
Meeting of the Governing Body Date of meeting: 4 January 2018	 Vale of York Clinical Commissioning Group
Report Title – Medicines Commissioning Committee Recommendations October and November 2017	
Purpose of Report For Information	
Reason for Report These are the latest recommendations from the Medicines Commissioning Committee (October and November 2017).	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Covalent Risk Reference and Covalent Description
Emerging Risks (not yet on Covalent)	
Recommendations For information only Clinical Executive Committee have approved these recommendations	

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Recommendations from York and Scarborough Medicines Commissioning Committee October 2017

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	TA471 : Eluxadoline for treating irritable bowel syndrome with diarrhoea		<p>Eluxadoline is recommended as an option for treating irritable bowel syndrome with diarrhoea in adults, only if:</p> <ul style="list-style-type: none"> the condition has not responded to other pharmacological treatments (for example, antimotility agents, antispasmodics, tricyclic antidepressants) or pharmacological treatments are contraindicated or not tolerated, and it is started in secondary care. <p>Stop eluxadoline at 4 weeks if there is inadequate relief of the symptoms of irritable bowel syndrome with diarrhoea.</p> <p>Specialists have indicated that only patients refractory to diet measures, loperamide and a TCA would be considered which is said to be uncommon.</p> <p>The pathway for review of treatment benefit at 4 weeks and further supply in a timely manner (if needed) requires clarification from specialists. In the meantime, the group agreed that eluxadoline should be added to the formulary as an Amber Specialist Initiation drug in line with TA471.</p>	Amber Specialist initiation	<p>Annual cost per patient = £1,146.60</p> <p>Estimated patient numbers from YFT specialists is less than 10 patients per year.</p>
2	TA474 : Sorafenib for treating advanced hepatocellular carcinoma		<p>Sorafenib is recommended as an option for treating advanced hepatocellular carcinoma only for people with Child-Pugh grade A liver impairment, only if the company provides sorafenib within the agreed commercial access arrangement.</p>	Red	<p>No cost impact to CCGs as NHS England commissioned.</p>
3	TA475 : Dimethyl fumarate for treating moderate to severe plaque psoriasis		<p>Dimethyl fumarate (Skilarence®) is recommended as an option for treating plaque psoriasis in adults, only if the disease:</p> <ul style="list-style-type: none"> is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and has not responded to other systemic therapies, including, ciclosporin, methotrexate and PUVA 	Red	<p>Cost saving compared to use of unlicensed Fumaderm® and biologics.</p> <p>Annual cost of Skilarence® 120 mg to 720 mg per day = £771.68 to £4,630.08</p> <p>Current patient numbers: Vale of York – 4 patients; dose range</p>

		<p>(psoralen and long-wave ultraviolet A radiation), or these options are contraindicated or not tolerated.</p> <p>Stop dimethyl fumarate treatment at 16 weeks if the psoriasis has not responded adequately. An adequate response is defined as:</p> <ul style="list-style-type: none"> • a 75% reduction in the PASI score from when treatment started or • a 50% reduction in the PASI score and a 5-point reduction in DLQI from when treatment started. <p>The proposed place in therapy by YFT dermatology specialists is as a further option to be used in a similar way to the agreed use of apremilast i.e. those with a contraindication/intolerance to biologics, in exceptional cases for those who have a significant psychological problem with injections, or if biologics had failed.</p> <p>A cohort of patients were on treatment with Fumaderm® - an unlicensed product containing dimethyl fumarate as the main active ingredient; these patients have been switched to Skilarence® - 4 patients each in York and Scarborough. Fumaderm was on the formulary as a Red drug for specialist use only but the Trust has proposed that patients who have been successfully switched to Skilarence be transferred to the GP for ongoing prescribing. The suitability of primary care prescribing of Skilarence requires further assessment. In the meantime, the group agreed that it should be added to the formulary as a Red drug.</p>		<p>120 mg to 360 mg daily Scarborough – 4 patients; dose range 120 mg to 720 mg daily</p> <p>As a NICE approved licensed drug, there may be slightly more use than unlicensed Fumaderm, however specialists do not expect the numbers to change greatly, and it may delay or avoid the need for biologics in some patients.</p>
4	<p>TA476: Paclitaxel as albumin-bound nanoparticles with gemcitabine for untreated metastatic pancreatic cancer</p>	<p>Paclitaxel as albumin-bound nanoparticles (nab-paclitaxel) with gemcitabine is recommended as an option for untreated metastatic adenocarcinoma of the pancreas in adults, only if:</p> <ul style="list-style-type: none"> • other combination chemotherapies are unsuitable and they would otherwise have gemcitabine monotherapy and • the company provides nab-paclitaxel with the discount agreed in the patient access scheme. 	Red	<p>No cost impact to CCGs as NHS England commissioned.</p>
5	<p>RAG status for Spiolto Respimat®</p>	<p>It had been identified that Spiolto Respimat® (tiotropium and olodaterol) is currently on the formulary as an amber drug for COPD. However this is not in line</p>	Green	<p>Confirmation of RAG status</p>

		with the COPD pathway as other LABA/LAMA combinations for COPD are on the formulary as green drugs. Therefore a green status was agreed for Spiolto Respimat®.		
6	Non-transplant indications for mycophenolate	<p>A shared care guideline for mycophenolate use for non-transplant indications is currently in development. Non-transplant indications are unlicensed and have not previously been formally approved by the committee. The group approved the inclusion of the following indications on the basis that there is information available supporting the use of mycophenolate for these indications and they are recognised uses of mycophenolate. In addition, these indications were found in mycophenolate shared care guidelines from other areas. The Trust has historically used mycophenolate for these indications.</p> <ul style="list-style-type: none"> • connective tissue disease • vasculitis • systemic lupus erythematosus • dermatomyositis • polymyositis • severe psoriasis • severe atopic dermatitis • blistering conditions • pyoderma gangrenosum • autoimmune bullous dermatoses (e.g. pemphigus) • uveitis • scleritis 	Amber Shared Care	No significant cost impact expected as use for these indications is current practice.

Recommendations from York and Scarborough Medicines Commissioning Committee November 2017

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	TA477 : Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee		Recommended as an option for treating symptomatic articular cartilage defects of the knee, only if: <ul style="list-style-type: none"> the person has not had previous surgery to repair articular cartilage defects there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) the defect is over 2 cm² and the procedure is done at a tertiary referral centre. 	N/A	No cost impact to CCGs as NHS England commissioned.
2	TA478 : Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma		Recommended as an option for treating relapsed or refractory systemic anaplastic large cell lymphoma in adults, only if: <ul style="list-style-type: none"> they have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 and the company provides brentuximab vedotin according to the commercial access agreement with NHS England. 	Red	No cost impact to CCGs as NHS England commissioned.
3	TA479 : Reslizumab for treating severe eosinophilic asthma		Recommended as an option for the treatment of severe eosinophilic asthma that is inadequately controlled in adults despite maintenance therapy with high-dose inhaled corticosteroids plus another drug, only if: <ul style="list-style-type: none"> the blood eosinophil count has been recorded as 400 cells per microlitre or more the person has had 3 or more severe asthma exacerbations needing systemic corticosteroids in the past 12 months and the company provides reslizumab with the discount agreed in the patient access scheme. 	Red	No cost impact to CCGs as NHS England commissioned.
4	TA480 : Tofacitinib for moderate to severe rheumatoid arthritis		Recommended as an option, with methotrexate, for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with a combination of conventional DMARDs, only if:	Red	Based on the list price, the average cost per patient for the first 6 months is estimated at £4,050.60, and for subsequent years £9,001.19. A Patient Access

		<ul style="list-style-type: none"> disease is severe (a disease activity score [DAS28] of more than 5.1) and the company provides tofacitinib with the discount agreed in the patient access scheme. <p>Tofacitinib, 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:</p> <ul style="list-style-type: none"> disease is severe (a DAS28 of more than 5.1) and they cannot have rituximab and the company provides tofacitinib with the discount agreed in the patient access scheme. <p>Tofacitinib can be used as monotherapy for adults who cannot take methotrexate because it is contraindicated or because of intolerance, when the criteria above are met.</p>		<p>Scheme is in place details of which are confidential.</p> <p>The guidance is not expected to have an impact on resources. YFT intend to continue using baricitinib which has similar recommendations (TA466) and is less costly than tofacitinib (when the PAS for both have been taken into account).</p>
5	<p>TA481: Immunosuppressive therapy for kidney transplant in adults (Updates TA85)</p> <p>TA482: Immunosuppressive therapy for kidney transplant in children and young people (Updates TA99)</p>	<p>Basiliximab, when used as part of an immunosuppressive regimen that includes a calcineurin inhibitor, is recommended as an initial option to prevent organ rejection in adults having a kidney transplant.</p> <p>Immediate-release tacrolimus (Adoport, Capexion, Modigraf, Prograf, Tacni, Vivadex), when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in adults having a kidney transplant. Tacrolimus granules for oral suspension (Modigraf) should be used only if the company provides it at the same price or lower than that agreed with the Commercial Medicines Unit.</p> <p>Mycophenolate mofetil, when used as part of an immunosuppressive regimen, is recommended as an initial option to prevent organ rejection in adults having a kidney transplant.</p> <p>Rabbit anti-human thymocyte immunoglobulin, prolonged-release tacrolimus, mycophenolate sodium, sirolimus, everolimus and belatacept are not recommended as initial treatments to prevent organ rejection in adults having a kidney transplant.</p>	<p>Tacrolimus, mycophenolate, sirolimus already on formulary as amber drugs and basiliximab already on as a red drug.</p>	<p>No cost impact to CCGs as NHS England commissioned.</p>

6	Dimethyl fumarate (Skilarence®) for plaque psoriasis RAG status review	Skilarence® was added to the formulary in line with TA475 as a red drug, replacing unlicensed Fumaderm®. The Trust proposed that patients successfully initiated on Skilarence® are transferred to the GP for ongoing prescribing therefore MCC reviewed the suitability of Skilarence® as an amber drug. The group agreed that Skilarence® should remain as a red drug taking into account monitoring requirements, safety issues, high cost & PbR excluded status of Skilarence, as well as other local area decisions.	Red	Previously approved in line with TA475; confirmation of RAG status.
7	Medroxyprogesterone acetate injection (Sayana Press®) for contraception RAG status review	Sayana Press® currently has a red RAG status on the formulary (restricted to family planning clinic use only). The group were asked to review this and consider a green status following requests from GPs to be able to prescribe Sayana Press to patients instead of Depo-Provera®. Both are progestogen-only long acting reversible contraceptives. However, Depo-Provera is administered by IM injection while Sayana Press is administered by SC injection. Unlike Depo-Provera, Sayana Press is licensed for self-administration by patients following adequate training which could save nursing time and free up appointments. The group noted that the Faculty of Sexual and Reproductive Healthcare supports self-administration of Sayana Press because of the potential benefits to women and services. The group agreed to a change of the RAG status from red to green.	Green	Comparative annual drug acquisition costs per patient: Depo-Provera: £26.04 (dosing every 12 weeks) Sayana Press®: £27.60 (dosing every 13 weeks)
8	RAG status of Depo-Provera®	Depo-Provera did not have a RAG status on the formulary. During discussions regarding the RAG status of Sayana Press, the group also agreed a green RAG status for Depo-Provera.	Green	Confirmation of RAG status.
9	RAG status of phenoxymethylpenicillin, co-amoxiclav and doxycycline	It was identified that these antibiotics do not have a RAG status on the formulary. The group agreed a green status in line with antibiotic guidance.	Green	Confirmation of RAG status.